

***Traumatic Stress in Care-Providers Responding to a Pediatric Mass Casualty
Event: The Ethics of Inadequate Training and Preparation in Regard to
Psychological/Moral Wounding***

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Traumatic Stress in Care-Providers Responding to a Pediatric Mass Casualty Event: The Ethics of Inadequate Training and Preparation in Regard to Psychological/Moral Wounding

Peter Sternberg, L.C.S.W. December 15, 2011

For many years there has been discussion in the emergency response community about the state of disaster preparedness especially when it comes to pediatric victims. Most of this discussion has been:

- a detailing of how children differ from adults in their susceptibility to greater and more rapid morbidity and mortality from toxic agents and physical wounding,
- about the availability of medical supplies that fit children, and
- determining proper pediatric doses of medications.

Government agencies and Universities have produced written and video material for health care providers and the public focused on various issues in disaster response such as decontamination and how to spot and respond to PTSD in children. The non-hospital medical community, the mental health community and schools have been informed that their personnel may all be called upon to help respond to a mass casualty event. Despite the attention and hand-wringing the topic of pediatric disaster response has drawn for years, there remain gaping holes in the training, drilling and common sense preparation for the rescuers, responders and health care providers.

In previous papers I have detailed issues regarding preparation, management and specific interventions (12) with children and their families *during the event* to expedite treatment and minimize lasting trauma (11). This paper completes the previous two by addressing the moral/ethical and practical issues that flow from the *disturbed conditions* that underpin care giving in a pediatric mass casualty event. This is perhaps the most daunting circumstance a rescuer, responder or health care provider will face.

An Outline of the Paper

I A Brief Story of a Mass Casualty Event

The scenarios of:

- the Policeperson,
- the Fireman,
- the Hospital Chaplain,
- the Housekeeper,
- the Discharge Planner and,
- the Emergency Services Coordinator

The scenarios 15 to 45 minutes later

II Did These Scenarios Need to Occur?

III Potential outcomes to the Scenarios

- Outcome Number 1 (the wish)
- Outcome Number 2 - a Picture of Traumatic Stress (the reality)

IV Review and Discussion of Outcome Number 2

V How Did this Happen?

VI The Forays into Ethics

VII What is Necessary

- Covenantal Social Contract
- Stress Inoculation

VIII Conclusion

As told to the author: The hospital administrator tells the hazmat decontamination instructor his services are no longer necessary. The instructor says to the administrator: “Without training, your staff will be in *extreme danger* if they have to respond to a hazmat situation.”

The hospital administrator replies: “*I’ll take that chance.*”

To experience the topic, imagine the following:

The Event:

A freight train passing through a community derails rupturing a tanker carrying an organophosphate compound (4). The prevailing winds carry the toxin throughout the community and within minutes the inhabitants in a two mile radius of the accident begin tearing. Included in the affected area are two grade schools, a middle school, a high school and two preschools. Before long the number of calls to EMS overwhelms the combined resources of the surrounding communities that have responded. The incident has become a mass casualty event. The scenarios you will now encounter unfold shortly after Public Health officials were notified that this is a mass casualty event.

The Scenarios:

- **The Policewoman** from the affected community has been called to a nearby hospital and told to set up a perimeter for the decon area. The hospital decontamination holding area is becoming crowded with children from the aforementioned schools. The area is being overrun with parents frantic to find their children. Residents and workers from the affected area are also flooding in. In their frantic state, the parents will not stay out of the decontamination area, further overwhelming the decontamination process. The policewoman is faced with the following:
 - She must try to establish order without using force.
 - Parents are refusing to be re-directed and pleading for assistance to find their children.
 - The policewoman witnesses children becoming ill and falling to the ground with no medical intervention forthcoming. She is powerless to intervene and

aghast at her job of keeping parents from their sick children.

There is no signage, prepared statements or practice in routing a victim surge into a locked down medical center. There has been no preparation to immediately route frantic parents coming to a locked down medical center into a fully staffed *Family Support Area*.

- **The Fireman** is at a grade school dressed in hazmat gear. The initial cloud has dispersed to the point that the Incident Commander orders field decontamination at the school. As they practiced many times, the fireman and his company set up a decontamination shower line and are ready to get the children and staff moving through.
 - They have some success getting the 5th and 4th graders to follow instructions to disrobe and move through the line. With the younger children it becomes more difficult to gain their cooperation. The younger children are visibly frightened by the firemen in their gear. The firemen had not practiced a contingency for getting frightened children through the line.
 - When a 1st grader starting down the line can no longer see his teacher in front of him he panics. He stops moving and starts screaming and the line behind him stops.
 - Other children begin crying and are frantically looking for their teacher. The fireman in his hazmat gear goes into the decon line to try get the children moving but the sight of him further terrifies the children. Some of them start to run. The children waiting to be decontaminated observe this scene and become agitated. Some run.
 - The fireman is being told via his headset to get the children through the line. He knows time is of the essence but he cannot get control of the situation. He becomes frustrated and increasingly anxious as he feels he is failing the

children and his company.

