Preparing Ahead Wisely And Ethically to Stave Off Crisis Standards of Care

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Around every corner of the COVID-19 pandemic await questions of ethics, perhaps none so unanticipated and vexing as the fair distribution of scarce medical resources. Beginning on day one of the pandemic with a shocking lack of personal protective equipment (PPE), patients and professionals have faced a reality long slumbering, undisturbed in the bowels of the decentralized health care system in the United States: the rationing of health care resources. In emergency rooms from coast to coast, the pre-pandemic default of seeing all comers became impossible and treating based on need was supplanted by the calculus of cost-benefit. Scarcity affected ventilators, staffed beds, antivirals, monoclonal antibodies, oxygen and blood products — a sign of failing preparation for a global public health crisis.

To demonstrate the stark reality of pandemic unpreparedness, consider the following description of New York City in April 2020 as America's health care system buckled in response to SARS-CoV-2 reaching its shores:

> Tents are now strewn across Manhattan's Central Park — field hospitals in the literal sense — that resemble the convalescence wards of the 1918 flu pandemic. They sit a stone's throw from some of the world's most expensive real estate. Not to mention some of the world's most luxurious brick-and-mortar hospitals. ... At a certain point, the calculus of American doctors will switch from the default of preferentially caring for the person who appears sickest to caring for the person with the greatest chance of benefiting from care.[1]

The ongoing scramble for medical resources continues to teach hard lessons about the importance of disaster preparedness.[2] The United States was woefully unprepared, caught by surprise by SARS-CoV-2, not having heeded the warning bells of Ebola, SARS, H5N1 and others. We should have been better prepared for public health disaster as individuals and a country — yes, there would have been sickness and death, but nowhere near the mind-numbing numbers of over 78 million infections and more than 950,000 deaths. Our tendency to ignore the possibility of catastrophe until the flood waters reach the roof only further deepens the disaster and ensuing despair.

BE PREPARED

Our primary ethical obligation in meeting the challenges of crisis response is to be prepared, a haunting and woefully unfulfilled responsibility during this pandemic as our decentralized, market-driven health care system faced critical shortages of supplies and staff, negatively impacting hospitals, long-term care facilities, health care providers and, critically, those they serve. "Just-

in-time" supply chains, "right-sizing" and other market-based competitive business models conspired against preparedness, leaving vulnerable patients — from those with COVID-19 to those suffering a heart attack or severe brain injury — susceptible to the harm of "worse outcomes."[3,4]

A recent report from the U.S. Government Accountability Office noted "persistent inefficiencies" in the United States' pandemic response, including inadequate coordination among public health agencies, problems with data collection and unavailability of testing and medical supplies. These deficiencies are nothing new considering our previously hindered responses to a variety of threats, including infectious disease — H1N1, Zika and Ebola, for example — and extreme weather incidents such as hurricanes.[5]

Given novel infectious disease, global travel and climate change, disaster preparedness is far from a luxury in a world perilously unprepared to deliver a rapid and adequate response to future threats. The pandemic has made plain that it is utter folly to attempt to work out an effective response when knee-deep in the flood waters of disaster. Developing ethically informed protocols — ideally before disaster strikes — supports better-informed, values-based, brave decisions by bedside professionals, health care executives, public health officials and government leaders during the uncertainty of a quickly unfolding public health crisis. It may also buoy public trust, ease fear and reduce misinformation.[6] Maximizing preparedness minimizes harm to patients, professionals and communities, and facilitates more time in the familiar territory of everyday health care rather than crisis.

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CHANGING TIMES AND UNCHANGING PRINCIPLES

Pandemics and other public health emergencies require striking a delicate balance between the duty to care for "the patient in front of me" — the focus of clinical ethics under everyday conditions — and the duty to tend to "the public's health" by caring for "the community around me." In a public health crisis, the primacy of individual autonomy and choice is modulated, perhaps supplanted, by concern for the common good and considerations of fairness.

