COMMENTS

The Chennai floods of 2015: urgent need for ethical disaster management guidelines

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Abstract

India has suffered several natural disasters in recent years. The super cyclone of Orissa in 1999 and the tsunami on the south-eastern coast in 2004, both led to major developments in disaster management abilities in the country. Almost a decade after the last major disaster that hit south India, the recent floods in Chennai in 2015 brought to the fore a whole set of ethical considerations. There were issues of inequity in the relief and response activities, conflicts and lack of coordination between the government and non-government relief and response, more emphasis on short-term relief activities rather than rehabilitation and reconstruction, and lack of crisis standards of care in medical services. This paper highlights these ethical issues and the need for ethical guidelines and an ethical oversight mechanism for disaster management and response.

Introduction

The heavy rainfall of the annual northeast monsoon that occurred between November and December 2015 affected the southern states of Tamil Nadu, Andhra Pradesh, as well as the union territory of Pondicherry. Chennai, the capital city of Tamil Nadu, was particularly hard hit by these floods. This flood, which is said to be the worst in about a century, resulted in a massive displacement of close to 18 lakh people in the city. The damages and losses have been estimated between Rs 50,000 and Rs 100,000 crore. Significant flood relief activities were operationalised in the city by the government, non-governmental organisations (NGOs), political parties, the National Disaster Response Force (NDRF), the Indian Navy as well as several international aid organisations (1). The Chennai floods of 2015 were characterised by some important ethical issues. The most important issues were equity and fairness related to delivery of relief and rescue services, conflicts and duplication of efforts of the government and non-government agencies, focus on immediate response and lack of emphasis on long-term rehabilitation efforts, and issues of crisis standards of care.

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The International Federation of the Red Cross and Red Crescent Societies defines disaster management as the organisation and management of resources and responsibilities for dealing with all the humanitarian aspects of emergencies, in particular preparedness, response and recovery to lessen the impact of disasters (2). The objective of disaster management is to reduce community vulnerability to disasters and enhance community coping. Disaster management comprises five phases – prevention, mitigation, preparedness, response and recovery. In the long term, rehabilitation, reconstruction and sustainability are other considerations. The core principles of disaster management include–comprehensiveness, progressiveness, risk-driven response, integration of efforts, multi-sectoral collaboration, coordination of activities of multiple stakeholders, flexibility, and professionalism (3).Though there is no consensus on the definition of code of ethics for disaster management by professional bodies, the code of ethics of the International Association of Emergency Managers emphasises respect, commitment, equity, justice and professionalism(4).

This paper considers examples from the Chennai floods and compares them with instances of the tsunami that hit the coastal areas of Tamil Nadu in December 2004 and the super cyclone of Orissa in 1999. The analysis in this paper will adopt a public health approach to disaster response rather than a purely medical response to disasters.Therefore, issues of social determinants of health and public health issues will be addressed alongside the provision of medical services.The paper attempts to outline important ethical considerations for developing an international guideline for ethics of disaster management.

Equity and fairness issues related to delivery of relief and rescue services

Several NGOs and international non-governmental organisations (INGOs) contributed funds for the delivery of relief services during the Chennai floods. Several INGOssuch as the Catholic Relief Services (CRS), CARITAS CASA, World Vision, Oxfam, CARE and ADRA poured in materials, personnel and funds to work in the flood-affected areas. Also, these donor agencies along with national and local agencies got fully involved in the exercise to finalise common needs

assessment tools, assessment areas, sample size, planning on data collection, data compilation, analysis and report writing within their timeline. During normal times, these INGOs deliver services through partner NGOs based on the needs assessment in their project area. But during the Chennai floods, due to the suddenness of the emergency and lack of information about the vulnerable pockets, the relief operations were undertaken through their partner agencies without a proper needs assessment.This led to differential distribution of relief materials which was perceived as discriminatory and biased[1].

While the city of Chennai was at the centre of all media attention and relief activities, its close coastal neighbour Cuddalore suffered as much if not much more damage due to the rains, but not much attention was paid to relief there. Chennai being the capital city and home for much commercial and political activity in Tamil Nadu, it recevied media attention much earlier and for much longer than Cuddalore. Cuddalore needed more long-term recovery, due to agriculture lands and rural areas where reach is difficult. Besides, the donors were not provided with proper information and they were not prepared to support without local NGO partners. Chennai being the capital, the INGOs themselves could visit the affected areas with the local community support and provide relief materials to the affected communities.