There has been no established protocol for linking the oldest children with the youngest and having them go through the shower line together holding hands. The children have not seen someone in hazmat gear before. The children, school staff and fire dept. have never had a drill. (12)

- **The Hospital Chaplain** has been told that her post is the ED and she is to respond to staff requests for intervention with patients who are in critical condition and also to frantic family members. The ED has never experienced an influx of patients like this before. And no staff member has been confronted with an influx of children in various states of distress. The chaplain is faced with the following:
 - The noise level in the ED is deafening and disorienting.
 - Conflicting urgent demands are made for her attention and do not stop.
 - She sees staff members becoming frustrated and overwhelmed.
 - Although she is a member of the hospital's disaster planning committee, she has never heard this situation discussed nor has the staff ever practiced this in a drill.
 - She begins to feel herself "out of her body" – witnessing but not involved in the scene around her. She is in shock.

The Chaplain and the ED have not drilled getting frantic parents to the *Family Support Area*. There are no protocols known to the ED staff and the Chaplain that guide her duties in this situation. (12)

- **The Housekeeper.** Among other hospital staff, members of the housekeeping staff are summoned to the decontamination prep area to form teams and "suit up" to

conduct decontamination. The Emergency Department RN in charge of the decontamination area is following a placard telling her how to suit up the decon team. Although she takes their vitals, no where on the card does it say that staff should be given fluids and nutrition prior to being sealed in the rubber hazmat gear. The suit-donning-team (staff members who assist others getting dressed in the hazmat suit) have never practiced affixing duct tape to the seams they are sealing and consequently leave no tab for the suited staff member to pull to get the tape off when it is time for suit removal. The Decon Boss has no anti-fogging agent for the mask her team is donning and applying an anti-fog agent is not part of her check list. The housekeeper, once suited, is faced with the following:

- Within two minutes of being suited up she can not see very well because her mask has fogged. This increases her sympathetic nervous system reaction which increases her body temperature, increases the fogging and increases the amount she is perspiring.
- The Decon Boss is yelling instructions to her but she can not hear very well due to the hood she is wearing. She makes it out to the Hot Zone where the decontamination will occur.
- She attempts to engage a victim and begin the decontamination process but finds that she can not communicate directions to the victims because of the mask she is wearing. She can be heard if she yells. There are no other arrangements for communicating with the victims.
- Within five minutes her breathing is rapid and she is feeling lightheaded. The exertion of trying to do her job in a sealed rubber suit has her sweating profusely. She heads out of the “hot zone” toward the “warm zone” but is told her shift is not over and the next team is not ready for entry. She heads back into her work. She does not feel well and is scared.

Since there have not been realistic drills, the information on the placard is accepted as adequate although it is untested and unmodified by the staff using it. Hence, critical details such as: tabs for tape removal, use of antifog agents, adequate hydration/nutrition, and basic methods of communication have been neglected. Staff members are having their *first experience in a hazmat suit during this event.* (12)

- **The Emergency Services Coordinator.** The Emergency Services Coordinator is standing 30 yards upwind of the decontamination holding area. Beside her are Fire Dept. and Police Dept. Lieutenants. They observe that in addition to EMS bringing new victims that supposedly have been decontaminated in the field, other victims are arriving on their own and all victims are co-mingling. They also observe that it is impossible to bring order to the ever swelling group. Small children are observed to be suffering serious effects of the toxin more rapidly than the adults in the group.
 - The Coordinator sees that there is a need for triage in the decon area but can not accomplish that because that contingency has not been thought through, planned for or staffed.
 - The Fire Lieutenant suggests decontaminating everyone in the group with their equipment but by now they do not have the manpower available to do this and there are children who are no longer on their feet and able to follow directions.
 - The Coordinator tries to give directions to the crowd but can not be heard amidst the pandemonium. She observes Security and Police attempting to keep parents away from the group by sending them to the outskirts of the area but they return to press toward the decon holding area yelling for their children.
 - After a bit more time the Coordinator observes children urinating on

themselves, drooling and having trouble breathing. She is horrified by the chaos and is overwhelmed with what she is witnessing. She is besieged by staff and administrators who are also at a loss. She thinks that administering Atropine may help stabilize the victims in the worst condition. She convinces the ED director that this is imperative. She knows the victims can not wait for her to get into hazmat gear so she goes into the decon waiting area without protective gear to administer by injection, as many doses as she can to the neediest victims.

The need for *Triage* in the decontamination area has been mentioned by various people for years but no protocols have been accepted or practiced to get the smallest victims to the front of the decon line or to medically treat victims while they are waiting to be decontaminated. See: *A Parking Lot Triage* in Sternberg, “Practical Considerations for Management of Pediatric Victims during Hazmat Decontamination” (12).