Despite the temptation to abandon value priorities and the hard work of ethics in favor of expedience during crisis, it is imperative that standards and virtues remain resolute. President Jimmy Carter frequently reminds The Carter Center staff, through a quote from his high school teacher, that they "must adjust to changing times and still hold to unchanging principles."[7]

Admittedly, contextual uncertainty renders doing ethics amid pandemic a bit like trying to catch a greased pig. Rather than replacing ethics with expedience, what is needed is a deeper commitment to right attitudes and actions. Holding onto core ethical principles — respect for persons, the duty to care, stewardship of medical resources and staff, common good, fairness,[8] transparency and accountability[9] — is more important, not less.

THE CONTINUUM OF CARE

Public health emergencies are disruptive and difficult, testing assumptions, principles and commitments and having far-reaching and uncertain impact on individuals and communities. Because the United States health care system could not rapidly expand to accommodate skyrocketing COVID-19 infections, not only did hospitals confront the inability to care for wave after wave of COVID-19 patients but they also failed to help those suffering everyday maladies such as heart attack, stroke and physical injury. From Alaska to Florida, hospitals plunged into the harsh reality of rationing, forced to dust off or to develop crisis standards of care to stave off ad hoc gurney-side treatment decisions and to provide transparent

guidance for resource-driven triage.

During a public health disaster such as COVID-19, resource availability is not a case of "here today, gone tomorrow"; supplies and personnel tend to oscillate from day to day and dwindle over time. Think of resource allocation during disaster not as an irreversible cliff drop but instead along a continuum from conventional to crisis care. It includes bidirectional movement as resource availability remains fluid, ebbing and flowing over time.[10]

- **Conventional care** is everyday care in which hospitals, health care systems and emergency medical services provide expected interactions and services consistent with the community standard of care. ("We have enough.")[11]
- **Contingency care** involves modifications to everyday care in response to mounting system stress as patient numbers rise and the inventory of supplies and staff falls. The hallmark of contingency is the required provision of "functionally equivalent care," that is, care "... intended to provide benefit to patients comparable to what they would receive" under everyday circumstances and requires that patient-centered care continues.[12] Any changes in patient care — such as using continuous positive airway pressure instead of a ventilator in the treatment of COVID-19 pneumonia — must produce similar medical outcomes in line with patient preferences and medical well-being.[13] The goal is to continue to provide high-quality care while slowing depletion of critical resources and protecting patients and staff from disproportionate harm caused by scarcity. ("We can make do.")
- **Crisis care** occurs when demand for critical resources far surpasses supply. This necessitates the implementation of policies and procedures to allocate insufficient resources transparently, consistently and fairly. Crisis standards of care protocols guide health care providers and systems in determining how to provide the best care possible under the extraordinary circumstances of meager resources and triage. The goal of crisis standards of care activation is to prevent hospital collapse and to stretch supplies and staff to minimize morbidity and mortality despite the resource crunch. ("We have run out and have nowhere to turn.")

Although gallons of midnight oil were consumed writing and rewriting crisis standards of care, there is compelling evidence they have not necessarily been activated when needed. For example, recall the earlier cited images of tents in Central Park or the scenes from news reports of ambulances idling in Los Angeles hospital parking lots as emergency rooms were awash in patients. As hospitals were overcome with the desperately ill, the pleas of local health care leaders often received a lack of response from politically wary government officials responsible for crisis standards of care activation.[14] Such inaction denied beleaguered hospitals and providers essential, consistent and transparent guidance for heart-wrenching allocation decisions. This inaction resulted in ethically troubling bedside triage, ad hoc rationing and undue harm to patients, providers, hospitals and communities.

In addition, retrospective review of the results of crisis standards of care implementation indicates that many triage scoring strategies, initially developed for other diseases such as sepsis, are not appropriate for COVID-19 triage and further amplify health disparities.[15] Given the reluctance of political leaders to initiate crisis standards of care, the inaccuracy of the scoring systems for COVID-19 triage and the inevitable heartbreaking toll of scarcity, every effort must be expended to avoid crisis and triage and to remain in contingency during surge and shortage. As under crisis conditions, good decision-making during contingency must be guided by ethically informed decision-making frameworks. Disaster preparedness requires being prepared for contingency in an effort to avoid activation of crisis standards of care and triage protocols.

