# Interim Ethical Recommendations in Medical Management in the Covid-19 Crisis

PCP Ethics Committee
28 March 2020

## Introduction

As this set of recommendations is being written, the pandemic is raging across the globe leaving governments and health authorities of even the most sophisticated countries, beleaguered, disorganized and unprepared to mount a systematic response for a crisis never been experienced in the modern world.

Healthcare providers are molded and trained with a mindset of individualized patient care. Public health emergencies such as the COVID-19 pandemic that we now face, clinicians are obligated to change their paradigm, including, in some situations, acting to prioritize the *'community above individual' policy* in fairly allocating scarce resources. The shift from patient-centered practice supported by clinical ethics, to public-focused care guided by public health ethics, creates great tension for clinicians.[1] The degree of effect this paradigm shift on health care varies with the preparedness, stability and resilience of government health structure, allied support agencies, and every individual expected to participate within the crisis management protocols.

In health crisis situations healthcare organizations and healthcare institutions have the ethical duty to provide recommendations where the clinicians can base their decisions on. The angst that clinicians may experience when asked to make difficult decisions for reasons not related to the welfare of their patients should not be underestimated. It may lead to debilitating and disabling distress for some clinicians. One strategy for avoiding this tragic outcome is to use a triage committee set-up to buffer clinicians from this potential harm. The triage committee is preferably composed of volunteers who are respected clinicians and leaders among their peers and the medical community or institution.[2]

The objectives of these recommendations are the following:

1. To provide frontline responders a guide in making ethical decisions in management of the emergent COVID-19 crisis situation.
2. To diminish potential distress for clinicians when decisions involve conflict between patient-centered care and public health duties

The ethical framework these recommendations are based on the principles of physician's duties that should balance the following:

1. Duty of care that is foundational to heal care
   - Non-abandonment
   - Relief of suffering
   - Respect for rights and preferences of patients
2. Duty to promote moral equality of person and equity
   - Distribution of risks and benefit to society
   - Promote public safety and community health
   - Fairly allocate limited resources
   - Transparency in the manner of allocation of treatment

**Three Ethical Duties of Health Care Leaders Responding to COVID-19**

1. **The Duty to Plan.** In a situation where there is a foreseeable scenario of ethical challenges to occur in a public emergency, healthcare leaders ought to lay out a plan that can guide providers of healthcare if and when ethical conflicts are actually in front of them. The moral conflict in practice becomes a source of stress when duties and values are blurred by the situation. These challenges affect the health care workforce and how a health care institution serves the public and collaborates with public officials.

   What needs to be planned in the COVID Scenarios
   a. Identification of potential triage decisions, tools and processes
   b. Level of care (ICU vs. medical ward vs. temporary set-ups vs. home monitoring
      - Initiation of life sustaining treatments (CPR, ventilation support)
      - Comfort focused care
   c. Shortages of staff, space and supplies

2. **The Duty to Safeguard.** Health care organizations and leaders have a duty to the medical workforce. In the surge of epidemic/pandemic amid deteriorating conditions the doctors, nurses, and medical support staff are at heightened risk of occupational harms. In the COVID crisis, it has to consider the following:
   a. Age
   b. Underlying health conditions
   c. Direct healthcare providers for high risk family members
   d. *Medical students/nursing students are considered as a vulnerable population and have to be protected, not obliged to become frontliners

3. **The Duty to Guide.** The level of ethical tension starts when the line needs drawn between Public Health Ethics defined by fair allocation of limited resources and public safety vs. Patient Centered Ethics defined by respect for rights and preference of individual patients. This defining line is made especially stark when life-sustaining interventions are not available to all patients who could benefit from these interventions. In such situations, frontliners would likely have to make a difficult choices. e.g. prioritizing ventilator support, ICU vs. regular room or ward, allocation of critical resources to patients who will benefit the most.

   The hospital or health system's institutional ethics services including ethics consultation services such as palliative care and pastoral care services have to be activated to function as resources for clinicians and teams experiencing uncertainty and distress under normal conditions.
   Although the ultimate goal is to 'save most lives', it is imperative that patients who are diagnosed as COVID suspect (PUI) or COVID Positive (Confirmed), must be treated with utmost care and compassion.