The Various Scenarios 15 to 45 minutes later at the hospital:

- **The Housekeeper and the Discharge Planner.** The housekeeper we met earlier has become tachycardic and dehydrated. As a result, she becomes unsteady and then faints. Fortunately one of her fellow team members is nearby, observes her becoming unsteady and eases her to the ground.
 - The team member who eased the housekeeper to the ground is a hospital discharge planner who has never before dressed in a hazmat suit. He felt a bit claustrophobic as the hood and mask were put in place. Last minute instructions given did not include the vital information to shower the youngest victims first.
 - The discharge planner had been sufficiently distracted from his claustrophobia by the scene he encountered until the housekeeper began to faint. He noticed

the Decon Boss yelling instructions to him from the “Warm Zone” as he dragged his teammate toward her.

- The decontamination of victims has stopped because everyone is attending to the fallen staff member. The victims in the waiting area who are not suffering worsening symptoms are becoming increasingly panicked. The tension level escalates.
- Through yelling and pantomime the discharge planner understands that to get the housekeeper into the Warm Zone he must remove the duct tape that is used to seal the seams of her hazmat suit. However with his gloves on and no tab having been created for removal, he cannot remove the tape. The discharge planner begins to panic. He already is having trouble seeing because his mask has fogged and he is sweating profusely.
- The Decon Boss sends her next team in but they are unclear as to whom they are to attend first. When the new team begins to shower the victims instead of aiding the housekeeper, the discharge planner, in complete panic, starts running and tearing at his hazmat suit. The Decon Boss in an act of desperation enters the “Hot Zone,” drags the housekeeper into the “Warm Zone” and cuts her out of the hazmat suit. She is breathing but unresponsive as she is taken to the ED for treatment. The “Warm Zone” is compromised.

The decon team having never been adequately trained, does not realize that their fallen comrade is always the first priority. The staff have no practiced set of actions to fall back upon during this highly adrenalized scene since almost everyone is having their very first experience in decontamination.

- **The Chaplain** has notified her *Hospital Incident Command* manager that she needs additional help and suggests that calls go out to the clergy in the community. The manager obtains the OK for this but says that they will have to be credentialed before

they can work in the hospital. The Chaplain is besieged by staff and families asking where families should go, how can they find their loved ones and how can they get updates on their loved ones status.

- The chaplain makes calls to the local clergy and gets assurances from half of them that they will respond. Due to the demands on her, the chaplain is unable to wait for them to arrive and complete the credentialing process. They will not be available for duty for at least 60 minutes. Consequently, after they arrive and are credentialed by the hospital, the community clergy do not know where to go or what is needed from them - further delaying their impact.
- The chaplain is encountering distraught parents that are with their very ill children and hysterical parents trying to find their children.
- The chaplain feels utterly overwhelmed and unprepared for the scene she is in and she continues to feel as though she is watching herself from outside of her body, while attempting to function as she goes from one encounter to the next.

Pre-credentialing resources from the community that may be needed in a crisis would have greatly reduced lag time and confusion. Prior orientation would have allowed these community chaplains to be immediately effective. (12)

- **The Fireman** and his company have managed to gather up most of the children although they realize some children are unaccounted for because they have run away or are hiding. They have modified the decon procedure, gotten most of the children rinsed and on buses to the hospital. They are now searching the building and grounds.
 - The fireman has found a couple of young children hiding together. Some of the children appear to be in serious physical distress; all are terrified or are in shock.

- After the last of the children have been deconned and sent to hospital, his company is called to the hospital where they are to help address the pandemonium outside the ED.
- The fireman is dejected by his sense of failure. He and his company are fearful about what they will encounter at the hospital. As a group they feel that what occurred at the school was a mess and they are depressed.
- **The Policewoman** observes a person in a hazmat suit wildly running away from the decontamination area, tearing at the hazmat suit. She is alarmed for that person and also wonders what is behind that behavior. She feels a rush of anxiety.
 - The policewoman sees the crowd waiting for decontamination looking startled at the suited staff person running away from the area. She sees panic spreading through the crowd.
 - Victims are approaching her with questions. Their distress escalates when she says she does not know what is happening.
 - She notices the victims moving toward the entrance of the showering area while hazmat suited staff are trying to keep them out. She calls her supervisor for direction. There is no policy or procedure for this situation. She feels lost, overwhelmed and horrified.
- **The Emergency Services Coordinator** has administered all of the Atropine injections the ED made available. She remains with the victims awaiting decontamination because she has been exposed to the contaminant. She watches with horror as the scene degenerates further:
 - more children are on the ground, some are seizing,
 - more parents are breaching the barrier and hysterically searching for their children,
 - a suited decon staff person is running from the scene – frantically tearing at the decon suit and,

- the crowd is pressing toward the entrance to the Emergency Department. She knows within a matter of minutes the ED will be breeched. She is psychologically overwhelmed, and mute from shock.