THE ETHICS OF CONTINGENCY

Although numerous ethically informed triage frameworks to guide crisis care have been proposed, critiqued and debated,[16] less energy has been devoted to the ethics of contingency, an unfortunate oversight given that contingency is what protects patients and personnel from the harms of local, national and global resource depletion. The goal is to avoid crisis and ensuing triage or — if avoidance is not possible — to stall, shorten and manage it through the development and implementation of contingency decision-making frameworks and protocols that are ethically informed, transparent, in line with hospital, system and community values and fulfill the duty to care for patients and society while facilitating rapid return to everyday conventional care.

Recognizing the importance of contingency guidance, Dr. David Alfandre, associate professor with the Departments of Medicine and Population Health at NYU Grossman School of Medicine, and colleagues have proposed an ethical framework to guide planning and implementation of response to COVID-19 surge and resource scarcity.[17] Based on the ethical guidance offered by the University of Toronto Joint Centre for Bioethics in response to the SARS pandemic of 2003,[18] this contingency framework relies on both substantive values, such as the duty to plan, equity and trust and procedural values, such as stakeholder identification, communication and functionally equivalent care. Importantly, those directly impacted by potential changes in health care delivery during contingency — not only clinicians and hospital leadership but also patients and families — are involved in the planning process.

Informing and guiding responses to scarcity within hospitals, regions and the state, the "Ethical Framework for Transitions Between Conventional, Contingency, and Crisis Conditions,"[19] published by the Minnesota Department of Health, offers "an operational construction" of functional equivalence to "... enable ethical, consistent, real-time decision making at the bedside, and to support coordinated responses from local to state levels of incident management."[20] Emphasis is placed on the importance of communication, collaboration and organizational leadership to avoid extreme operating conditions and to support the equitable distribution of resources among communities by, for example, load balancing through patient transfer or coherence among facilities in delaying elective procedures. Anticipating disputes over changes in care during contingency, the Minnesota framework suggests ethical modifications of conventional conflict-resolution protocols over the continuum of care.

Given the weighty task of mitigating scarcity and preventing collapse of hospitals and health care systems, the development of contingency frameworks must engage moral imagination, be value-driven and include input from community members with lived experience and a stake in the outcome, particularly those most impacted and/or at risk of substantive harm, such as racial-ethnic minorities, low-income populations, unhoused or incarcerated persons and hospital staff suffering moral distress or moral injury. The dynamic nature of the continuum of care dictates that policies and procedures must be ethically informed, flexible, open to change and revisited regularly in real-time.

Planning for contingency is important for good patient care and responsible stewardship of resources but does not get to the root of the problem: the dearth of vital resources and trained staff. Hospital systems, municipalities and states need to establish efficient mechanisms for resource sharing and load balancing during disaster. Disaster preparedness requires reliable supply chains and a shift from a "just-in-time" to a "just in case" mindset, stockpiling PPE and medications and decreasing reliance on "travelers" (contract nurses) for nursing care. Health care marketplace competition must give way to deep cooperation in protecting the public's health and attending to health equity.

WE MUST BE DIFFERENT

Amanda Gorman, poet and author of "The Hill We Climb," who spoke at President Joe Biden's inauguration in 2021, wrote in a recent essay for *The New York Times*:

> Our nation is still haunted by disease, inequality and environmental crisis. But though our fears may be the same, we are not. If nothing else, this must be known: Even as we've grieved, we've grown; even fatigued, we've found that this hill we climb is one we must mount together. We are battered but bolder, worn but wiser. I'm not telling you to not be tired or afraid. If anything, the very fact that we're weary means we are, by definition, changed: we are brave enough to listen to, and learn from, our fear. This time it will be different because this time we'll be different. We already are.[21]

The health care industry must be bolder and wiser, brave enough to identify, understand and remedy the considerable failings exposed by the pandemic, beginning with scarcity and inequity. Catholic health care with its unflinching commitment to respect for persons, especially those who are most vulnerable, is poised to lead the preparation for the inevitable next time — when health care will be different, when we as individuals and communities will be different. Hopefully, we will be leading the way, better prepared together.

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NOTES

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JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

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Reprinted from *Health Progress*, Spring 2022, Vol. 103, No. 2