Routledge
Taylor & Francis Group

Psychiatry
Interpersonal and Biological Processes

ISSN: 0033-2747 (Print) 1943-281X (Online) Journal homepage: www.tandfonline.com/journals/upsy20

Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital, by Sheri Fink

Edmund G. Howe

To cite this article: Edmund G. Howe (2014) Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital, by Sheri Fink, Psychiatry, 77:4, 401-408, DOI: 10.1521/psyc.2014.77.4.401

To link to this article: https://doi.org/10.1521/psyc.2014.77.4.401

copies. The innumerable copies of the scrapie prion in the diseased brain fold to form the amorphous amyloid structures characteristic of neurologic spongiform diseases. Experiments in genetically altered mice proved conclusively that scrapie was caused by a prion. Prusiner also demonstrated that mutations in prion proteins gave rise to familial forms of the human spongiform-associated diseases.

Having established in his own mind the basic biology of prions, Prusiner then found himself engaged in battles on two fronts: On one hand, many scientists and science writers were still very skeptical about the whole prion theory; on the other, there were a few investigators who accepted the validity of the concept, but claimed that they, rather than Prusiner, had first conceived of it. Prusiner's ideas received wider interest following the revelation that some consumers of beef from strangely acting cattle in Britain had come down with a form of CJD at much younger ages than had been previously observed in that disorder, giving rise to the term *mad cow disease*. The origin of this epidemic was the feeding of cattle with sheep offal from some animals that had scrapie. The prion in turn passed on to and was expressed in a small number of the unfortunate consumers of the scrapie-infected beef.

The scientific evidence Prusiner had uncovered and the occurrence of mad cow disease convinced most, but even to this day not all, skeptics that prions really existed and that they were indeed protein in nature. Prusiner received the Lasker Award in 1994 and the 1997 Nobel Prize in Physiology or Medicine. He was the sole winner of the latter award that year, a most unusual honor, both because he had discovered a novel principle of infection and the lonely struggle he had undergone to have his heretical theory accepted. In 2010, Prusiner received the National Medal of Science from President Obama, the highest honor this country awards to scientists. While a few scientists and science writers still have difficulty accepting Prusiner's concept of prions, there is strong evidence that his research will point the way to understanding and developing treatments for some of our most serious, unsolved problems in neurology and psychiatry.

SHERI FINK. Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital. New York: Crown Publishers, 2013. 558 pp.

Reviewed by EDMUND G. HOWE

Dr. Sheri Fink's book Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital is three books in one. First, it describes what happened at Memorial Medical Center in New Orleans after Hurricane Katrina. The hospital was isolated due to flooding, and during the storm the facility lost electricity. It was unclear when rescuing missions for all patients and staff would take place. Second, this book reviews and summarizes key aspects of selected ethical issues brought about by these events. Third, it provides a sketch of Dr. Anna Pou, the one physician, an otolaryngologist who stayed at the hospital until rescue, and who was accused of performing active euthanasia during this time.

Memorial Medical Center and the events that occurred there became nationally known when it seemed plausible, or even likely, that Dr. Pou, perhaps with the help of others, carried out active euthanasia on one or more patients to save them from suffering over a time frame that was not known, but could have gone on for several days. When Dr. Pou was arrested, there were 50,000 pages of evidence (p. 364). The grand jury did

Edmund G. Howe, MD, JD, is Professor of Psychiatry and Director of the Programs in Medical Ethics at the Uniformed Services University in Bethesda, Maryland.

Address correspondence to Edmund G. Howe, MD, 4301 Jones Bridge Road, Bethesda, MD 20814-46799. E-mail: edmund.howe@usuhs.edu

not indict Dr. Pou or any other staff members on any of the 10 counts brought against them.

