49. Ethical aspects of a multi-casualty event*

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Background

A multi-casualty event is characterized by the inability or lack of means of the physician involved to do the maximum in order to save life or limb of all the casualties.

The guiding professional principle is to do the most possible for the maximum number of casualties, and not the best for all of them.

In such a situation, the physician is required to employ the triage method, which implies a potential of less than optimal treatment for some of the casualties and is even liable to cause their death or disability.

In such an event, non-medical entities such as relatives, curious bystanders, police personnel and media people, are also involved and their contribution to the task is minimal and sometimes even negative or an encumbrance.

The aim of this position paper is to formulate the position of the Ethics Board of the Israeli Medical Association on various aspects related to a multi-casualty event.

Definition of a multi-casualty event

A multi-casualty event is the result of a catastrophic incident that affects a large number of people. An event of this kind may occur during wartime, armed conflict, a terrorist attack or a civilian disaster. In an event of this kind, there is generally an imbalance, if only fleeting, between the needs of those requiring treatment and the capability of those giving the treatment to meet this need within a given period of time. Medical service in such situations requires organizational and technical aspects in addition to ethical aspects. This position paper will, however, be limited to addressing the ethical aspects.

The ethical code for medical treatment during a multi-casualty event or disaster

a) The ethical principles of medical screening during a multi-casualty event or disaster: medical screening (triage) is intended to solve a momentary or permanent situation of a relative lack of means and/or manpower, as opposed to the needs of the patients. In triage, the physician is required to decide the order of priorities and the allocation of resources for treatment of the patients and the casualties. By its very definition, it is possible that giving priority to some of the casualties may deny, or at least delay, the best treatment for another casualty.

b) The guiding ethical principles in triage, which aim to make it fair and professionally

optimal, include the basic ethical principles familiar to us from the accepted literature:

1. The principle of beneficence
2. The principle of autonomy
3. The principle of non-maleficence
4. The principle of distributive justice
5. In addition, the principles include the rights of those giving the treatment, such as the right to personal security of the treating personnel, the rights of society and of the State.

1. The principle of beneficence

The physician has an obligation to do his best and attempt to ensure that the system in which he works will do its best to give the patient the best treatment, to prolong his life, and prevent disability and suffering.

In a multi-casualty event or a disaster, the incompatibility between the needs of numerous casualties and the limited existing capabilities, if only in the first stage, obligate maximum caution in the formulation of priorities for treatment, but also maximum speed. Triage is sometimes performed under difficult physical conditions and with limited data. The physician doing the triage will formulate a triage policy based on the concrete conditions existing at the time of the event.

- First priority – The physician will treat casualties and patients with an immediate risk to their lives, whom he thinks can be saved.
- Second priority – The physician will treat patients and casualties who need immediate treatment, even if the treatment is not lifesaving.
- Third priority – The physician will treat patients and casualties whose treatment may be delayed for a reasonable time without causing harm.
- Fourth priority – The physician will treat patients and casualties about whom it seems to the physician performing triage that the chances of saving their lives are non-existent given the relevant conditions of time and place.

2. The principle of autonomy

Even someone being treated in a multi-casualty event has the right to decide about his fate, such as where he wishes to be taken and who will treat him. Furthermore, the patient is entitled to refuse to receive medical treatment in general or a specific treatment in particular. The physician treating him shall, as far as possible, respect the wishes of the patient.

The physician shall primarily be subject to the need for proper distribution of resources and the prohibition of showing preference to one patient over another. For example, it is possible that the team moving the casualties from to the hospitals will not be able to consider the wishes of a certain patient to be taken to a specific

hospital. Furthermore, the physician may choose a priority for treatment different from that desired by the patient.

3. The principle of non-maleficence

The physician treating the casualty shall use accepted medical methods in accordance with the standards customary at that time.

4. The principle of distributive justice

The physician shall give medical treatment in accordance with the priorities determined by him or by someone authorized to do so, in accordance with medical criteria, with no other considerations, such as the age, sex, religion, nationality, social or economic status of the casualty. In general, the physician giving the treatment shall attempt to save the maximum number of casualties possible, even at the possible price of reducing the chances of saving an individual.

