case study

The Disasters of March 11th

On March 11, 2011, one of the most powerful earthquakes ever recorded occurred off the northeast coast of Japan. It destroyed buildings, damaged infrastructure, and killed people in the Tohoku region. The associated tsunami was even more destructive, engulfing coastal areas and obliterating whole towns. The earthquake and the tsunami together occasioned a third disaster: the meltdown at the Fukushima nuclear power plant. The toll of these disasters was immense: 25,000 dead, 6,000 injured, 300,000 homeless, and countless lives shattered.

Many people responded to these disasters. Family members and neighbors rescued people and cared for victims. Police, fire fighters, and military personnel responded to the call for help. Hospitals implemented disaster plans and provided emergency care. Many health care workers provided acute care, and, after the first phase of the disaster response, some turned their attention to the need for continuing and preventive care.

Like most people, Dr. Makoto Sato was horrified by the destruction and suffering that he saw. He wanted to help and felt that he should, but doing something appropriate and effective was not easy. He is a general internist and biocynicist at a university medical center in Hokkaido, the large island north of Tohoku. When he saw the disaster scenes on television, his immediate impulse was to pack up his car with supplies and head to Tohoku. But that was not practical: throughout Tohoku, many roads were damaged, gas was in short supply, and phone service was disrupted. Even if he got to the affected region, what he could do best might not be what was needed. The immediate needs were for water, gas, and electricity. Dr. Sato followed the news, but even the news was confounding: Japanese and international accounts of the nuclear disaster were quite different.

Dr. Sato continued to follow the news and discuss the events with his family, colleagues, and students. But gradually his life returned to its normal pattern, dominated by the concerns associated with teaching, doing research, caring for patients, and taking part in family life. These immediate concerns left little room for other activities. As time went on, he was left with a slight but lingering bad feeling: a vague sense that he could have—and should have—responded to these disasters.

What should Dr. Sato have done then? What should he do now?

commentary

by James Dwyer

I know the feeling. From both near and far, I have watched disasters unfold and wondered what I should do. Often I’ve done nothing and then lived with a vague sense of unease. In 2005, I watched with horror from afar as political indifference and structural injustice compounded the destructive force of Hurricane Katrina. On September 11, 2001, I was less than two miles from the World Trade Center. I went to the medical center where I worked, but I was not needed; I went to donate blood, but I was not needed.

When people think about ethical issues in disaster response, they often focus on dramatic cases of triage and the allocation of scarce resources. But I think that Dr. Sato’s situation raises more common and difficult ethical issues. These issues don’t have a name. They have something to do with responsiveness, solidarity, and social responsibility—they are about when and how to take responsibility for effecting change. They also have to do with the difficulty of integrating social responsibility into habits, practices, and institutions.

I believe that responsibility in ethical life is open, creative, and social. Of course, we have some specific responsibilities as doctors, teachers, parents, and citizens. However, in all roles and aspects of life, there are large areas in which we need to take some responsibility, but what responsibility to take, and how much, cannot be specified without context. Specific responses must be constructed in light of our abilities, positions, privileges, commitments, and situations. I don’t think that any ethical theory or method can tell us what to do in a situation like Dr. Sato’s, but I want to suggest how we might approach the problem.

What should Dr. Sato have done then and there? As a human being and a medical doctor, he should have tried to respond to the immediate and urgent needs of the people in Tohoku. He started to respond: to do so was his first thought. But I want to suggest that he
should have been more creative. The choice was not between getting in his car and doing nothing. Lone individuals coming from afar are not very effective, unless they are trained, equipped, and organized. Dr. Sato should have discussed with people at his university what they might do together to aid those in need and to assist health care workers in Tohoku. There was more potential in the situation than he saw and realized.

What should Dr. Sato do now? That is a difficult question because most of us are better at immediate, on-the-scene responses than at long-term change—certainly the people of Tohoku responded with great civility and dignity. Now that the immediate phase of the disaster is over, Dr. Sato should gradually shift emphasis from what his appropriate response should be as a human being and medical doctor to what it should be as a citizen. He should look to see how structural injustices compounded the natural disasters. And he should look to see how common interests could be addressed in better ways. Together with others, he could discuss the disaster plans at hospitals, the resilience and sustainability of communities, the needs and participation of vulnerable groups, the care of the elderly in cities and rural communities, the relationships between many organizations as possible: medical associations and hospitals in the disaster area, and local medical associations in his own city.

In addition to gathering information, Dr. Sato would have needed to construct a reasonable schedule for himself. He could have made a rotating schedule with colleagues who share his desire to help; perhaps they could take turns going to Tohoku once or twice a month, as their energy levels and workloads allowed. Since the major ongoing medical needs involved chronic conditions of the elderly, a manageable schedule that allowed them to offer long-term, continuous care would have been crucial.

I also think that Dr. Sato should have taken his students with him. Going into the field to support this relief work could be an important opportunity for them to learn the significance of medical work. In refuges and temporary shelters, doctors encounter patients as whole human beings. They cannot focus only on disease, but must take into account patients’ environments and life stories, including the traumatic aftermath of the disaster: the loss of houses or jobs, for instance, and the death of loved ones.