Since the book involves three distinctive subjects, I will discuss them each of them in separate sections. The book is 558 pages long and has abundant notes and an extensive word index. Dr. Fink, the author, is a physician and Pulitzer Prize winner. How she writes will be illustrated in the quotes that follow. For me, though, it is the discussion of Dr. Pou that is most compelling. The last section of this review is therefore about her. Dr. Pou has been called, on the one hand, a Mother Teresa and a Florence Nightingale (p. 432) and, on the other, "evil" (p. 269). "You're that doctor," she feared patients might say (p. 307).

Who was Dr. Pou then and who is she now? And why might she have done what she did if she did? In the first section of this review, I will describe the hospital disaster scene and address some ethical issues, since these issues are embedded and inextricably related. In the second section, I will discuss these and other ethical issues more exclusively. In the third and last section, I will discuss who Dr. Pou was and is and what she may have done.

Finally, I will make a point about "ethics." This point is critical in all contexts and particularly so in assessing what may have occurred here.

WHAT HAPPENED AT MEMORIAL?

Hurricane Katrina had a catastrophic effect in many places in New Orleans. Dr. Fink presents two examples that are particularly chilling. The first is about a sheriff who was reported to have said on the radio that there might be a shark swimming outside a hotel (p. 179). The second was that at a medical facility other than Memorial, National Guardsmen had come in with their guns to protect patients: "Cars lined up with snipers at the lead" (p. 378). However, the issue that made headlines, of course, was the possibility of active euthanasia. These events unearthed many ethical issues.

Doctors Going Outside Their Usual Limits/Taking Risks

What physicians and other care providers should do when they must go beyond their usual medical standards and/or expertise to best meet patients' needs is one of the ethical dilemmas that may occur during disasters. (I will refer to all care providers as "doctors" from this point on.)

For example, all the patients on kidney dialysis needed water. There was no electricity, and the city water was thought to be contaminated with chemicals and bacteria, making it dangerous to use, even for bathing (p. 66). Since water was needed to perform dialysis, staff members formed an assembly line to boil water in a microwave and then stockpiled it for later use.

Boiling water was one of the many makeshift measures the staff utilized. Other examples entailed more risk. Another involved the circumstances surrounding the birth of a premature baby. Since incubators and ventilators were not available, a neonatologist blew puffs of air into the newborn's lungs and took other extemporaneous measures that enabled the baby to survive (p. 98). Dr. Fink provides another example involving a doctor in India who had devised an inexpensive way to provide babies with life-saving breaths, since they too lacked ventilators (p. 484).

Doctors' choices, here and in other contexts, may involve decisions about which risky procedures they should or should not perform when local medical resources are insufficient to support patients' needs post-procedure. They may, for example, have to leave a patient with a barely functioning leg if their local resources cannot adequately take care of them or bring them back home for care. The latter alternative would, of course,

be most humane, but during a disaster, this could involve extremely large numbers of people and be considered unfeasible.

Even the usual ethical norms may be intentionally ignored and overridden. One example took place in Haiti after an earthquake. There was a child with an infected leg that needed amputation in order for him to survive. His mother, however, refused to give her informed consent. This child's doctor took the mother to see her child, undid his bandages, and showed her his wound. It was painful to look at and to smell. She consented.

Triaging

Dr. Fink describes triaging procedures in detail. Triaging too raises a host of ethical questions. Staff divided patients into three categories (p. 137). Dr. Fink discusses how leading experts have, in the past, differed on whether this common triage practice should be carried out. Some have opposed the utilitarian ethical ground on the approach on which triage is based. She relates here, for example, John M. Taurek's view that "suffering is not cumulative between individuals" (p. 142), and cites a view of C. S. Lewis that says, "When we have reached the maximum that a single person can suffer…we have reached all the suffering there can ever be in the universe" (p. 143).

Dr. Fink relates that these views stem from the earlier work of philosopher John Rawls, who emphasized giving to each according to his or her needs (pp. 140–142). Rawls's work did not address the needs of the global community. For example, since there could be a worldwide pandemic, perhaps we should give some of our own resources now to help less-well-off nations prepare for a future disaster.

Dr. Fink speaks to what we should be doing, what we are doing now, and what we should be doing in the future.