5. The safety and security of the medical team-rights and obligations of the medical team when faced with a potential threat

The teams treating casualties during a state of emergency experience various levels of personal risk as part of their jobs (police, soldiers, MDA personnel, physicians and nurses). During the event, the physician is obligated to assume a relevant and immediate risk, if this will lead to the fulfillment of his professional obligation to treat patients and casualties.

However, members of a medical team who are themselves injured are of no benefit to the cause. Injury to the medical team is liable to come from the act that caused the event or from the persons who caused the event.

In predictable states of risk (war, epidemic, work in a hazardous environment) the medical team and their managers are obligated to initiate and execute reasonable preparations (exercises, protective equipment, immunization, etc.) in order to be capable of operating in a hostile environment.

In the absence of proper advance preparations for the situation encountered by the medical team (for example, the absence of protective equipment against an infectious biological generator) the team shall act to the best of its judgment in order to help the casualties, without affecting their capability to help other casualties as well.

States of emergency involving numerous casualties in different regions

The event usually commences in an area that is not a medical facility.

It is also likely to involve an intermediate stage – a temporary improvised medical facility

at a less than optimal level. It will continue in the process of transferring the casualties. It will end in a proper medical facility.
The special nature of the first three situations is that the potential for violent injury to the team is more real than in an orderly facility, and this should be taken into account.
The entry of a medical team to the line of fire: In the event of risk to life, the physician, together with the security entities, shall estimate the risk involved in entry to the location of the event versus the obligation to save lives. When speaking of a potential for injury not caused by humans, the same principle applies.

Educational aspects

a) Part of a physician's basic professional training must include treating casualties in a multi-casualty event.
b) The involvement of medical school staff in the planning and updating of the studies is essential, as is that of physicians engaged in this field on a daily basis.
c) Medical schools should offer continuing education programs for medical personnel, nurses, and paramedics on the subject of multi-casualty events.
d) Medical schools and other institutions of the medical community are committed to educating the community and para-medical personnel regarding the medical aspects of coping with a multi-casualty event. Physicians will lead the writing of treatment protocols and the planning of education programs on the subject.
e) Physicians will take steps to promote capabilities of the system and the community to treat casualties in a multi-casualty event and to promote understanding of the medical system during such events.

Ethical principles in a biological event

a) The allocation of preventative treatment resources within the medical system:
A physician shall not participate in decisions regarding the allocation of limited resources on a non-medical basis, such as age, sex, race, religion, nationality, economic or social status.
In situations in which there is preventative treatment (such as immunization) for a biological event, the system is obligated to offer such treatment to the medical staff. If there are insufficient means of preventative treatment for the entire medical staff, the health system shall specify the order of priority for giving the treatment. This shall be done in consultation with medical specialists in the field and subject to the rule that treatment will be offered to those in the highest level of danger, such as the relevant researchers and laboratory workers, the medical staff most exposed to the contagious patients, and the epidemiological staff.
b) The physician's obligation to treat infectious patients:
1. If a physician refuses to accept the treatment offered to him, and does not have

a contra indication, this shall not exempt him from his obligation to appear in his place of work and treat persons affected by the event.

2. If the physician has a contra indication to the treatment, he shall be entitled to decide whether he wishes to treat persons affected by the event and under which conditions.

c) The limits of the risk that the physician is obligated to take in the treatment of infectious patients:

1. If the system has supplied the physician with the required means of protection, has trained him and furnished him with the knowledge required for optimal functioning in the given situation, the physician shall be obligated to function as required, and shall give treatment.
2. If the system is unable or does not wish to supply the aforesaid means, the physician is not obligated to endanger himself beyond the limits that he sets for himself voluntarily and with his colleagues and specialists in the subject.

d) A patient who endangers the public and/or the medical staff:

1. A distinction should be made between a patient who endangers society and one who only endangers the staff giving the treatment. The laws of the State and the relevant regulations are obligated to give the means to deal with both situations; in other words, to prevent the patient from becoming a danger either to society or to the staff giving the treatment.

