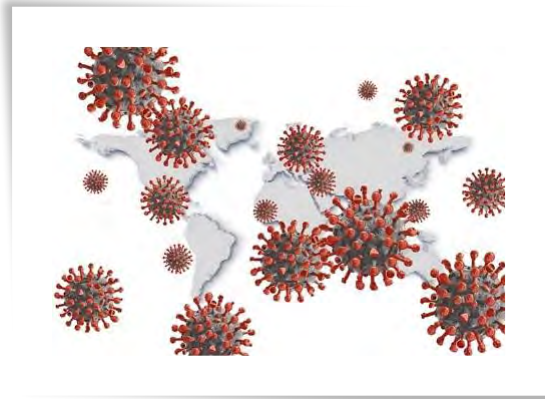


# Bioethics Grand Rounds

## COVID-19 Series Session 1

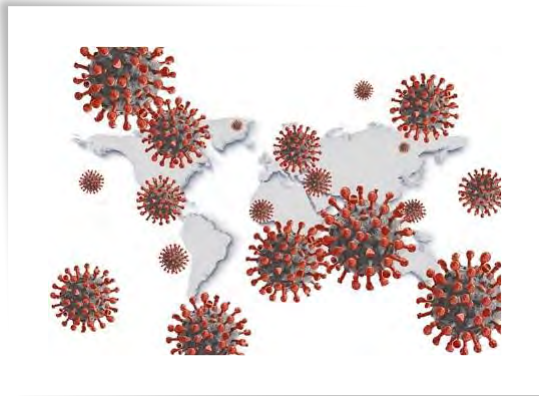


**Ethics in Triage Criteria:**  
Should there be Priority Status  
for Healthcare Workers?

May 7, 2020

# WELCOME

## Ethics in Triage Criteria: Should there be Priority Status for Healthcare Workers?



### **Mark R. Tonelli MD MA**

Professor in the Division of Pulmonary, Critical Care & Sleep Medicine and Ethics Consultant at the University of Washington Medical Center

### **Nancy S. Jecker PhD**

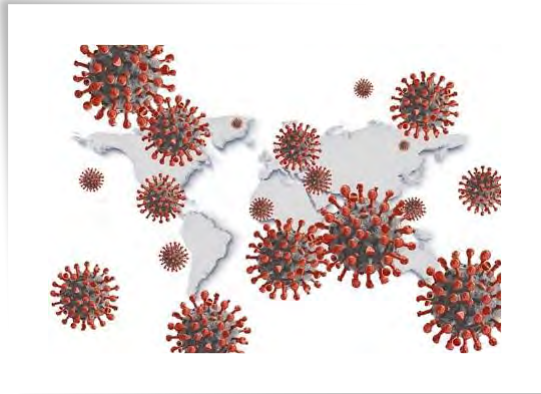
Professor of Bioethics and Humanities at the University of Washington School of Medicine

### **Douglas S. Diekema MD MPH**

Director of Education Treuman Katz Center for Pediatric Bioethics, Professor of Pediatrics, and Chair of Institutional Review Board at Seattle Children's Hospital

# Session Objectives

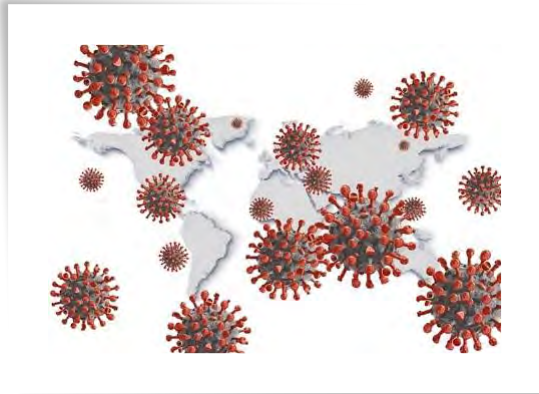
## Ethics in Triage Criteria: Should there be Priority Status for Healthcare Workers?