Giving Morphine

The events here also raised ethical questions at patients' bedsides. The chief one, of course, was the one that gave rise to Dr. Pou's arrest. Did Dr. Pou give sedative drugs with the intention of killing? The key to determining the answer to this question was whether the sedating drugs Dr. Pou gave these patients to relieve their suffering had accumulated over time, due to such problems as kidney and liver disease and were therefore unusually high on some autopsies. Or had Dr. Pou given sedating medications in bolus amounts because she intended to end their lives? (p. 263).

Doctors faced the clinical question of whether to give a drug like morphine to relieve a patient's pain knowing that this action could precipitate their premature death. This question also occurs outside disasters. Many doctors in this situation evoke and rely on a concept known as the doctrine of "double effect" (p. 160). According to this doctrine, doctors may ethically give morphine to relieve a patient's suffering if death is not intended but is unavoidable. They cannot administer morphine for the intended purpose of killing the patient.

Ethically, it is noteworthy in appraising this situation that some ethical authorities dismiss the moral relevance and the use of this doctrine entirely. They believe that the relative pros and cons of giving or not giving a drug like morphine speak for themselves. They believe, therefore, that the relative gains and risks of giving versus not giving morphine should be directly weighed against each other and compared. The question is decided on this basis alone, and not on intention. They assert that weighing in doctors' intentions only serves to muddy the waters.

Deceit

Dr. Fink's descriptions of what happened also raise ethical questions involving deceit. Some staff who were working in the hospital right after the disaster lied to patients' loved ones. They lied to avoid the risk of evoking anger and opposition. They could only do what they could do since resources were so limited. The staff also engaged in what may have involved some deception after the disaster was over. This behavior was intended to protect the hospital from lawsuits. If a family member questioned the decision not to evacuate a loved one during the hurricane, the staff was instructed to respond uniformly that this was, in every case, to prevent undue risk to the patient (p. 141).

Ethical issues, such as euthanasia, how to use limited resources, the doctrine of double effect, and deceit, are paradigmatic of similar ethical questions that arise both here and abroad in disaster and non-disaster contexts. The events here and these discussions pertain not only to what happened at Memorial but to what we do and should do in medicine more generally.

CORE ETHICAL PROBLEMS THAT AROSE

Less Care for "The Poor"

Dr. Fink notes when and how economic aspects of our medical care have changed. She says, "By the early 1980s, health care was a medical marketplace" (p. 45). I will elaborate in the next section how this affected Dr. Pou. Said simply, she was aggrieved.

Prioritizing Care During Disasters

A great ethical disagreement still looms in regard to whose needs during emergencies or disasters should take priority. Should the overriding principle be the greatest good for the greatest number, or should dis-utilitarian values be cranked in so that those with disabilities can be treated more equally? Dr. Fink also points out another view. Should those of us who are older consider declining medical care when medical resources are limited so that the younger people can benefit (p. 48).

The concept of declining care may be based on deontological values, or values not based on consequences, though intuitively this may not seem to be the case. That is, treating people with dignity by treating them equally may mean to value one person's life as equal to any other person's life, young or old. Yet, treating people equally may be construed in a different way (Gostin, 2006). Giving people equal access to a long life may be a different and possibly ethically more sound criterion. If so, those older have had this life; those younger, have not.

At Memorial during Hurricane Katrina, of course, these questions were at the forefront (Holt, 2008). For example, what do we do with patients too heavy to move or those who are bedridden? Analogous questions may arise in regard to those with severe cognitive impairment and/or are extremely mentally ill. Dr. Fink reports one instance in another institution where patients who were unable to say their names were not given intravenous fluids (p. 378).

Different schemes for allocating limited resources have been and still are being newly proposed. Some purport that during disasters, patients such as those with do-not-resuscitate orders, the elderly, those requiring dialysis, and those with severe neurological impairments should be the last to be placed on ventilators or the last to be admitted to hospitals (p. 469).