Did These Scenarios Need to Take Place?

Approximately 15 to 45 minutes into the event, each of our actors is suffering frank psychological and moral harm in part, because every one of these situations is largely preventable and/or correctable with adequate preparation and training. What might adequate preparation look like? Consider the points made in the boxes below in the previous scenario descriptions. For an in-depth treatment of this question see: “Practical Considerations for the Management of Pediatric Victims During Hazmat Decontamination,” 2005, 2011 at pediatricdisasterplanning.org and “Acute Crisis Intervention with Pediatric Victims and Their Families During a Mass Casualty Event,” 2005, 2011, at pediatricdisasterplanning.com. Both of those papers are by this author. Here is a quote from the second paper that touches on just one component of adequate preparation:

“We live our daily lives largely dismissing the possibility of mass casualty disasters – let alone disasters that have numerous pediatric victims. And we live our daily lives expecting and assuming that our rescue and healthcare systems will respond adequately to whatever befalls us. Here is an alternate vision:

In addition to education, (*excluding* “just-in-time education” which informs the individual of risks to their wellbeing *just prior* to their deployment) it is through periodic drills that the moral and practical obligation of preparation is fulfilled.

The drills ***must present realistic scenarios***, meaning staff are faced with:

- realistic numbers of victims - approximating true levels of distress,
- realistic time lines,
- realistic sounds,
- realistic pressure,

- realistic actors,
- and a realistic amount of time for the drill to unfold.

There is little reason to believe that the system will function without this level of preparation. There is little reason to think there will not be devastating sequelae at all levels from the failure to prepare.” (11)

We will consider why that training and preparation did not take place a bit later.

Potential Outcomes to the Scenarios

Outcome Number 1 (the wish)

Somehow, order was restored at the hospital and decontamination proceeded without further delay. The most sickened individuals were decontaminated first and received the medical attention they needed. The families were successfully routed to the *Family Support Area* – a large enough area where adequate numbers of staff assisted them in finding their loved ones, obtained information on the condition of their loved ones and facilitated reunion. Other trained staff were present to provide psychological first aid thereby minimizing the depth and duration of trauma. Once order was restored all of the actors we met were able to function and their personal sense of stress and pressure subsided to a manageable level. Once the event was over, rest, quiet, nutrition and debriefing allowed them to feel calm and restored. They learned that although it began in chaos, the event was successfully managed and their coordinated efforts preserved life and limb.

In the weeks following the incident, *Staff Support Services* were immediately established for outreach and follow-up. With the support of their supervisor, many of these actors, received help with lingering stress and referral for psychological treatment when needed.

Outcome Number Two – A Picture of Traumatic Stress (the reality)

The hospital’s ED was breached by contaminated victims who have panicked. As the victims rushed the ED the Police and Security Staff were at a complete loss. The Police and

Hospital Security were told to bring order to the ED, where they became exposed to contaminated victims. The chaos in the ED was not contained there and soon there were contaminated victims in various states of medical distress in many sections of the hospital.

This chaos resulted in the deaths of children and adults who otherwise could have been treated. It also resulted in an increased number of children and adults whose injuries became more severe due to delay in treatment. “Follow-up studies of individuals who have been exposed to high levels of organophosphorous compounds have shown that certain neurobehavioural changes may develop in them,.... these affects include, drowsiness, confusion, lethargy, anxiety, emotional lability, depression, fatigue and irritability. Many of the studies of long term affects of high-dose organophosphorous compound exposure are limited by the non-specific nature of these symptoms and by the low sensitivity and specificity of the neuropsychological scoring systems. On the other hand, some of these symptoms could be attributed to the sequelae of convulsions, anoxia, respiratory failure and cardiac arrhythmias that these patients might have suffered during the acute cholinergic syndrome.” (9) The families that breeched the hospital’s lockdown efforts were frantic to locate their relatives. This resulted in delays to the treatment of their loved ones. It also resulted in damage to the hospital, injuries to the hospital staff and to the family members themselves. A significant number of family members sustained traumatic psychological injury as they encountered some of the more horrifying scenes at the hospital. There were no organized efforts to reach out to the family members after the event to debrief, support and treat them. Consequently, the damage they experienced became consolidated (*consolidation* is a term this author uses to describe the transition from *active traumatic stress* to *post-traumatic stress disorder*). In the months following the event, lawsuits were filed against the hospital by a number of these families. The hospital had increased legal/financial exposure and liability because their policies and procedures were incomplete and inadequately implemented.

After the event was over, the actors dispersed; some going home, some going back to work. Through news reports they became aware of the magnitude of the chaos of the event

and how that chaos contributed to morbidity and mortality of children and adult victims. This news deepened the shock and trauma for every one of these actors. They began exhibiting signs of psychological traumatic stress: inability to sleep, changes in appetite, inability to concentrate, depressed mood, intrusive thoughts, irritability, anxiety and withdrawal.