Odisha learnt important lessons in disaster management from the 1999 super cyclone. As part of disaster management and mitigation measures several cyclone shelters were built. Disaster risk reduction (DRR) systems were set up including individual, community, government and NGOs (5,6). In October 2013 when the cyclone Phailin hit Odisha, the state's disaster preparedness, risk reduction and response minimised the damage with a loss of 21 lives compared to around 10,000 lives lost to the 1999 super cyclone. The community involvement and establishment of disaster management systems helped in equitable delivery of disaster management services (7). On the other hand, Chennai was totally unprepared for the floods despite the robust disaster preparedness activities following the 2004 tsunami. The lack of preparedness and community level systems led to inequitable service delivery. Usually the most vulnerable groups during disaster situations are persons with disabilities, the poor, people belonging to scheduled castes and tribes, the elderly, migrant populations and people living in geographically inaccessible areas. Community empowerment for disaster preparedness would have addressed the needs of these special vulnerable populations.

Conflicts and duplication of efforts of the government and non-government agencies

The Chennai floods saw conflicts between the government and non-government agencies during the relief activities. There were several reports of non-government relief materials being intercepted by political party workers and prevented from reaching the affected people (8). There were also reports of some political party workers interrupting non-government relief materials and putting up stickers and seals of the respective parties on them to claim them as their own relief materials. In some areas of Chennai that were visible to the media, a lot of relief activities were carried out by both government and non-government agencies (8). There was duplication of services in certain areas, while certain other areas were completely unreached. Certain interior villages from the main road along the Paalar river in Kancheepuram district, industrial belt of North Chennai and rural Tiruvallur district and villages in Cuddalore, Panruti and Parangipettai blocks of Cuddalore were worst hit by the rains and relief operations were in a mess during the initial stage (9).

Coordination of activities was urgently required between various stakeholders(8).There are several reasons why coordinated government and non-governmental action is a successful model in disaster situations:

- The micro-level community-based initiatives which the NGO can demonstrate can be effectively scaled up by the governmental machinery.
- Coordination of governmental and non-governmental activities will lead to efficient utilisation of scarce resources.
- Duplication, overlapping and confusions can be prevented.
- NGOs can take up specific sectors of disaster management such as community. organisation, women's self-help group formation, livelihood generation, etc. which can effectively supplement the governmental efforts.
- The strength of NGOs is involvement with communities and therefore community based disaster management planning can be effectively done with NGO support.

The super cyclone of 1999 in Odisha wreaked serious havoc in the state. In the initial emergency response phase there was poor coordination between governmental and non-governmental action. However, the state learnt from this experience and to ensure the GO-NGO coordination, the Orissa State Disaster Mitigation Authority (OSDMA) was set up as an autonomous nodal agency for coordinating disaster response, preparedness and mitigation activities of government and non-governmental bodies. In 2001, when floods hit Odisha again, the disaster management was successful because of the coordinated action of the GO and NGOs (10).Following the tsunami of 2004, though robust GO-NGO coordination systems were set up in Tamil Nadu, such coordination was not sustained. The lack of coordination of the disaster response was evident in various activities in Chennai.

Conflicts between government and NGO activity, duplication and confusions undermine the key ethical principles of disaster response as elucidated by the Red Cross and Red Crescent (2). There is an ethical obligation to coordinate GO and NGO activity to optimise the disaster management process.

Focus on immediate response and lack of emphasis on long-term rehabilitation efforts

The previous experience from the super cyclone of 1999 and subsequent floods and cyclones in Odisha have shown that long-term rehabilitation and rebuilding of the lives

of thousands of people who are affected by the disaster is the most important and most difficult aspect of disaster management (11). While short-term efforts of rescue and relief can be achieved effectively because of the media attention and general sense of distress in the community as well as external support, long-term rehabilitation requires meticulous planning and coordination. There has been a lot of activity during the immediate flood response situation in Chennai. The kind of sustained interest in rehabilitation of thousands of people who have lost their homes and belongings and who have been forced to migrate will have to be observed over time. The media focus on the long-term response, the international support and external efforts seem to be waning. There was no proper data about the migrant workers. It was not clear how many survived the floods and even among the survived it was not clear whether they were eligible for the relief support provided by the government. The major disasters that happened in India during the last decade suggest that we still have much to learn in terms of integrating resources in order to achieve effectiveness in long-term disaster management. Indeed, strengthening community capacities that can reduce vulnerabilities drastically and providing information to the government about the vulnerable communities especially to women and children can help the system to prepare effective disaster plans. Similarly, strengthening policy decisions, integration of rehabilitation services and sharing of resources can be a crucial element in development. There is a need for systems to be in place to ensure sustained efforts in the long term.