A specific, more current, example involves children who have rare cancers. Some medications for these children are not available in sufficient amounts; therefore, schemes for prioritizing these limited resources are

now being proposed. Some of the criteria for deciding which children should be treated prior to others under these schemes are very controversial. Among the last criteria proposed in some schemes, after other criteria have been exhausted, could create this scenario: A child who, as far as we know, lacks the capacity to relate meaningfully to others and who also has siblings who could potentially have less attention and thus be indirectly harmed if this child survives could be denied these limited medications.

Palliative Sedation

The concept and practice of palliative sedation may involve patients with a terminal illness in hospice care who request to be "put to sleep" so that they are and remain unconscious until they die. They may request this so they do not have to continue experiencing what to them is an agonizing awareness that they are just waiting to die. Some have previously experienced depression. Some among this group say that the existential pain they experience, knowing that they are just waiting to die, is much, much worse than "just" being depressed.

This type of possible intervention poses many ethical questions for hospices and other medical institutions. Should they offer this type of palliative care and if they do, to what extent if any, should they let this be known? And why? If they let this be widely known or fully transparent, if they tell this to every patient entering hospice, some patients may find the prospect of relief from their "existential dread" by these means too inviting to refuse. Yet, if patients nearing the end of life do have access to palliative sedation, they may miss out on an alternative experience. They could find their last days or weeks the most meaningful of their lives. They could, for example, use their last days and hours with family members to express their love and appreciation and to ask to be forgiven and to forgive.

Ethical Theory

Throughout these discussions, Dr. Fink often presents competing ethical grounds for the issues she narrates. One starts, for example, where one might expect: "The first thing, he thought, was the Golden Rule" (p. 8). But the theory moves quickly to medical realities, which often involve judgment and uncertainty. Is there, for example in these instances, a place or no place for staff to decide that it is time for a patient to die? Dr. Fink provides an example: "When patients like this were so disfigured they appeared to be dying cell by cell from the inside out… It's time… to go and talk to the family," an ICU nurse said (p. 219).

Families in these contexts may, of course, feel most desperate. Dr. Fink reports on a staff member who, after Hurricane Katrina, spoke to the media only on the condition that they were willing, outside the hospital, to try to help her family. She went "on camera," Dr. Fink reports, for "a promise from the news crew to help rescue her children" (p. 231).

Crises like this also raise new ethical and empirical questions. One voiced here by a staff member was whether the worst-off patients would want to make sacrifices for others who were better off or had better prognoses. Patients who did not wish their lives to be prolonged by extraordinary measures might not want to be saved during a disaster at the expense of others (p. 98).

We can and should ask, was this question used here? And, if so, would it be used to rationalize not giving patients equal care?

What Changes Should Be Made During Disasters?

There are numerous questions that can and should be raised in regard to when and how standards of care during disasters should be changed, if at all. This book is re-

plete with examples. Should, for example, the relative moral weight and, thus, priority be given to saving patients' lives versus relieving their pain differ? (p. 47). This issue involves determining, both during disasters and at normal times, what should count as pain, and how should staff "err" when this answer is not known. An example that Dr. Fink uses is whether patients are suffering when they experience agonal breathing (p. 303). Agonal breathing is the gasping reflex that patients may have shortly before they die. Some experts currently believe that this breathing pattern does not cause suffering because during agonal breathing patients are naturally hypoxic.

Other experts believe, however, that this may not be the case. They believe that these patients may still be suffering. Should doctors give patients in this state morphine to relieve their suffering even if they do not know whether these patients are suffering? Should the answer depend on whether this occurs during a disaster or not?

Dr. Fink says, "Still, the gasping looks uncomfortable, a sharp contraction that rocks the body as if the patient is struggling to breathe, horrifying family members and even nurses when it persists." She continues, "Moral and legal culpability for the deaths rested on wisps of contrast between wanting, foreseeing, and intending death" (p. 303).