The responders we met all sustained pronounced psychological damage and were in some state of psychological shock. This was due to a number of factors:

- the lack of preparation,
- the sense of helplessness interfacing with each personal psychology,
- the fact that many victims were children and,
- the breakdown of the system within which they were expected to be competent.

This damage is moral and psychological wounding. The root of the moral wounding is a deep sense of betrayal. More on betrayal later.

Half of the actors did not report for work even one month after the incident due to their psychological distress (based on the work of Robert Maunder, M.D. who researched hospital staff involved in the SARS outbreak in Toronto in 2003 (6)). Worker's Compensation claims were made. Disability claims based on PTSD followed. Some of our actors never returned to their previous line of work (6). One of our actors struggled with suicidal ideation and at least one other filed a lawsuit against the hospital. In addition to PTSD, there were increased numbers of: troubled marriages, alcohol and drug abuse and clinical depression.

Discussion

Outcome Number 1 is not remotely possible. Some version of Number 2 will occur.

If you think Outcome Number 2 is overly dramatic, unsubstantiated hyperbole written for effect, discount the devastation in it by **50%**. The outcome is still catastrophic! If you are inclined to discount the picture of Outcome Number 2 by more than say, 60%, interview someone who has actually donned a Level 3 hazmat suit and attempted, *in a drill*, to do

decontamination, someone who has attempted, *in a drill*, to give direction to victims in a decontamination holding area. Ask them what it is like to hear someone or be heard. Ask them how their vision is after 8 minutes in the suit. Ask your Fire Department if they have ever done a decon drill with the children at your local grammar school and what contingency plans they have for dealing with hysterical parents. You may be appalled - in which case you are realizing that outcome Number 2 – ***discounted by 50%***, is not at all implausible.

By the way, notice that I omitted: darkness, cold to freezing temperatures, precipitation and wind (remember, people are being showered outside) - *any one occurrence of which would decrease your discount by 50 - 100%*. Notice also that in this exercise we followed ***one*** grammar school. Unaccounted for in our exercise are the two preschools, the other grammar school, a middle school and a high school. (If you think this is an unusually high number of schools to be within the affected area let me assure you that this is precisely the case within 2 miles of the freight tracks that are ½ mile from my home.) Go ahead, use your imagination.

“I’ll take that chance...” (With ***your*** life.)

How Did This Happen?

Add to the scenarios you just read that each actor is surprised by their circumstances. Only those actors who worked in Disaster Response had any idea before the last minute what they were going to be called upon to do. The other actors were not informed of the physical, psychological or moral danger. No prior realistic training prepared these actors for the demands of the situation.

Consequently, they were utterly unprepared for the execution of the actual work or the sensory, psychological, cognitive and spiritual (SPCS) assault they were experiencing. They did not know that they were being betrayed.

Our First Foray into Ethics

There was no real preparation for the actors (even for those who worked in Disaster

Management). There was no informed consent on their part to participate in this event. This can be stated in the inverse: since there is no informed consent, there is no real preparation. How can you prepare for something of which you are uninformed? And yet, the actors were thrown into action.

One might ask: if one's consent is irrelevant and preparation incomplete, how does that change, does it change the experience of "the SPCS assault"?

When one is told to act – forced to act by a "benevolent authority" (parent, teacher, boss, coach, police officer, platoon leader, Governor, religious leader, Public Health Official Commander-in-Chief, etc.) there is the belief that the action is for, or in one's best interest. Even if one's "best interest" is contained within the best interest of a group, the individual being pressed upon to act can feel respected, noticed, cared about and important since they are a member of the cared-about group. This actor, feeling at least a minimum level of respect can endure great sacrifice for the benefit of the group at the direction of the "benevolent authority." Whatever harm that comes to the actor is not irrelevant. In enduring harm, they do not feel "wasted." The harm that comes to them is accepted as a price that must be paid. The burden of that cost is shared by the "benevolent authority" as well as the rest of the group. Hence, the individual making personal *sacrifice* in this manner does not feel betrayed. They do not feel expendable. To repeat: they do not feel they have been *wasted*.

The previous paragraph is the author's description of the moral and ethical covenant between society and the individual. This is the covenant between the benevolent authority and those they have authority over. This is the covenant that prevents power differentials in a family unit, a military unit, a classroom, the workplace, the judicial system, the government, etc. from being abusive or exploitive. The platform for the covenant is *respect*.

When the covenant is broken or doesn't even exist, the outcome is mistrust, betrayal and some level of paranoia. The authority may be able to use power to obtain compliance but they are no longer benevolent. The authority's neglect of the covenant makes them to some degree, either by commission or omission, malevolent. Their power is now perceived by the

other as coercion or force. The operating platform is *fear*.

All are diminished by this state. It is psychologically destructive, morally corrupt and spiritually bankrupt.