- 1. Identify key ethics questions related to triage algorithms in the context of public health emergencies.**
- 2. Recognize ethics conflicts in prioritizing healthcare workers in the allocation of scarce resources due to the COVID-19 pandemic.**
- 3. Understand different ethical perspectives on whether healthcare workers should have priority access to scarce medical resources in a public health emergency.**

# Session Overview

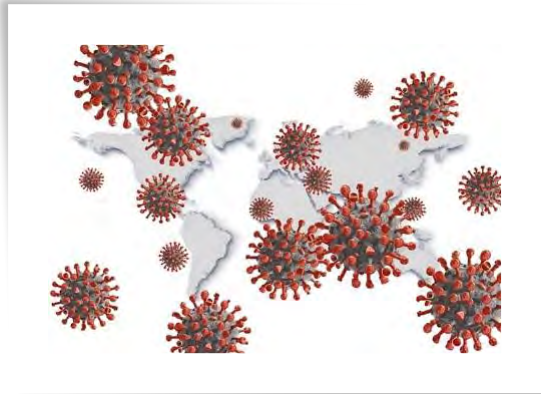
## Ethics in Triage Criteria: Should there be Priority Status for Healthcare Workers?



- 1. Overview of Triage Algorithms in Public Health Emergencies (10min)**
- 2. Overview of Ethical Considerations of Priority Access for Healthcare Workers (30min)**
- 3. Questions (15min)**

# Disclosures

## Ethics in Triage Criteria: Should there be Priority Status for Healthcare Workers?



**Dr. Tonelli, Dr. Jecker and Dr. Diekema have nothing to disclose.**

May 7, 2020

# Overview of Triage Algorithms in Public Health Emergencies

# Allocation of Scarce Crucial Resources

- Crisis Standards of Care
  - Inability to provide basic standard of care due to limitation of a crucial resource(s). (e.g. ventilators, trained staff)
- Maintaining Standards
  - Goal: Providing the greatest good for the greatest number.
  - Defining 'greatest good' requires careful consideration of values.
  - Triage guidelines aim to operationalize these ethical values.
  - Triage guidelines aim to avoid incorporation of ethically irrelevant features.

### Assumptions for use:

1. Health Officer has declared a crisis situation requiring scarce resource management and crisis standards of care, where crisis standards of care is defined as *“a substantial change in usual healthcare operations and the level of care it is possible to deliver which is made necessary by a pervasive or catastrophic disaster”*.<sup>2</sup>
2. Healthcare systems are overwhelmed despite maximizing all possible surge and mitigation strategies impacting the space and/or staff and/or supplies needed to deliver usual levels of care.

### Ethical Framework:

Washington State has adopted and will use the ethical framework developed by the National Academy of Medicine, which stresses the importance of an ethically grounded system to guide decision-making in a crisis standards of care situation. All decisions and communications will be based on the ethical principles below. The National Academy of Medicine defines these ethical principles as:

- **Fairness** – Standards that are, to the highest degree possible, recognized as fair by those affected by them – including the members of affected communities, practitioners, and provider organizations, evidence based and responsive to specific needs of individuals and the population.
- **Duty to care** – Standards are focused on the duty of healthcare professionals to care for patients in need of medical care.
- **Duty to steward resources** – healthcare institutions and public health officials have a duty to steward scarce resources, reflecting the utilitarian goal of saving the greatest possible number of lives.
- **Transparency** – in design decision making, and information sharing.
- **Consistency** – in application across populations and among individuals regardless of their human condition (e.g. race, age disability, ethnicity, ability to pay, socioeconomic status, preexisting health conditions, social worth, perceived obstacles to treatment, past use of resources).
- **Proportionality** – public and individual requirements must be commensurate with the scale of the emergency and degree of scarce resources.
- **Accountability** – of individual decisions and implementation standards, and of governments for ensuring appropriate protections and just allocation of available resources.<sup>3</sup>

## Northwest Healthcare Response Network

[https://nwhrn.org/wp-content/uploads/2018/10/Scarce\\_Resource\\_Management\\_and\\_Crisis\\_Standards\\_of\\_Care\\_Overview\\_and\\_Materials-2020-04-10.pdf](https://nwhrn.org/wp-content/uploads/2018/10/Scarce_Resource_Management_and_Crisis_Standards_of_Care_Overview_and_Materials-2020-04-10.pdf)



## STEP 2: Determine if patient meets ICU Inclusion Criteria

### 2A: Patients must have at least one of the following INCLUSION CRITERIA:

1. Requires ventilatory support, either invasive or non-invasive
  - Clinical evidence of impending respiratory failure
    - Refractory hypoxemia ( $SpO_2 < 90\%$  on  $FIO_2 > 0.85$ )
    - Respiratory acidosis ( $pH < 7.2$ )
  - Inability to protect or maintain airway
2. Hypotension (SBP  $< 90$ ) secondary to either an acute medical or trauma condition, with clinical evidence of shock (altered level of consciousness, decreased urine output, or other evidence of end-stage organ failure) refractory to volume resuscitation that cannot be managed in a non-ICU setting.