Another question creates a dilemma. Should hospitals have a different policy about placing patients in restraints during disasters? (p. 49). Here again, this is a context in which Dr. Pou, this time in a non-disaster setting, had a marked response that I will discuss later.

Giving Prior Information

What should patients be told prior to an impending disaster? What should patients be told about what the staff will do if a disaster occurs? Should all patients facing this potential risk be told, for example, that at some point their own personal doctors may no longer give priority to their interests over others? (p. 80). Should they be informed that if they have a do-not-resuscitate order they may be among the last patients the staff will treat? (p. 92). And, likewise, should they be told that if they do choose to receive hospice care, this may mean that if there is a rescue, they may be among those most often left behind? (pp. 91–92).

Dr. Fink shares ethical proposals regarding some of these problems. She speaks of the need for the public to have a voice in triage proposals, thus questioning the degree, if any, to which these decisions should be left to doctors during disasters. She cites an approach called "deliberative polling." This is a method developed by Professor Jim Fishkin at Stanford which shows that as people become more informed, their views change (p. 479). She points out that a public majority may insufficiently recognize and respond to the needs of others who are among the worst off (p. 481). Therefore, even with full disclosure, it may be that further checks on what should be done remain necessary.

Dr. Fink's most important insight is that during disasters, the places at risk, like Memorial Medical Center, should have an ongoing awareness of both the resources they have available internal to the hospital and the resources that are "on the way." This updating may need to be as frequent as every hour (p. 484).

Because Dr. Pou did not have an ongoing awareness of those resources as she made her decisions, the situation was exceedingly more difficult. Brian Flynn and Anthony Speier say, rightly and insightfully when commenting on Dr. Pou and this book, "The book reflects an apparent absence of a unified command structure within the hospital, so decision making was not fully informed but rather ad hoc. People were left with their own individual perspectives to guide them rather than a rational decision making process" (Flynn & Speier, 2014).

Dr. Fink says, "One of the greatest tragedies of what happened at Memorial may well be that the plan to inject patients went ahead at precisely the time when the helicopters, at last, arrived in force, expanding the available resources" (p. 483).

DR. POU

Dr. Pou's father, Dr. Frederick Pou, was a doctor who sometimes scheduled office appointments until ten o'clock at night. He also made weekend house calls and often took his daughter with him when she was a child. "Pou learned early," Dr. Fink reports, "what a doctor's job was" (p. 37). Her brother, who was 5 years her senior, died of cancer when he was 43. Dr. Fink writes, "Pou said she was haunted by the way he 'lingered'" (p. 39).

I noted earlier that Dr. Pou "reacted" when health care became, in Dr. Fink's words, a "medical marketplace." Dr. Pou then faced new difficulties in being able to treat patients who were poor. Those who could not pay and did not need urgent care, Dr. Fink reports, could then be turned away. Dr. Pou said to friends, "This is the worst… I've never had a day like this" (p. 41).

This response mirrors another she had when one of her patients had been put into restraints. "We can't have this!" she told a hospital risk manager. She insisted that a worker be found who would sit with her patient 24 hours a day. This earned Dr. Pou the respect of the nurse in charge, Dr. Fink asserts, who saw her as having exceptional compassion for her patients (p. 49). Dr. Pou showed this compassion often. "Sometimes," Dr. Fink writes, "she fought after other physicians would have given up hope" (p. 129).

During this disaster, Dr. Pou's not giving up is evinced still further by many of the things she did after Memorial had lost its capacity to provide electricity. To suction a patient's secretions, for example, Dr. Pou was "reduced to" tickling the back of a patient's throat to stimulate a cough reflex (p. 128).

At the same time that Dr. Pou was feeling the stress of a possible conviction and was being, in her word, "terrorized" by reporters, she still responded most compassionately to one of her worst-off patients who was undergoing "drastic, dangerous, facial reconstruction." She told the patient and his wife to "call anytime, day or night," which they frequently did, as Dr. Fink tells us (pp. 307–308). Dr. Pou was so worried about this patient and so concerned with his recovery that she posted signs in the intensive care unit warning anyone caring for him not to put pressure on the left side of his face, neck, shoulder, or arm (p. 333).

