

## VCHIP CHAMP VDH COVID-19

May 1, 2020 | 12:15-12:45pm Call Questions and Answers\*

Wendy Davis, MD, FAAP, Vermont Child Health Improvement Program, UVM

Breana Holmes, MD, FAAP, Director of Maternal & Child Health, Vermont Department of Health (VDH)

### **Practice Issues – Ethical Considerations Regarding COVID-19**

*Tim Lahey, MD, MMSC, Infectious Disease Physician & Director of Clinical Ethics, UVM Medical Center, Professor, UVM Larner College of Medicine*

Currently, we have been trying to expand our clinical capacity to deal with extra cases of COVID-19 in hopes that we never have to ration, and as of now, we have not had to. We knew we needed to be ready to ration thoughtfully, transparently, and fairly if we had to. The situation is unpredictable and we are hoping we have seen the worst. Of course, we will see, particularly with our neighboring states having high incidences.

When you think about rationing resources in a time of scarcity, you collide with the Trolley Problem. The idea is that you, as a physician/clinician, are the person standing on the tracks with the switch. The trolley is going to either kill the five people on the tracks or one, therefore saving four lives. If you ask people the question, most will avoid it rather than answering what they would do. If forced to answer, most will choose for one person to die rather than five. Social scientists have done these experiences where you can engage an active or a passive participant in this. Were you a witness to this system that passively led to the death of one vs. the five, or did you personally turned the switch yourself? What if you had to commit a sin in order to make that happen, for instance lying to someone to have them change the course. What that be more acceptable or not for flipping the switch? What if you committed murder? Pushed one person in front of trolley to prevent the five from being killed. Would that be worse than flipping the switch? And then you can get into human bias; could you tell yourself a story about the people to modify your willingness to make such a choice? What if you were invisible when you pulled the switch? Would you be more willing to act this passionately?

We don't want to make the decision to allocate resources, but in times of scarcity, we have to. We have to base those decisions on legitimate factors knowing we that have temptation to do it for illegitimate reasons. We started at UVMMC and expanded across the network. This is a network-wide policy with individual institution specific procedures that align and make it work locally. Most recently, we have embedded that work in an updated Vermont Crisis Standard of Care, and that update is not fully complete. The content described today is what will be in the policy document.

If we have to decide, decisions will be based on medical factors (acuity/prognosis criteria) and not social factors (employment, wealth, insurance status). Whatever the decision is, we must respect the dignity in treatment of all patients and render whatever care we possibly can to the greatest degree feasible. We know we are not perfect so there needs to be an appeals process. Due to the delicacy of decisions, we need to be transparent in the decision-making process and review the process periodically in case we need to revise it.

1. If there is no scarcity, we stick with the current state of affairs, which is a first-come, first-serve approach. Note: we need to recognize there is injustice in the way health care is currently applied and we still need fixes. This system is not designed to be the intervention to fix inequity in all cases.
2. If there is a rationing signal, this would come in the form of incident command signals of rationing need based on status of beds/ventilators.
3. The triage leader then relays institutional setting to the caller, such as acuity criteria for getting into bed, into ICU, onto ventilator. In some cases, it could be obvious. Other times, patients considered may not be obviously different.

\*Note: This is a paraphrased synopsis of the call and is not a word-for-word transcription.

4. In such a case where the choice is unclear, the triage leader confers with another triage leader and makes a team decision.
5. If they don't think it's obvious, then the case is brought to an appeals group (blinded to social factors). If the appeals group don't think it's clear, then the group will randomize to make a decision. The decision is based on a 3-step evaluation process.
  - i. Apply inclusion and exclusion criteria
  - ii. Calculate MSOFA score
  - iii. Assign people to a triage category

You can imagine inclusion criteria for various interventions. Exclusion criteria is based on reasons person would not be expected to survive based on factors outside of COVID-19 conditions. If the person doesn't have that and does meet inclusion criteria, then use the MSOFA score to gauge how sick they are. That would segregate them into four categories: 1) probably fine without intervention, 2) really need intervention and otherwise pretty good prognosis, 3) resource use may not result in good patient outcome, and 4) sick enough to be lower on the priority list.

The guidelines for what can be considered or not considered include: (factors that may be considered) validated metrics that gauge acuity of illness and prognosis are encourage with mSOFA score correlated with COVID-19 mortality. Another factor that may be considered is the prognosis and likelihood of treatment response based on risk factors relating to an existent even, co-existent end-stage failure of a major organ (i.e. heart, lung, liver, or brain), and other accepted medical factors. We also need to recognize that the availability of resources are also important (i.e. if there's no dialysis machine at the facility and a patient needs it no matter what, then we may not be able to provide resources). Importantly, we want to be careful and avoid biasing social factors (i.e. sex, gender identity, disability or degree of disability, health insurance or ability to pay, socioeconomic and social status factors, etc.).