Back to our earlier question: if one's informed consent and opportunity to prepare is irrelevant – does that change, how does that change our actors experiences? Well, what do we know from the vignettes?

- Whatever training the actors had did not prepare them for this scene nor was their training readily adaptable to this scene.
- They did not know how to operate as a coordinated group.
- They had not been briefed on the impending demands, hazards and risks.
- Oversight, leadership and support was inadequate.
- None of the hospital actors except for the Emergency Services Coordinator were asked if they would perform these duties under these circumstances. Nor were they told that performing these duties was a condition of their employment.

Our Second Foray into Ethics

The absence of planning for the event and the absence of care about the actors during and after the event (let alone the victims) point inexorably to some combination of the following factors:

1. In an effort to save time and money; planning, training and the education of actors was not a priority.
2. The authorities and officials, private and public, were in denial about what they and their people might face and be required to do.
3. It is OK to engage in moral/ethical “flexibility.” It is OK to use people and if need be, waste them because of numbers 1 and 2.

What do you think the affect would be on you if you were subjected to the scenario we initially considered and you realized that you had essentially been wasted? If you were the parent of a child harmed by the catastrophic failure of the system, how would you feel

about Number 3 above? If you were an administrator or an official that bet wrong, how would you feel about Number 3 above?

Our Third Foray into Ethics

When this awful scene occurs, (notice this is not an “if” issue) the finger pointing will be vicious as all parties seek shelter from the moral and legal recrimination that will surely follow. The media, the pundits and the political parties will all contribute to “help identify the guilty party.” “Who could’ve let this happen?” (Think aftermath of Hurricane Katrina.)

What you are not likely to see is each and every decision maker within the system step forward and take responsibility for their participation in Numbers 1, 2 and 3. What you are not likely to see is the public vocalize and take responsibility for its complicity: in denial, in the make-do-with-less mentality and in *our* willingness to waste lives.

What you *are* likely to see are some number of lawsuits that stem from personnel being harmed while following their superior’s directives without having received “*advance notice of potential harm*” and “*just-in-time training*” from their supervisors. In my experience the vast majority of people giving direction to others have no conception of their responsibility and hence liability in these two areas.

Beyond blame and running for cover, who will question the moral and ethical platform from which we point at someone else and inform *them* of *their* moral and ethical obligations: of their Duty-to-Care, of their Duty-to-Serve? This is continued in The Fourth Foray.

Our Fourth Foray into Ethics

Duty-to-Care and the Covenant

In the health care and first responder professions there is a creed, a moral imperative if you will, that members of these professions have a duty to respond; to provide care even at

their own peril or pain. This is referred to as “duty-to-care”. I have heard it openly referenced in seminars dealing with Disaster Response and I have seen it operating implicitly in the health care and first responder cultures. It is the basis for some very interesting moral/ethical posturing and in two cases, legislation. Writing a commentary in the Journal of the American Medical Association in 2008 (1), titled: “Potential Penalties for Health Care Professionals Who Refuse to Work During a Pandemic”, Carl Coleman, JD and Andreas Reis, MD state that “...Maryland and South Carolina have enacted laws that authorize license revocations, fines or even imprisonment for HCPs (Health Care Providers) who disobey public health officials’ orders to work during public health emergencies. These penalties would apply even to HCPs whose occupations do not ordinarily encompass clinical responsibilities or to HCPs who are not currently part of the workforce...” Later in the same article Coleman and Reis describe the argument that “special skills give rise to ethical duties.” However, they point out that although we take as a given the ethical duty to rescue when we are able, we do not expect an individual to attempt rescue at their peril. We might see that action as supererogatory, but would not expect it. Coleman and Reis find the stance of expecting and compelling HCP response in our current understanding and configuration as not legally or morally justified.

In “Beyond the Call of Duty: Compelling Health Care Professionals to Work During an Influenza Pandemic,” (2) Carl Coleman: ...”rejects commonly made assertions about health care professionals’ ethical obligations, including the claim that health care professionals ‘assume the risk’ of infection, that a ‘social contract’ requires health care professionals to work despite potential health risks, and that individuals who have urgently needed skills have an obligation to use them.” It concludes that, “while it is legitimate to sanction health care professionals for violating voluntarily assumed employment or contractual agreements, they should not be compelled to assume life threatening risks based solely on their status as licensed professionals.” Essentially, Coleman rejects the notion of compelling supererogatory behavior despite the effort to demand it through the Model State Emergency Health Powers Act (MSEHPA).