**Guidelines for Institutional Ethics Services Responding to COVID-19**

1. Clinical ethics consultation (CEC) services, clinical ethics consultants, and ethics committees should recognize duties to promote equality of persons and equity in distribution of risks and benefits in society and consider how best to support clinical practice during a public health emergency.
2. A hospital's institutional ethics services should prepare for service during a public health emergency.
3. Leaders of institutional ethics services, such as ethics committee chairs or clinical ethics consultants, should determine the availability of committee members and consultation providers for service during a public health emergency, mindful that clinicians may have patient care roles and that many members will be limited to remote access.
4. Preparation to provide ethics services during a public health emergency should focus on the consequences of contingency levels of care for patient-centered care, the consequences of crisis standards of care for patient preferences, and how ethics services will support clinicians in managing foreseeable ethical challenges in the care of patients with COVID-19. Training in or working knowledge of key principles of public health ethics and disaster response is integral to preparation.
5. Ethics leadership should support and contribute to discussion, review, and updating of relevant policies and processes with reference to the ethical duties outlined in this document.
6. Ethics services should collaborate with interdisciplinary palliative care services concerning practice under contingency and crisis conditions, in view of their frequent collaboration under normal conditions and the likelihood that these services will be short-staffed.
7. Ethics services should prepare to respond to staff moral distress under crisis conditions, with attention to different clinical areas, such as the emergency department, medical ward, and ICU, and to support across shifts. Training in or working knowledge of key principles of public health ethics and disaster response is integral to preparation.
8. Clinical ethics consultants should review and update consultation processes and practices to accommodate resource limitations, infection control restrictions, and visitor restrictions.

**RECOMMENDATIONS IN MAKING ETHICAL DECISIONS DURING THE COVID-19 CRISIS**

The rapid turn of events in the current pandemic resulted into crisis situation where prioritization of treatment needs to be done because of the scarce resource relative to the vast number persons being affected. The need for triaging is necessary to save the most lives by making ethical decisions in prioritizing patients for care, rationing scarce resources, and making decisions about who will and will not receive potentially lifesaving therapies.

**1. MEDICAL PERSONNEL**

a. TRIAGE TEAMS in crisis areas should be created to make decisions in the event of management conflicts.
   i. The institution may decide to have separate triage teams assigned to different crisis areas[6]
      1. Primary or Emergency Triage Team makes decisions regarding the priority for assessment and initial treatment of patients when they first arrive at the hospital, usually the emergency room.
      2. Secondary or Critical Care Triage makes decisions regarding priority of care in the intensive care unit
   ii. It is ideal that a triage team leader be designated in each triage area to make quick assessment of situation and the finalized decision of the team.
   iii. The team should be composed of volunteers who are respected clinicians and leaders among their peers and the medical community. The members of the team should include representatives from:

*Nancy Berliner et al, Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19), Guidelines for Institutional Ethics Services Responding to COVID-19 The Hastings Center, March 16, 2020 (Used with permission)*

1. Internal medicine department (pulmonary, cardiology, renal, infectious disease, gastroenterology, neurology)
2. Anesthesia department
3. Nursing Department
4. Administrative Department
5. Surgery Department
6. Other support Services (Palliative Care, Pastoral Care)

iv. A triage team leader must be appointed

b. Doctors and nurses with high risk comorbid conditions must not be assigned as frontliners in critical areas (e.g. ER, ICU)
   i. Elderly
   ii. Immuno-compromised patients (diabetics, transplant patients, cancer patients, glomerulonephritis and autoimmune disease patients on steroids, etc.)
   iii. Pulmonary patients (COPD patients, asthmatics etc.)
   iv. Cardiac patients (post MI, heart failure patients, etc.)
c. Medical personnel on the frontlines should be prioritized to be provided the optimum, accepted standard personal protective equipment.
d. Priority areas should be given adequate staff support to lessen the risk of having to attend to tasks that can be delegated to support staff members. Prioritize staffing according to level of responsibilities needed.
e. Make sure all members of the medical team in each area are oriented to the precautions, responsibilities, and standing protocols to diminish conflicts in the execution of their respective tasks.
f. WRITTEN PROTOCOLS in making ethical decisions must be put in place to avoid inconsistencies in decision making.