### 2B: To determine critical care resource allocation the following should be considered:

- Expected duration of need of critical care resource
- Prognosis for survival based on medical assessment under current epidemiology and **relevant** comorbid conditions that impact survival. \* Co-morbidities that do not affect prognosis will not be considered.

*\*Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:*

- Severe congestive heart failure
- Severe chronic lung disease
- Central nervous system, solid organ or hematopoietic malignancy with poor prognosis for recovery
- Severe cirrhotic liver disease with multi-organ dysfunction
- Response to current treatment
- Degree of Organ Dysfunction as measured by the MSOFA (Modified Sequential Organ Failure Assessment Score) - *Please see Step 6 regarding use of scoring system*
- Prognostically relevant decompensation from a person's baseline health status, such as degree of frailty\*\* that impacts survival. given the current circumstances that make crisis capacity triage necessary.

\*\* In medicine, "frailty" is most often defined as a syndrome of physiological decline in life, characterized by marked vulnerability to adverse health outcomes. For example: frail adults are less able to adapt to stressors such as acute illness or trauma than non-frail adults.

## Northwest Healthcare Response Network

[https://nwhrn.org/wp-content/uploads/2018/10/Scarce\\_Resource\\_Management\\_and\\_Crisis\\_Standards\\_of\\_Care\\_Overview\\_and\\_Materials-2020-04-10.pdf](https://nwhrn.org/wp-content/uploads/2018/10/Scarce_Resource_Management_and_Crisis_Standards_of_Care_Overview_and_Materials-2020-04-10.pdf)

Should triage algorithms include any prioritization of healthcare workers whose work puts them at higher risk of COVID-19 infection?

**Audience Poll**

# Ethics Frameworks & Considerations



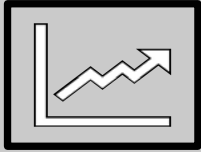
# Prioritizing Frontline Workers During the COVID-19 Pandemic\*

*\*From Jecker NS, Wightman AG, Diekema DS,  
Forthcoming 2020, Prioritizing Frontline Workers During  
the COVID-19 Pandemic, Am J Bioethics 20*



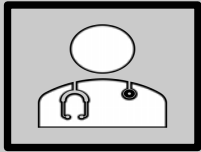
## *Priority to Frontline Healthcare Workers*

- *Physicians & Nurses*
- *Respiratory therapists*
- *Others HCW in the room while an infected pt is present*



### ***Multiplier Effect***

*Benefits not only providers,  
but patients*



### ***Social Contract***

*Society grants privileges in  
exchange for providers  
committing to help the sick*



### ***Reciprocity***

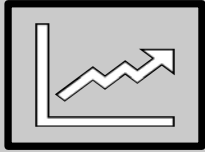
*Society has a duty to give  
back to those who assume  
high risk & give to society*

# Ethics Arguments



# *Priority to Frontline Non-Medical Personnel*

- *Custodians*
- *Security*
- *Others in the room while an infected pt is present*



### ***Multiplier Effect***

*Benefits not only workers,  
but patients*



### ***Reciprocity***

*Society has a duty to give  
back to those who assume  
high risk & give to society*



### ***Respect***

*It violates respect for  
persons to view people  
as replaceable*

# Ethics Arguments



# Broad v. Narrow Social Utility

- *Broad: a person's overall value to society*
- *Narrow: a person's short-term value to society during an emergency*



# *Where do we draw the line?*

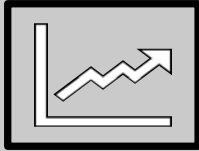
- *What about HCW not caring for COVID-19 pts?*
- *Hospitals cafeteria workers, patient transporters?*
- *Bus drivers, grocery clerks?*