The rumors about this plan have helped inform us what people are worrying about but also helped us to get the language right. People worry that the goal is to figure out who does not get the care. Our goal is to maximize the number of lives and people we can save. Another rumor is around people with CF and various types of disabilities and they are worried that the disadvantage in health care will continue with COVID-19 resource allocation decisions. It is important to reassure people the UVMHC documents do not include those diagnoses and actually forbid consideration of single diagnosis as exclusion criteria. The Vermont guidelines are also being updated accordingly. A valid point that is harder to critique and to address is health inequities. If you come to COVID-19 with risk factors related to a poor prognosis from COVID-19 that was caused by social injustice, then a decision to allocate resources away from these individuals is perpetuating injustice. Likelihood of hypertension in certain oppressed populations could lead to poor COVID-19 outcomes. Not all interventions can fix all problems. It should not be ignored and we should track to see if this plan unwittingly exacerbates those inequities. Also, we need to grapple with the fact and fight in many ways to address those inequities. It is a delicate balancing act we are trying to strike. I hope that gives you a sense of how we're trying to balance resource allocation challenges for ventilators and ICU beds.

Dr. Breena Holmes asked a question regarding NYC's experience in the social justice arena with COVID. We will likely be hearing about that for months to come. One NYC hospital came right up to edge of using it, but there were families leaning towards comfort measures, so in the end it was not needed. Another hospital used it on one occasion. More research will be needed to show how social determinants correlate. What can we do in terms of addressing social inequities?

We think decisions should be based on medical factors, and age over 65 is a strong validated factor in COVID-19 patients. If you're deciding between two patients and one is over age 65, then that would be medically defensible exclusion criteria. Should you just look for likelihood of surviving the next couple of weeks? Or should you count up the numbers of life years saved? It makes sense that one would want to save the life of a 12-year-old over a 52-year-old due to the number of years of life saved. The problem that

comes into play there is two-fold. Disability rights activists would say that differentially impacts them, thus exacerbating existing factors. It is also unknowable whether that specific 12-year-old would live longer than that specific 52-year-old. It is more ethically defensible to focus on short-term benefit to avoid disability rights issues, but other physicians do feel it's defensible because it feels like saving a child over an adult feels more fair.

### Questions/Discussion

**Q: How do you feel about pharmacists testing for COVID-19 at their pharmacies? I suspect we will set an age-cutoff below which is not a good idea. There are major structural considerations around infection control and physical layout. I am more interested about clinical conversations and how pharmacies fit in. New information from the CDC on front of the nose testing requires both nostrils and holding for 10-15 seconds to do it right, otherwise we can get false negatives, which would be a big problem. Please send comments to Dr. Breena Holmes.**

**Q: Have you added the newer, additional CDC symptoms to your screening tool before visits?**

*A: Wendy Davis, MD, VCHIP: I will briefly show the "new" sx's. The CDC has officially acknowledged the loss of smell/taste, headache, muscle pain, sore throat and shaking/chills.*

*A: Tim Lahey, MD, UVM MC: As we shift into surveillance mode ( i.e. looking for pockets of emergent COVID-19 in need of intensified measures), having a broad sense of sx will be helpful for a while, and then hopefully we can let our paranoia about this virus fall into the shadows of history.*

**Q: What are you hearing about this development, regarding the new symptoms acknowledged by the CDC?**

*A: Breena Holmes, MD, VDH: I think it is helpful to mention again to the general public in the context of wanting to increase our testing. We've just had so many restrictions over the weeks about who could be tested and as we expand, we need to remind people that the clinical presentation is starting to be better understood and broader.*

**Q: I have this image that a lot of patients who were not good candidates for ventilators got intubated because they did not have any advanced care planning. Is this not the case? Palliative care has played such an important role in Vermont. Both with the rapid dementia post COVID and others and end of life issues.**

*A: Breena Holmes, MD, VDH: Early on, the opposite was true in VT. Several patients at long term care facilities had advance directives and never went to the hospital and DNR was honored.*

*A: Tim Lahey, MD, UVM MC: The general default is that people's advanced care planning is honored. If DNR, then they're not intubated. This pandemic has introduced uncertainty and confusion. EMS providers are wondering if perhaps in place of rationing, they should decide whether they should provide care or not if there is a specific question of whether or not the patient wants to be intubated due to COVID-19 was not addressed. We are asking EMTs to decouple that from the original patient's wishes.*

**Q: I appreciate the reporting of COVID cases/ deaths by race. I'm wondering about proportion of deaths for the VT population, especially in more ethnically diverse communities (Burlington, Winooski)?**