**2. PATIENTS**

**a. ALLOCATING CRITICAL CARE[4]**

i. In a situation off extreme shortage of facilities such as availability of ICU beds, allocation must aim at prioritizing beds to patients with greater chances of therapeutic success. Those who have the "greatest life expectancy" must be given Priority
ii. Criteria based type and severity of the disease, presence of comorbidities, impairment of other organ/systems and their reversibility
   1. Inclusion criteria:
      a. Requirement for mechanical ventilator support
      b. Hypotension with evidence of shock (altered LOC, decreased urine output, refractory to volume resuscitation and requiring inotropic support.
   2. Exclusion criteria:
      a. Low probability of survival
         i. cardiac arrest not responsive to resuscitation
         ii. severe irreversible neurologic injury
      b. Short Expected Life Expectancies
         i. Malignancies with poor prognosis
         ii. End stage organ failure with expected survival very short expected survival e.g. severe heart failure, severe COPD and advanced hepatic cirrhosis.
   3. Clinical suitability
   4. Must <u>not</u> be "first-come, first-served." basis
iii. Allocation of patients to be admitted must be discussed by the medical team in dialogue with the patient/family as applicable
iv. the decision must be made in a timely fashion
v. adapted to the available resources

**b. ALLOCATING VENTILATORS**

i. The goal is to save the most lives as defined by the patient's short-term likelihood of surviving the acute medical episode.
ii. Triage clinicians should proactively engage in discussions with patients and families regarding do-not-intubate orders for high-risk subgroups of patients before their health deteriorates. Once patients have already been placed on mechanical ventilation, decisions to withdraw it are especially fraught.[2]
iii. Three Steps In The Allocation Protocol:
   **1. application of exclusion criteria,**
      a. Irreversible shock
      b. Unwitnessed arrest, recurrent arrest
      c. Trauma related arrest
      d. Severe, irreversible neurologic condition at high risk for mortality
      e. Patient or patient's surrogate declines mechanical ventilation
      f. Other conditions that may be considered but are highly debatable depending on the status (advanced cirrhosis, dialysis dependent patients, cancer patients with advanced metastasis)
   **2. assessment of mortality risk**
      a. based on clinical assessment using SOFA Score*
      b. Patients who have a moderate risk of mortality and for whom ventilator therapy would most likely be

lifesaving are prioritized for treatment

c. Age, social worth and job function shall not affect allocation (high officials, healthcare worker are not specifically prioritized over other patients

**3. periodic clinical assessments ("time trials")**

a. official clinical assessments at 48 and 120 hours after ventilator therapy has begun are conducted to determine whether a patient continues with this treatment.

b. Triage decisions are made based on ongoing clinical measures and data trends of a patient's health condition, consisting of:

i. the overall prognosis estimated by the patient's clinical indicators, which is indicative of mortality risk by severity, and number of acute organ failure(s)

ii. the magnitude of improvement or deterioration of overall health, which provides additional information about the likelihood of survival with ventilator therapy.[3]

iii. **Guiding principle for the triage decision:** The likelihood of a patient's continuation of ventilator therapy depends on the severity of the patient's health condition and the extent of the patient's medical deterioration.

c. In order for a patient to continue with ventilator therapy, s/he must demonstrate an improvement in overall health status at each official clinical assessment.

d. After the 120 hour assessment, patients are evaluated every 48 hours with the same clinical framework used in previous time trial assessments.

e. In addition to removing the responsibility for triage decisions from the bedside clinicians, committee members should also take on the task of communicating the decision to the family.

**c. WITHDRAWAL FROM VENTILATOR**

i. In situations that ventilator availability is in extreme shortage, the evaluation of status of intubated patients is crucial if withdrawal from ventilator may be recommended.

ii. Decisions to withdraw ventilators during a pandemic in order to make the resource available to another patient cannot be justified if in the following situations,

1. it is not being done at the request of the patient or surrogate representative
2. it be cannot be claimed that the treatment is futile

iii. Decision to withdraw will have based on the evaluation criteria previously defined.