An article on the CDC Website titled “Virulent Epidemics and Scope of Healthcare Workers’ Duty of Care” (10), Daniel Sokol, M.D. discusses the “Special Obligation of Doctors to their patients... doctors and nurses have more stringent obligations of beneficence than most... termed ‘duty of care’”. In a section of the article headed “Virtues of Patients and Their Duty of Care” Sokol states: “Patients too have a duty to care for healthcare workers. Part of this duty is not to require doctors to transcend the bounds of reasonable risk during treatment and to respect and acknowledge their roles outside the realm of medicine.” Sokol later discusses how the language: *Duty of Care* can become corrupted: “...the term may become a subtle instrument of intimidation, pressuring healthcare workers into working in circumstances that they consider morally, psychologically, or physically unacceptable. The phrase duty of care can thus be ethically dangerous by giving the illusion of legitimate moral justification.” Toward the close of the article, Dr. Sokol again returns to the idea that the patient has a role to play here: one of having realistic expectations. I believe that Dr. Sokol’s position addresses the mutuality and hence respect in the relationship between the healthcare provider and the patient (public). By extension I believe this mutuality and respect is necessary between healthcare administrators/public officials and the healthcare provider.

Those who believe that the expectation of supererogatory behavior is implicit in the social contract between HCPs and the public seem to feel that this is justified by the stature and status that is conferred upon HCPs along with the fact HCPs chose a life of giving and care taking and therefore derive deep satisfaction (the intangibles) from that life. Those who hold forth seem to believe that because HCPs have “special knowledge, special skills,” HCPs, for moral and ethical reasons, ought to forfeit reasonable self concern, self respect and concern about their families.

Some professional organizations have attempted to address the ethics of obligation in disaster response. Coleman cites the AMA (2) declaring that: “ individual physicians have an obligation to provide urgent medical care during disasters ...this holds even in the face of greater than usual risks to their own safety, health or life.” Coleman goes on to contrast that position with ANA (American Nurses Association) and quotes: “ [..nurses have given care

to those in need, even at risk to their own health, life, or limb,' but that 'in certain situations the risks of harm may outweigh a nurse's moral obligation or duty to care for a given patient.' Nurses are to make their own judgments based on "critical thinking and ethical analysis."”(2) The positions and arguments about moral obligation, social contract and legal obligation through employment and licensure are ambiguous and at times conflictual.

I am taking a very different tack. I propose that it is hypocritical to the point of *bad faith* that an authority (read also as *The Public*) can find it acceptable to reference another's duty-to-care (or in the case of the military, duty-to-serve) while eschewing any sense of duty *to* those being "asked" to care or serve. I find that this point is completely neglected and is the essential point of this paper. I propose that we don't get to do that! The standard must instead be the covenant in which there is trust, care and respect. *That* is the basis for a moral and ethical social contract. Any manipulation of the social contract takes us back to frank hypocrisy and bad faith. I believe anyone "asked" to care (or serve) in bad faith has a moral and ethical justification should they opt to decline since the authorities (and the public they serve) have taken the position that for their own convenience it is morally and ethically permissible to waste the life of the one being "asked". The consequence of being "asked" (compelled) in bad faith is itself, psychological and moral wounding. This wounding is profound and separate from any other physical, psychological, cognitive or spiritual wounding the individual may encounter as result of her/his service. For a picture of the depth and breadth of this wound speak to a Viet Nam Veteran (Shay). Perhaps they will convey to you the way their character has been "undone" by being treated as superfluous while being compelled to participate in the morality and character twisting of war. (The Viet Nam Veteran's damage is intensified by their knowledge that in part they were wasted for what was later evaluated by many to be for "no good reason".) Dr. Jonathan Shay in his brilliant books, "Achilles in Viet Nam" and "Odysseus in America"(7, 8) describes "moral wounding:" as the condition in which an actor feels betrayed by the authority directing his actions and who claims responsibility for the actors' best interests. Dr. Shay describes the

affects of traumatic experiences in combination with moral wounding as *causing damage to the individual's character* (italics mine) perhaps exemplified by the loss of faith in the system or leaders that *broke faith* (italics mine).

When we “ask” others to serve in bad faith we destroy the very moral and ethical basis upon which we have a right to ask them to serve. They have something; a skill, experience or training that we feel we need. Based upon that, we feel we have a right to “ask” them to serve. Then we tell them that their needs: to be respected, to matter, to be cared about, to be treated fairly, are not our concerns. Our moral and ethical platform is destroyed by our bad faith. We have, in Shay’s language, “broken faith.”

What is Necessary

Covenantal Social Contract

In the case of disaster response (and other service) to operate within the *covenantal social contract* means: anyone who might be put in harms way (*any variety of harm*) must be told of the potential harm that could visit them (and by extension their families) when they are considering taking on the position.

- People have a right to understand what could be asked of them in the most *extreme* circumstances.
- People have a right to understand the circumstances under which they can decline to *care or serve*.
- People have a right to be informed verbally and in writing of the ways they can be harmed – even permanently, by traumatic stress.
- They have a right to be fully trained, educated and drilled to execute what will be required of them.
- People have a right to the meaning and value that accrues to their lives through the good faith of the covenant. People have a right to know their lives will not be wasted.

