

Ethical Framework & Responsibilities COVID-19

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Balancing Individual Patient-Centered Duty of Care with Obligations to Protect and Promote the Public Health

**Focus on Individual Patient
DUTY OF CARE**

- Clinical care is patient-centered
- Promote health & wellness
- Alleviate suffering
- Care aligned with goals, preferences, priorities of the individual patient

**Focus on Community
FAIRNESS & EQUITY**

- Protect community health
- Promote public safety
- Fair and equitable allocation of limited resources
- Respect for the moral equality of persons

Guiding Ethical Principles in a Public Health Crisis

- **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.²

Shifting Ethical Priorities

Usual standard of care

- Respect for patient autonomy
- Maximize benefit to each of your patients
- Fidelity/allegiance to each patient
- Not all who could benefit receive treatment (due to lack of access/insurance)

Public Health Crisis/ Altered Standards of Care

- Respect for common good, not individual autonomy
- Maximize benefit to the greatest number of people
- Allocate scarce resources responsibly
- Not all who could benefit receive treatment (due to scarcity)

Importance of Advance Care Planning

- Understand and affirm goals and values.
- Support naming of a health care agent.
- Address priorities and what matters most in the event of an acute or life-threatening illness.
- If there is an existing DNR/COLST order, affirm decision to avoid unwanted interventions and ensure goal-concordant care.
- If priorities include not being resuscitated or receiving aggressive medical interventions, obtain a DNR/COLST order from clinician.

Conventional, Contingency, Crisis Capacity



- **Conventional Capacity:** Ordinary use of resources (spaces, staff, and supplies) and standard of care
- **Contingency Capacity:** Disruption of ordinary use of resources and practices, but care provided is functionally equivalent to usual standards
 - **Conserving:** canceling elective procedures to preserve PPE
 - **Substituting:** telehealth instead of in-person clinic appointments
 - **Adapting:** Cleaning PPE for re-use rather than disposing each time
- **Crisis Capacity:** Disruption to standard of care due to inadequate resources, but goal is sufficiency of care (provide the best possible care given the circumstances)

Crisis Capacity

TRIAGE: Efficacy & Equality

- Identify those who are least likely to survive regardless of treatment.
- Determine if patient is unlikely to improve sufficiently to:
 - (1) survive outside the acute care setting
 - (2) perceive benefits of treatment.

Caring Continues

- Health care providers will always consider the preferences of individual patients, **BUT** when community need becomes the priority it may not be possible to accommodate all individual patient wishes.
- They will continue to **care for** every patient who does not receive the resource.
- They will continue to **care about** every patient and their family.
- Work to provide access to appropriate palliative care services and supports

**Utilitarian
Calculus**

**Scarce Resource Allocation
Policies & Protocols**

A Fair and Just Process

CDC Guidelines for a Fair Process Approach

- Consistent application of the process that minimizes individual interpretation
- Impartiality and neutrality of decision-makers
- Incorporation of current accepted medical practice criteria
- Respect and dignity in the treatment of all patients
- Allowance of an appeals process
- Transparency of the criteria/guidelines
- A dynamic process allowing for review and adaptation as the situation and resources change

Factors that may NOT be considered

1. Sex, gender identity, sexual orientation, race, ethnicity, national origin, religion, or pregnancy status
2. Disability or degree of disability (including physical disability, developmental/cognitive disability, functional status, mental health diagnosis, chronic disease diagnosis, positive status for infectious disease(s) including HIV and HCV)
3. Health insurance status or ability to pay for care
4. Socio-economic status, profession, or other social factors

Mechanical Ventilation Criteria During Crisis Standards of Care

Inclusion criteria for mechanical ventilation during rationing:

Requirement for invasive ventilatory support

- Refractory hypoxemia ($SpO_2 < 90\%$ on non-rebreather mask or $FiO_2 > 0.85$)
- Respiratory acidosis ($pH < 7.2$)
- Clinical evidence of impending respiratory failure
- Inability to protect or maintain airway

Hypotension ($SBP < 90$ mm Hg or relative to needs) with clinical evidence of shock refractory to volume resuscitation requiring vasopressor or inotrope support that cannot be measured in a ward setting

Exclusion criteria mechanical ventilation during rationing:

Severe trauma with poor expected outcome

Severe burns with any two of the following:

- > 60 yrs. of age
- $> 40\%$ of body surface area affected
- Co-existent inhalational injury

Unwitnessed, recurrent or unresponsive cardiac arrest

Metastatic malignant disease with poor expected response to therapy

Co-existent end-stage failure of a major organ (e.g. heart, lung, liver, or brain) with poor prior prognosis

mSOFA

Scoring criteria for the Modified Sequential Organ-Failure Assessment (SOFA) score

MSOFA Scoring Guidelines					
Variable	Score*				
	0	1	2	3	4
SpO ₂ /FIO ₂ ratio** or Nasal cannula or mask O ₂ required to keep SpO ₂ >90%	SpO ₂ /FIO ₂ >400 or Room air SpO ₂ >90%	SpO ₂ /FIO ₂ 316-400 or SpO ₂ >90% at 1-3 L/min	SpO ₂ /FIO ₂ 231-315 or SpO ₂ >90% at 4-6 L/min	SpO ₂ /FIO ₂ 151-230 or SpO ₂ >90% at 7-10 L/min	SpO ₂ /FIO ₂ <150 or SpO ₂ >90% at >10 L/min
Bilirubin level, mg/dL (μmol/L)	< 1.2 (< 20)	1.2–1.9 (20–32)	2.0–5.9 (33–100)	6.0–11.9 (101–203)	> 12 (> 203)
Hypotension†	None	MABP < 70	Dop ≤ 5	Dop > 5 Epi ≤ 0.1 Norepi ≤ 0.1	Dop > 15 Epi > 0.1 Norepi > 0.1
Glasgow Coma score	15	13–14	10–12	6–9	< 6
Creatinine level, mg/dL	< 1.2	1.2–1.9	2.0–3.4	3.5–4.9 or urine output <500 mL in 24 hours	> 5 or urine output <200 mL in 24 hours

From Vincent JL et al. The SOFA (Sepsis-related Organ Failure Assessment) score to describe organ dysfunction / failure. *Intensive Care Med.* 1996; 22:707-710.

Prioritization

Patient in need of mechanical ventilator			
Patient meets Inclusion criteria for mechanical ventilator; triage code assigned below			
mSOFA = 0 – 3	MSOFA = 4 – 7	mSOFA = 8 – 11	mSOFA > 11
Lower Priority	Highest Priority	Intermediate Priority	Lower Priority
<ul style="list-style-type: none"> • Highest chance of survival without treatment • Provide other therapies (supplemental oxygen, non-invasive mechanical ventilation, etc.) • Reassess as needed 	<ul style="list-style-type: none"> • Highest chance of survival with treatment • Reassess as needed 	<ul style="list-style-type: none"> • Resource use may be extensive and may not result in good patient outcome • Reassess as needed 	<ul style="list-style-type: none"> • Lowest chance of survival even with treatment • Provide other therapies (supplemental oxygen, non-invasive mechanical ventilation, etc.) • Provide palliative care as appropriate • Reassess as needed