   The Public Health Ordinance specifies instructions regarding reporting of an infectious disease and the prevention of the spread of the disease amongst the population. The Ethics Board of the Israeli Medical Association has published a position paper regarding the transfer of information to the medical staff about an infectious disease.

   These instructions are also valid for a member of the medical staff who has contracted a primary disease or from a patient. The Ethics Board of the Israeli Medical Association has published a position paper that addresses an incompetent physician and the obligation of reporting him.

e) Medical confidentiality

The laws and regulations related to protection and immunity of medical information apply also during an epidemic.

* "The poor of your village shall take precedence" and medical ethics in a multi-casualty event

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In 2008, a position paper was published, dealing with the treatment of the injured in a multi-casualty event. The position paper was written by a committee led by Prof. Pierre Singer and Prof. Finney Halperin. The paper deals with an unusual and extreme situation, in which the number of victims in an event far exceeds the number of caregivers. This situation is different from other medical treatment situations. Usually, doctors will try to save the life of every patient by any means at their disposal, a principle that stems naturally from the sanctity of life. When there are more wounded than physicians, the physician's role is to save as many people as he can, and therefore the order of precedence changes. The guiding principles in such a case are these: the doctor will provide medical help first to the severely injured who have a chance to survive, then the moderately wounded who may lose a limb or deteriorate, and only then will they return to the critically wounded whose condition is dire and chances of survival slim.

Another issue mentioned in the 2008 position paper is danger to the life of the attending physician. Must the doctor "enter the event" when there is an immediate danger to his life, or should he wait until the danger to his life has passed in order not to harm the chances of his saving the lives of the wounded? The doctor is expected to consider this issue as well and not act recklessly, which will benefit no one.

In the position paper, the phrase "the poor of your village shall take precedence" was mentioned as part of the triage considerations in instances of human violence that result in casualties among the perpetrators of the violence as well. Following the application of "Physicians for Human Rights" a discussion was held on 12.1.2015 in the Ethics Bureau regarding the use of this phrase.

The source of the phrase is in the Talmud (Bava Metziya 71a):

"When you lend money to My people, to the poor person [who is] with you…"

My people and foreigners - my people first,

Poor and rich - poor first,

Your poor and the poor of your city - your poor first,

The poor of your city and the poor of another city - the poor of your city come first."

In other words, the verse guides the giving of charity in order of priority. Applying the complex interpretation regarding the giving of charity to the order of precedence in the provision of medical care is, to say the least, problematic. Doctors swear in various oaths to give equal treatment to all who need it. Therefore, using the phrase "the poor of your city take precedence" is a stumbling block. Consider a case of an attack in Jerusalem, where there are 50 wounded and one doctor; if among the injured there are tourists from foreign countries, homeless people, Jerusalemites and affluent Tel Aviv

residents- who will the doctor treat first? It is clear from the example that the doctor would be expected to triage and begin treatment in accordance with medical need and no other consideration.

It can be assumed that because of the chaotic situations to which the paper refers, it would be difficult for a doctor to hone in on what each patient needs. There is a significant risk of errors in triage priority, which could be enormous if we add more components to the question of who precedes whom.

Therefore, it was decided to remove the phrase mentioned above.

The discussion was diverted by the media to other situations, in which there is an attacker, and it is clear who he is. Usually, in a multi-casualty event it only becomes clear later on who is the attacker and who is the victim, or where there is an equal number of wounded and physicians, allowing for proper care of everyone at the same time. This position paper does not deal with these situations. By the time the picture is clear, the victims are already in a hospital, where there is a sufficient number of doctors and the order of precedence will be according to medical principles.

The amendment to the position paper allows a doctor treating multiple casualties to exercise professional judgment, free from extraneous considerations. Also, the deletion of the phrase "the poor of your city take precedence" preserves the existing principle of non-discrimination found in Israeli law and the rules of ethics, and prevents moral deterioration in a slippery slope of treatment priorities that stem from non-medical considerations.