**d. ADVANCED CARE PLANNING and DO-NOT-RESUSCITATE DECISION MAKING**

i. In a pandemic situation, advanced care planning at the onset of serious acute illness will be beneficial and should be given priority for the following reasons:

1. to avoid intensive life-sustaining treatments when unwanted by patients
2. to avoid non beneficial or unwanted high-intensity care becomes especially important in times of stress on health care capacity
3. provision of non-beneficial or unwanted high-intensity care may put other patients, family members, and health care workers at higher risk of transmission of severe acute respiratory syndrome coronavirus

ii. The implementation of DNR orders can occur in 3 situations:

1. Patients or their surrogate decision makers may clearly understand and communicate that the patient would not want CPR if the heart were to stop and may even have a physician's order for life-sustaining treatments form that specifies such.
2. patients or their surrogate decision makers may follow the recommendation of a clinician to forgo CPR or intubation this may occur through a. informed consent b. informed assent (see appendix 1)
3. extreme situations in which CPR cannot possibly be effective, clinicians in some health care settings may unilaterally decide to write a DNR
   a. not uniformly accepted and reasons for decision need to be discussed with family by the triage officer (i.e. futility of care, harm to healthcare workers, limited resources that may be allocated for other patients)
   b. in extreme situations may be done to reduce the risk of medically futile CPR to patients, families, and health care workers

iii. Careful discussion with the patient and the family on the nature the illness and the scope of possible outcomes to illicit their views and possibly give advanced directives that can make decision making easier.

**e. USE OF ALTERNATIVE TREATMENT:**

i. For illness that has no proven cure the use of drugs as off label indication may be allowed for compassionate use

ii. Use of trial drugs provided previous trial use has shown some promise of clinical improvement.

iii. Patient or surrogate gave informed consent

**f. VISITATION/COMPANION RESTRICTIONS**: Institutions/hospitals must provide visitation policies that will protect the safety of health care workers and the welfare of the patient once put in isolation.

i. No companion policy is recommended for the following: [5]

1. Intubated patients
2. have no limitations in doing self-care

ii. Patients who are dependent for activities of daily living may be allowed a companion with strict precaution instructions to avoid getting infected or spreading infection to other.

iii. In extenuating circumstances such as imminent end-of-life, and the patient may need extra support, temporary

visitation may be granted access based on the assessment of the medical officer in-charge.

iv. In the event of near-death or death, arrangements may be made for a member of the family to be allowed to see the patient and make provisions for last rites according to the family's wishes with the permission from the triage team.

v. If the situation allows, patients are encouraged to stay connected with their loved ones through video or phone calls.

vi. vi. Should there be circumstances where extreme restrictions are imposed, proper communication must be done with the patient or family regarding important instructions such as details of restrictions, advanced directives and end-of-life issues.

g. **PALLIATIVE CARE AND PASTORAL CARE.** Pastoral and palliative services are vital components of care and must be put in place to manage emotional and psychological burden of patients, relatives and even the health care team in coping the stress, frustration, depression and grief amid the crisis situation.

This set of recommendations does not intend to supersede existing institutional ethical and maybe revised as deemed necessary.