***Both performing an essential service & assuming an exceptional risk are required for priority***



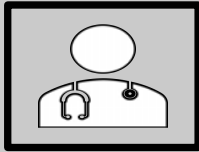
# Take-Aways

- *HCW should advocate for pts under the limits set by a fair allocation scheme*
- *A fair scheme gives priority to frontline HCW & nonmedical personnel*
- *The arguments for priority are narrow social utility, social contract, reciprocity & respect for persons*



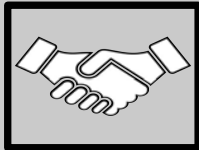
### ***Multiplier Effect***

*Providers will be unlikely (and some unwilling) to return before crisis averted*



### ***Social Contract***

*Extends to reasonable protection (vaccine, PPE) and treatment access, but not scarce resource priority*



### ***Reciprocity***

*Caring for infectious patients is part of the job and role of a professional*

# Ethics Counter- Arguments

# *Additional Counter-arguments*

- *Where do you draw the line? The difficulty of defining health care workers who qualify*
- *If restricted to HCPs, favors an already privileged group and exacerbates disparities*
- *It looks bad: Favoritism*
  - *‘Those who devised the clinical ventilator allocation protocol appeared to reserve special access for themselves’ (NY state task force on life and law, 2015)*

# Final Observations

- *Prioritization of HCWs can occur ‘at the top’: HCWs First in Line*
- *Prioritization of HCWs can be used as a ‘tie-breaker’ when being compared to others with similar likelihood of benefit and degree of need*
- *The latter is easier to justify, though remains controversial in the setting of COVID-19 (as opposed to the battlefield, for example)*

Should triage algorithms include any prioritization of healthcare workers whose work puts them at higher risk of COVID-19 infection?

**Audience Poll**

Has your opinion changed in the course of this session?

**Audience Poll**



**Questions?**

# Bioethics Grand Rounds

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**Want to claim CME/CEU credits?**

Fill out a survey after today's session to receive the CME/CEU forms:

**<https://redcap.link/BGRMay7>**



# Upcoming in the Bioethics Grand Rounds Series

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## **Session 2: Ethics in PPE Conservation: Homemade Masks and Supererogatory Actions**

**Wednesday, May 13th, 4-5pm PT**

**Jennifer Kett MD MA**, Pediatric Palliative Care at Mary Bridge Children's Hospital

**Maya Scott MSW, LSWAIC**, Palliative Care Consultant and Grief Therapist, Seattle Children's Hospital

## **Session 3: Ethics in COVID-19 Therapies: Research and Stewardship**

**Thursday, May 21st, 12-1pm PT**

**Olivia S. Kates, MD**, Senior Fellow Division of Allergy and Infectious Diseases at University of Washington

**Seema K. Shah JD**, Assoc. Professor in Pediatrics at Northwestern University Feinberg Medical School, Founder's Board Professor of Medical Ethics, Director of Research Ethics at Lurie Children's Hospital

**Douglas S. Diekema MD MPH**, Director of Education Treuman Katz Center for Pediatric Bioethics, Professor of Pediatrics, and Chair of Institutional Review Board at Seattle Children's Hospital

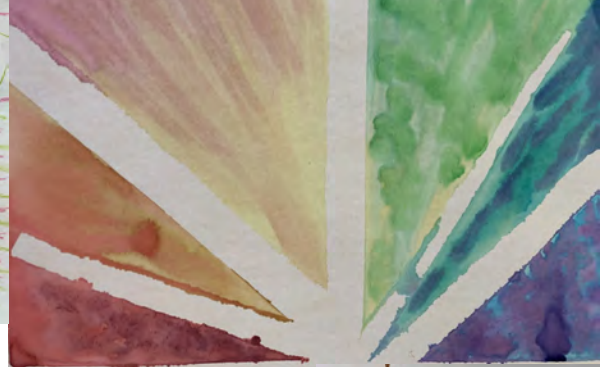
## **Session 4: Ethics and Healthcare Equity in COVID-19**

**Wednesday, May 27th 4-5pm PT**

**Paula L. Houston, Ed.D.**, Director Healthcare Equity at UW Medicine

**Edwin Guillermo Lindo JD**, Department of Family Medicine and Assoc. Director of CLIME at University of Washington

**Jay M. Brahmhatt MD**, Internal Medicine Residency, PGY-3, at University of Washington



# Thank You



Appreciation art courtesy of preschoolers at the Learning Tree Montessori in Seattle WA