Crisis standards of care

In disaster situations it is always a delicate balance between available resources and deliverable services. Such situations warrant alterations in the acceptable standards of care (12). One of the important primary responses to the healthcare needs in the flooded areas during the Chennai floods were the medical camps that were run by the government as well as the non-governmental sector. In some of these camps a single doctor examined and prescribed medicines for anywhere between 100 and 200 patients within a span of 3–4 hours. Many camps ended up as mobile pharmacies for dispensing over-the-counter medications for common minor ailments. Some of these camps were duplication of efforts. Whether these kinds of camps are useful in controlling disease outbreaks in disaster situations is questionable. Usually, very little attention is paid towards the quality of care in these settings.

Standards of medical care that should be delivered during crisis conditions are a matter of ethical debate. On the one hand, there is scarcity of resources and damage to the existing resources and a huge unmet need; on the other hand there is an influx of funds, materials and manpower from various government, non-government and international sources(12). Standards of medical care need to be set up by the disaster management authority through a consultative process.

The standards of care during the immediate disaster times are a challenge because there is a need to triage efficiently and allot scarce resources to those who absolutely need them. However, this status quo cannot be carried on over the long term. There is a need to have a long-term standard of care plan. The long-term plan needs to be sustainable and scalable.

Did Chennai learn from the tsunami disaster experience of 2004?

In response to the tsunami of 2004, several important disaster response initiatives were set up in India. Since Chennai was one of the affected areas in the tsunami, the disaster mitigation and management machinery was well established in Chennai. State and district level disaster management authorities were set up. Inter-ministerial and inter-state groups were set up in the planning commission for coordinating the disaster management planning. Warning systems were established at the village level. The warning systems were established with multiple channels of communication such as radio, television, satellite and Direct to Home (DTH) television. The tsunami relief efforts were focused mainly on community participation and capacity building and avoided a charity-based approach. Much was achieved in terms of disaster management and development after the tsunami (13).

Housing and reconstruction

Houses were rebuilt using disaster-resistant techniques with a distinct commitment to improve the quality of housing. The process of reconstruction taught the key lesson that all disasters constrain time, resources and manpower. The need for greater community participation in reconstruction was perceived.

Health and nutrition

Disease surveillance units were set up at the district level and these coordinated with the National Institute of Communicable Diseases and the National Institute of Epidemiology. Malnutrition prevention interventions were established and strengthened. Many guidelines were developed for health activities during relief and recovery periods and information disseminated to healthcare workers. The capacity of health workers to respond to disaster situations was improved. Medical and nursing colleges adopted disaster-affected villages and helped establish disaster mitigation measures in the villages. The need for strengthening capacity of health systems to address disaster situations was understood and measures were undertaken in terms of training and capacity building.

Public buildings, roads and infrastructure

Following the "build back better" policy, most damaged buildings were built back in resilient forms and with better structural and functional properties. However, the good practices of road building were not adopted throughout the city and several areas continued to have badly laid roads.

Psychological support

Adequate emphasis, training and capacity building was provided to various stakeholders including health workers, Anganwadi workers, school teachers, etc, to ensure psychological support during disaster situations.

Education

Disaster management was introduced as a subject in schools. Various measures were adopted for the quick return of children to schools after a disaster.

Disaster risk management

A disaster risk management (DRM) programme was initiated in six multi-hazard prone districts. The DRM aimed to institutionalise disaster management concepts into development activities and build the capacity of communities in disaster risk mitigation and preparedness.

Social equity

There were several reports of inequities in rescue and relief activities in the immediate post-tsunami phase. Households headed by women were found to be discriminated against. The fact that inequity exists was acknowledged by the government. The lack of systems to identify and track vulnerable communities was identified during the tsunami time. Therefore, with active community participation and greater stakeholder involvement, equity systems were ensured (13).

Coordination and information

District resource centres, village information exchange centres, etc. were established for effective coordination of rescue and relief activities where multiple donors, governmental and non-governmental agencies are active.