Now, more than a year after the disaster, there is still a need for Dr. Sato to go to Tohoku to support the people living there. Many are just now leaving temporary shelters and moving into temporary housing. This change is both good and bad. People now have more privacy, but this means they are isolated. After the Kobe earthquake, a considerable number died solitary deaths. This outcome should be avoided. The elderly with chronic conditions still need continuous medical care. This care should include mental health care—something that others besides the elderly require, as well. Recent reports estimate that 30 percent of nurses who work in the disaster areas suffer from posttraumatic stress disorder. Not only is their work very stressful, but many of them are themselves disaster victims.

In the face of all these problems, Japan’s government seems more concerned with introducing neoliberal policies on behalf of big corporations than with helping ordinary people recover decent lives. For example, the government has used the disasters as an occasion to try to give corporations access to fishing areas that were controlled by the fishermen’s union. In contrast to the government response, many volunteers have been doing marvelous work. However, the scale of the disaster is too big. More citizens’ initiatives are needed to help people who are burdened not only with psychological and physical problems, but also with economic ones. If he really wants to help, Dr. Sato should start such an initiative.

**commentary**

by Kenzo Hamano

Dr. Sato should have gone to the disaster area to help the people suffering there. But first he should have found out how to get there, where he could help the most, what kind of medical problems he would encounter, and what kind of medications and equipment he would need. The main medical needs this time were different from the needs in the Great Kobe Earthquake of 1995. Then, many people were crushed by furniture, houses, and buildings. They suffered from physical injuries, while this time the majority of people died by drowning in the tsunami. The elderly who survived the tsunami were crammed into evacuation centers and temporary refuges. Many suffered from complications associated with chronic conditions they had before the tragedy.

The importance of gathering information in this situation cannot be emphasized enough. Unfortunately, most lines of communication were down in the affected area. Many mobile phones did not work. Although satellite cell phones worked reliably, only a few facilities were equipped with those systems. Furthermore, there was no national agency to coordinate efforts and provide information, so to gather information, Dr. Sato would have had to contact as
In reflecting on what Dr. Sato should do, I want to keep in mind the social context. Under the current social conditions, certain kinds of actions may be supererogatory, but under different social conditions, the same actions might be obligatory. Dr. Sato’s feelings of unease and guilt may point to the need to change the current social conditions so that certain disaster responses become obligatory.

Although Dr. Sato’s sympathetic reaction is a sign of his moral nature, he should not have rushed to the disaster area. To do so would have been excessively dangerous and possibly harmful. Without better knowledge, he could have exposed himself to radioactive fallout and even spread it. Since the affected area had electrical outages and traffic problems, his presence might actually have hindered relief efforts. To be ethical, immediate responses need to be prudent and effective. Dr. Sato’s impulsive desire to help is neither.

But he should do something. He has a responsibility to create social channels for sympathetic responses that are prudent and effective, as well as safe for those responding. Because he is a health care professional, he has an obligation to help care for the victims of this emergency, and because he is a university professor, he ought to set a moral example for his students, as the Confucian tradition dictates.

There are many things that Dr. Sato can do. He can use his medical knowledge to help educate people about radiation exposure, the proper use of iodine, and the social consequences of hoarding medications. He can collaborate with others to form medical teams to care for the long-term needs of evacuees living in the Aizu area. He can fight against the discrimination encountered by those who need to relocate from the area of the nuclear disaster. As a teacher, he can help students reflect on what they might do and help them find effective ways to get involved while protecting young students who might be impulsive and lack experience.

But Dr. Sato needs to do more. He should be working with others to develop a plan. The Code of Conduct for the International Federation of Red Cross and Red Crescent Societies emphasizes the need to “build disaster responses on local capacities” and to “involve program beneficiaries in the management of relief aid.” Instead of thinking of himself as a helper, he can get involved in the self-resilient activity of Tohoku residents. And he can help his students to cultivate the habit of working with the community. If community members, volunteers, students, and organizers work together, they might be able to create a disaster response system in which every person has some role in dealing with future disasters. Then, actions that once seemed supererogatory might come to be seen as moral obligations that are implicit in people’s roles as neighbors, teachers, and doctors.

Since the most basic ethical task is to learn from experience, I hope that my own country, Taiwan, can learn from Japan’s experience. Taiwan and Japan are in similar situations: prone to earthquakes, tsunamis, typhoons, and mudslides. After World War II, both countries focused on economic development and tended to ignore environmental concerns. Indeed, both countries built nuclear power plants on the coast because calculations about cost-effectiveness dominated public decisions. Now much needs to change.

But I believe that change will be harder in Taiwan. We Taiwanese must find democratic ways to share risks, engage more people in public discussions, overcome social distrust, and foster a spirit of solidarity. Where to begin? People like me, who just slip back into their life routines after major disasters, need to listen carefully to different opinions and communicate patiently with different people. Then we need to put words and feelings into action.

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