## References


1. **Nancy Berliner et al,** Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19), Guidelines for Institutional Ethics Services Responding to COVID-19 The Hastings Center, March 16, 2020
2. **New York State Task Force on Life & the Law New York State Department of Health,** Ventilator Allocation Guidelines, November 2015
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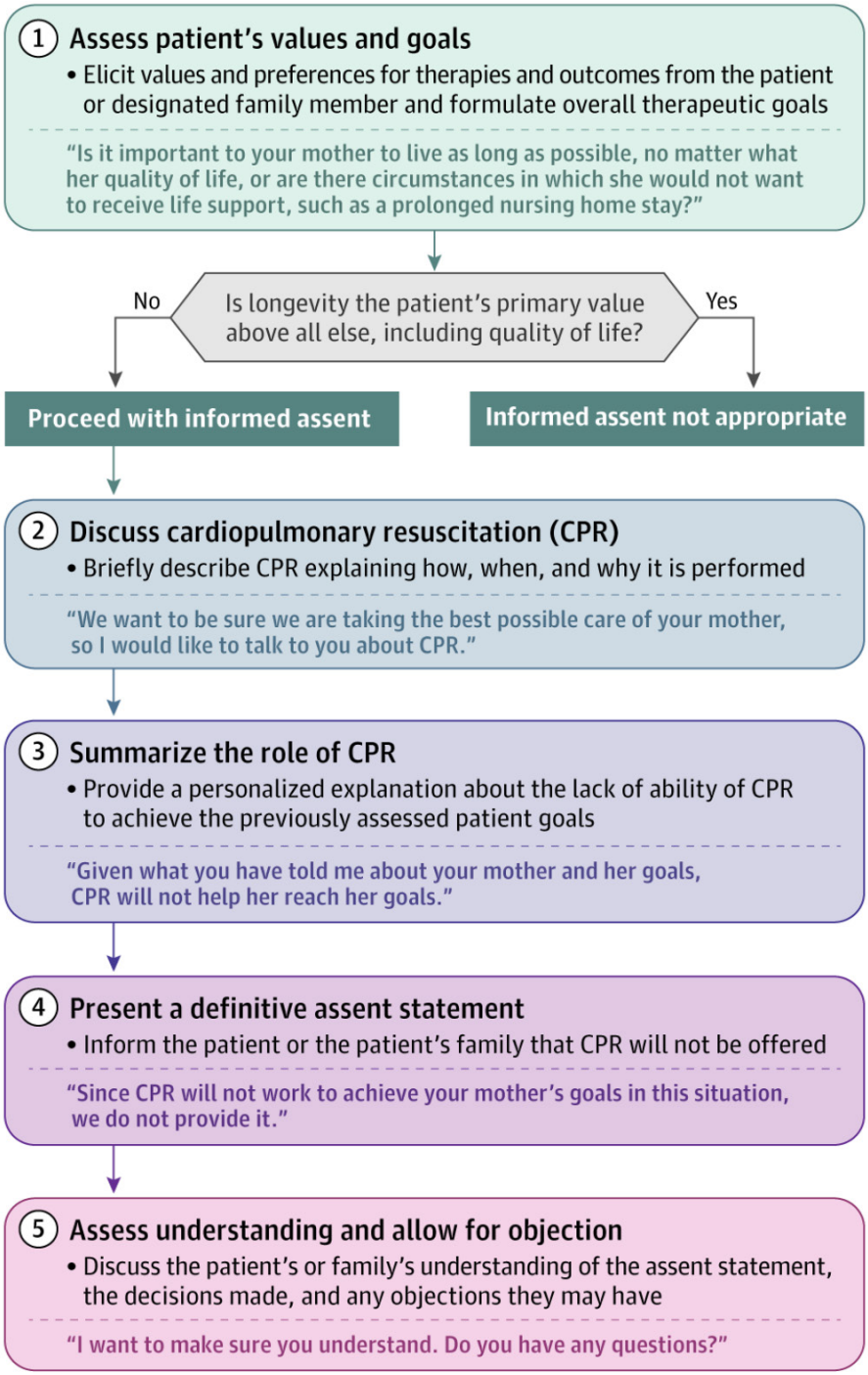
7. **7Curtis, R et al.** The Importance of Addressing Advance Care Planning and Decisions About Do-Not-Resuscitate Orders During Novel Coronavirus 2019 (COVID-19). JAMA March 27, 2020


1 Assess patient's values and goals
• Elicit values and preferences for therapies and outcomes from the patient or designated family member and formulate overall therapeutic goals
"Is it important to your mother to live as long as possible, no matter what her quality of life, or are there circumstances in which she would not want to receive life support, such as a prolonged nursing home stay?"
No
Is longevity the patient's primary value above all else, including quality of life?
Yes
Proceed with informed assent
Informed assent not appropriate
2 Discuss cardiopulmonary resuscitation (CPR)
• Briefly describe CPR explaining how, when, and why it is performed
"We want to be sure we are taking the best possible care of your mother, so I would like to talk to you about CPR."
3 Summarize the role of CPR
• Provide a personalized explanation about the lack of ability of CPR to achieve the previously assessed patient goals
"Given what you have told me about your mother and her goals, CPR will not help her reach her goals."
4 Present a definitive assent statement
• Inform the patient or the patient's family that CPR will not be offered
"Since CPR will not work to achieve your mother's goals in this situation, we do not provide it."
5 Assess understanding and allow for objection
• Discuss the patient's or family's understanding of the assent statement, the decisions made, and any objections they may have
"I want to make sure you understand. Do you have any questions?"

**Appendix I.**