The above learnings and systems were reviewed and reported in 2006, two years after the tsunami and everything was in place. Exactly nine years later in the same fateful month of December, the flood disaster struck Chennai and none of these key learnings seem to have helped in effective disaster management. The disaster risk management systems at the district and village levels could not sustain their activities and the motivation of the people and the systems. Though attempts were made to institutionalise disaster response, these proved insufficient.

Need for ethical guidelines for disaster management

Every disaster situation brings with it a whole set of ethical issues. Despite repeated experiences some ethical issues such as inequity in relief and response activities, lack of coordination, conflicts of relief activities and lack of emphasis on quality of care seem to plague the disaster management system. Specific guidelines are required for ethical conduct of disaster management. A consultative process of guideline development will help in mainstreaming ethical considerations in disaster response. The CDC guidelines on ethics of public health emergency preparedness and response provide a useful template. These guidelines propound harm reduction and benefit production, equal liberty and human rights, distributive justice, public accountability and transparency, public trust, community resilience and empowerment, public health professionalism and responsible civic response as the key ethical principles (14). The disaster management ethical guidelines should be rooted in sound ethical principles such as (15):

- Ensuring that benefits of relief and rescue activities reach the affected
- Avoiding, preventing and removing harms in the community
- Respecting individual autonomy even in times of disaster
- The compromise that individuals have to make for the sake of common good should be proportional to the benefits
- Ensuring equity
- Transparency in planning and policy in relation to disaster response
- Relevance to the needs of the community
- Responsiveness to changes in the community
- Accountability
- Community engagement and participation in planning and delivery of the disaster management to the maximum extent possible
- Sustainable action and sustainable outcomes.

Besides these guidelines, there is a need for establishing good governance mechanisms to oversee disaster management. Ethical oversight will ensure that these principles are followed.

Conclusion

Disasters pose a sudden and heavy burden on the affected areas. The first response to disasters usually comes from the local population. National and international support a well as regional resources are mobilized over time. The most important ethical issue isinequity of rescue, relief and rehabilitation works in various disaster-affected areas. Lack of coordinated action by multiple stakeholders including the government, non-governmental machinery and the international organisations also poses an important ethical problem leading to duplication of services in certain areas and lack of attention in others. Crisis situations demand a unique set of considerations which tend to modify the expected standards of care. In times of disaster, there is an ethical obligation to think of sustained solutions and long-term plans for restructuring and rehabilitating the affected communities. There is an immediate need to formulate ethical guidelines to govern disaster response.

Note [1] There is no documentation of this fact. It is from the personal experience of the first author, who was involved in coordinating relief and rescue efforts both in Chennai as well as Cuddalore.

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Robert Spitzer and psychiatric classification: technical challenges and ethical dilemmas

KS JACOB

Dr Robert Leopold Spitzer (May 22, 1932–December 25, 2015), the architect of modern psychiatric diagnostic criteria and classification, died recently at the age of 83 in Seattle. Under his leadership, the American Psychiatric Association's (APA) Diagnostic and Statistical Manuals (DSM) became the international standard.

Dr Spitzer died of complications of heart disease at the assisted living facility, where he lived with his wife, Janet Williams (1).

Dr Spitzer was born in White Plains, New York. He graduated in psychology from Cornell University in 1953 and in medicine from New York State University School of Medicine in 1957. He completed his psychiatric residency from New York State Psychiatric Institute in 1961 and his training in psychoanalysis at Columbia University in 1966. He spent his career at Columbia University and retired as professor of psychiatry in 2003.

American psychiatry in the 1950s was dominated by psychoanalysis, which had little interest in psychiatric diagnosis. This lack of emphasis resulted in significant and frequent diagnostic disagreements among psychiatrists. Psychiatry was facing a crisis of credibility. There were major scandals with normal people, posing as individuals with mental illness, being diagnosed, admitted to mental hospital and treated with psychotropic medication (2).

The late 1960s also saw many innovations in the field. The US-UK Diagnostic project highlighted significant discrepancies in practice between American and British psychiatrists (3). Edwin Gildea, at Washington University at St Louis, Missouri, advocated a medical model for psychiatry in which diagnosis played a crucial role. Encouraged by John Feighner, a discussion group led by Eli Robins and including Sam Guze, George Winokur, Robert Woodruff, and Rod Muñoz, reviewed key contributions to psychiatric diagnosis. They then set about developing new diagnostic criteria for major depression, antisocial personality disorder, and alcoholism. Their major

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