Finally, Dr. Pou visited him as she had promised she would. In describing this scene, Dr. Fink is more emotionally evocative than perhaps anywhere else. She writes, "The left socket gaped downward toward a reconstructed cheek several shades lighter than the rest of his skin. Below, an area of black nothingness bordered his nose. 'Do I see a grin on your face,' Pou asked" (p. 443).

The grand jury failed to indict Dr. Pou (pp. 444–445). Since then, she has worked tirelessly, by Dr. Fink's accounts, as she promised to, trying to inspire lawmakers to establish guidelines and immunity for doctors who find themselves in situations like the one she was in (p. 449).

I should add that Dr. Pou generally interacted warmly, equally, and indeed intimately with other staff—as long as she believed she did not have to fight with them for the sake of a patient. She had grown up with some of the nurses at Memorial who knew that her first serious boyfriend had been an anesthetist. When Dr. Pou was seen putting on lipstick at midnight, the nurses laughed and asked "Why now?" Dr. Pou's response was that in case she saw him, she wanted to look her best (p. 51).

After her arrest, Dr. Pou was profoundly affected. In one of the only times in this book that Dr. Fink speculates, she recounts this impression when Dr. Pou is

defending her actions during the disaster. "As she spoke, she nodded emphatically," Dr. Fink reports, "as if to bring along her interviewer or her audience, or perhaps to convince herself," as she said, "'We all did everything…that we could'" (p. 234).

I add, after some hesitation, that Dr. Fink comments periodically on Dr. Pou's appearance. After a group of medical colleagues praised Dr. Pou, Dr. Fink asks, "Was it her trembling lips? Her appealing eyes?" (p. 385). Another example is Dr. Fink's report that after Katrina, Dr. Pou got a "poufy shag" haircut (p. 415) and wore a diaphanous gown (p. 419). Dr. Fink is, of course, a reporter, and this is part of her role. Generally, I am wary of such descriptions. They may, in some contexts, say more about the reporter than the reported. I recall a commentator describing aspects of a person with HIV who added gratuitously that this person had acquired HIV through intravenous drug use. Since this information was not germane to what the commentator was saying, the reason he included it may have been because of his own bias.

However, in this book, I greatly appreciated Dr. Fink's describing how Dr. Pou was coiffed and dressed because it enabled me to imagine that she was doing well or, in any case, not worse.

CONCLUSION

Who then was and is Dr. Pou, and why might she have done what she may or may not have done? I am reminded of a friend who had been in an altercation with another and afterwards asked me who I thought was right. This was actually the wrong question. Sometimes, when there are two reasonably plausible and indeed sound underlying values, "ethics" cannot tell you which answer is "right."

This inconclusive aspect of moral reality can be illustrated in many ways. A current example is the extent to which states in the United States differ in their laws on assisted suicide. Most states do not allow assisted suicide; however, some do. Ethically, there are core fundamental values on each side, but "ethics" as a discipline lacks the means of determining which outcome is right: The sanctity of life is one core, ground value, and patients having the autonomy to relieve their own suffering is another.

This is one reason why juries can acquit a criminal defendant even when all its members believe that the person accused of committing the crime is, in fact, guilty. This is called "jury nullification." Dr. Fink believes this may be what happened here.

REFERENCES

Flynn, B. W., & Speier, A. H. (2014). Disaster behavioral health: Legal and ethical considerations in a rapidly changing field. *Current Psychiatry Reports, 16*(8), 457. doi:0.1007/s11920-014-0457-9

Gostin, L. O. (2006). Medical countermeasures for pandemic influenza: Ethics and the law. *Journal of the American Medical Association, 295*, 554-556.

Holt, G. R. (2008). Making difficult ethical decisions in patient care during natural disasters and other mass casualty events. *Otolaryngology: Head and Neck Surgery, 139*, 1810-1816.