EDITORIAL
From the Editor-in-Chief

James J. James, MD, DrPH, MHA

As the voice of the multidisciplinary disaster medicine community, *Disaster Medicine and Public Health Preparedness* strives to examine the plurality of factors that must be taken into consideration during the disaster planning process to ensure an effective and timely response. In doing so, the March issue of the journal highlighted one such factor that forced our readership to consider issues of both pragmatism and morality, as illuminated within the article "Allocation of Ventilators in a Public Health Emergency" by Powell et al.[1]

The authors presented a case wherein physicians could be confronted with a situation requiring a decision to ration a limited, life-sustaining resource (eg, ventilators) among a patient population whose needs exceeded the available resource. The making of such potentially contentious public health decisions is illustrative of the dynamic tensions that can arise between physicians' traditional professional duties to act as patient advocates versus a potentially countervailing duty to maximize the welfare of all individuals in need of care.[2] Such discord may be most palpable within the context of a declared public health emergency in which there is an increasingly recognized ethical,[3] and in some cases legal,[4] duty to respond. Accordingly, the disaster medicine community must engage in an open dialogue aimed at resolving such discordance and devising policies that will allow translation of relatively abstract ethical principles into usable decision models that will promote the highest level of ethical care possible within settings that do not allow for the provision of accepted care levels to all in need.

In addition to introducing the issue of ventilator allocation, the article also demonstrates an effective framework through which to navigate sensitive and potentially controversial policy topics. Powell et al recount a strategy through which general guidelines were devised in accordance with prevailing ethical norms and were then presented to members of the public to gather feedback. The latter step represents a measure of paramount importance within the field of public health ethics: the duty to make policies transparent and provide the public with the opportunity to join in and contribute to the debate. Public involvement fulfills 2 key purposes. First, it promotes justice and fairness in the planning process by allowing the individuals who will be primarily affected by public health policies to participate in their design. This process also facilitates a second end, that of educating the public regarding the need for policies, such as rationing, that will require a requisite level of understanding to facilitate cooperation. In fulfilling these purposes, it may be possible to obtain community consent for the policies that our medical and public health communities work to implement. A third beneficent outcome of the process is the identification of decision-making parameters and criteria prior to an event, which may help alleviate the paralyzing effect of confronting such ethical dilemmas. In situations in which inaction may well result in the greatest harm, this construct is imperative.

A multitude of ethical issues remain to be addressed and, I hope, resolved as we endeavor to develop effective disaster preparedness and response policies. The unfortunate reality is that disasters represent unique circumstances under which physicians' traditional ethical duties to individual patients may be thrown into conflict with their duties to the greater community.[5] *Disaster Medicine and Public Health Preparedness* will therefore continue to engage the disaster community in dialogue by including additional commentary and discussion articles on matters pertaining to public health ethics. I encourage our readers to participate actively in these efforts so that we can continue to seek ethically sound policy solutions that will effectively fulfill our own professional duties to promote the welfare of those whom we serve—our patients and our communities—and will contribute to informing and protecting our health care responders under the most difficult circumstances.

About the Author

Dr James is Director, Center for Public Health Preparedness and Disaster Response, American Medical Association.

REFERENCES

1. Powell T, Christ KC, Birkhead GS. Allocation of ventilators in a public health emergency. *Disaster Med Public Health Preparedness.* 2008;2:20–26.
2. Bostick NA, Levine M, Sade R. Physicians' ethical obligations when participating in quarantine and isolation measures. *Public Health Rep.* 2008;123:3–8.
3. Morin K, Higginson D, Goldrich M. Physician obligation in disaster preparedness and response. *Cambridge Q Health Care Ethics.* 2006;15:417–421.
4. Coleman CH, Reis A. Potential penalties for health care professionals who refuse to work during a pandemic. *JAMA.* 2008; 299:1271–1273.
5. Childress JF, Faden RR, Gaare RD, et al. Public health ethics: mapping the terrain. *J Law Med Ethics.* 2002;30:170–178.