Stress Inoculation

If the person who cares or who serves is treated as just described, they are naturally entitled to ongoing training and realistic drills. This will accomplish the dual tasks of: 1) increased individual and group competence and 2) permitting the actor, through the expert guidance of the trainer, to encounter notions of the horrific and the twisted.

Before, during and after drills the trainer is in an excellent position to do stress inoculation training. Lt. Col (Ret) David Grossman writing in “On Combat” describes how the military has used stress inoculation to achieve the aim of breaking down the inherent objection people have to killing others (3). The method has direct applicability to our topic: responders and care providers who will be called upon to face extremely destabilizing scenes of mass pediatric victims can be “inoculated” by encountering pictures, depictions, stories and enacted scenes in a titrated fashion which enables the individual to build some psychological buffer against shock. The individual should be able to say: “Oh wait, I’ve seen something like this before.” Grossman points out that without inoculation, when the individual is under extreme stress, the autonomic nervous system will take over and render that person to some extent crippled (3). I propose that being crippled in the pediatric disaster response moment has potential to devastate in the moment (inability to execute) and later (moral and psychological wounding). Human beings have an inherent tendency to protect children and to view them as vulnerable and needing effective care. Think about our actor’s sense of failure in the face of the severe PTSD described earlier.

Further, the titrated stress inoculation experience gives the individual a chance to hone their spiritual response/practice as a much needed resource. Whether religious in nature or not, those involved in a pediatric mass casualty event will need methods to attempt to integrate this traumatic experience. These methods may include being a member of a spiritual community, meditation, communion with nature, prayer, a philosophical approach, or a personal practice.

To conclude this section, attention to stress inoculation training affects the responder/care provider culture by:

- helping build psychological, cognitive (3), moral and spiritual resilience (ritual can play an important part in this experience (5)),
- making debriefing routine,
- helping to build a support network.

I chose a hazardous materials transportation accident to illustrate multiple systems breakdowns in a mass casualty event. The scenario illustrates the immediate and on-going additional burdens a surge in pediatric victims brings. The scenario allows us to encounter some of the ethical and moral issues of under-preparation and to observe the process of responders and care providers being morally and psychologically wounded.

Other mass casualty events, most especially those that would bring a surge in pediatric victims, will undoubtedly have many of these same issues. When you contemplate the following list of plausible events consider the history of occurrence and your estimation of the probability and impact of a future event:

- a bioterror event (anthrax 2001)
- a nuclear accident or terror event (Fukushima accident: Japan 2011)
- an epidemic disease (flu, SARS: 2002 - 2003)
- a chemical terror event (Sarin nerve agent in Tokyo subway: 3/1995)
- a chemical accident (Bhopal, India: 12/1984)
- school attacks (Virginia Tech: 4/2007, Northern Illinois University: 2/2008, Columbine High School: 1999, Beslan, Russia: 9/2004)
- natural disasters (earthquakes, tornado/hurricane, flood, tsunami, etc)

If we remove man-made terror events from the list as being “improbable”, we are still left with accidents and naturally occurring events. There is discussion in the Disaster Preparedness Community about the ethical issues that flow from a pandemic flu occurrence such as:

- the distribution of resources such as medication, vaccines and equipment (ventilators, etc),
- enforcing social isolation,

- determining order of care.

Often overlooked is Dr. Robert Maunder's study of 2004 SARS outbreak affecting Mt. Sinai Hospital in Toronto. The data shows the impact of the event was not only personal to healthcare workers but became a Human Resources issue (6):

- "1-2 years after the SARS, almost half (49%) of participants were experiencing distress in at least one domain of stress response, disordered sleep or burnout."
- "34% of all participants reported planned or actual decrease healthcare work."

The effects Dr. Maunder describes with SARS would, by any estimation, be intensified in a pandemic flu (or other similarly demanding event).

Consequently, it behooves us to extrapolate from the SARS event and predict moral/ethical issues and moral wounding experiences for care providers – in some measure brought on and/or exacerbated by inadequate stress inoculation with care providers.

Conclusion

I have attempted to address the moral and ethical complexities of "asking" (compelling) an individual (whether a first responder or a HCP) to respond to a pediatric mass casualty event. In doing so, I have tried to illuminate some of the attendant (and far too often neglected) issues in true preparation and training. I have attempted to debunk the moral/ethical position commonly taken in our society in which some members of the society ("the authorities" acting for the public) believe they have the right to tell another what the other's duty is *without any reciprocal duty* in responsibility, respect and care of that person. I have referred to this as moral/ethical "flexibility." I pointed out that from this stance people who are compelled to act out of duty may well end up feeling betrayed and wasted.

As an alternative to the inherently self serving moral/ethical platform of "flexibility," I propose that our authorities (public and private) and the public operate from the moral/ethical platform of *shared and mutual duty*. I believe this permits us, as a society, to call on our members with special skills, knowledge, experience and commitment to help us - because they would know, by how we treat them, that we would not waste them.

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