Ethical Issues related to Pandemic Influenza and the Role of Palliative Care

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Objectives

- Identify ethical issues which may arise in a public health emergency such as a pandemic
- Review potential triggers that raise ethical concerns
- Understand the obligations of healthcare workers to treat all patients
- Explore the increased need to provide palliative care in the face of a pandemic
Medical Ethics, Science, and Law

- Medical ethics is a discipline dealing with what we believe to be good or bad, right or wrong about the goals of medicine and the means used to achieve those goals.
  - *It is about what we should do, not necessarily what we can do.*
  - *Medical ethics well practiced requires a working understanding of medical science.*
  - *Ethics and law are not the same and political factors often determine which ethical stance a society establishes through the law.*
How do we do medical ethics?

- Many different theories and systems for “doing ethics.”
  - Deontological - duty based ethic. An action is right or wrong regardless of the consequences.
  - Consequentialist - an outcome based ethic. An action is right or wrong based upon the end result.
- In our era we rely most commonly on rule based ethics, appealing to basic principles to guide our actions.
  - Staying within these rules/principles may help define a moral safe harbor.
Basic Ethical Principles in Medicine

- **Respect for persons**
  - Treat others the way you wish to be treated as a moral being, that is respect their moral agency as you would wish your moral agency to be respected.
    - “Love thy neighbor as thyself” - Biblical tradition

- **Beneficence and Nonmaleficence**
  - Promote good and avoid harm
    - “I will go to the house of the sick for the benefit of the sick” - Hippocratic tradition

- **Autonomy**
  - Self governance
    - “Inalienable right to life, liberty, and the pursuit of happiness” - Secular legal tradition
Basic Ethical Principles in Medicine

• Justice
  - Distributive versus Retributive. We should be most concerned in health care about a just or fair distribution of resources.
    • “Justice, justice you shall pursue” - Biblical and Secular/Legal

• Fidelity
  - Faithfulness, both in telling the truth and being true.
    • “Am I my brother’s keeper?” - Biblical, but also Hippocratic as well as Secular/Legal if one sees Fidelity as the source of fiduciary duties
Effective medical ethics begins with a clear understanding of good clinical medicine.

In the case of a public health emergency such as pandemic flu, we may not know all that we need to know to make the best decisions.
What Happens in a Public Health Emergency?

Shift from emphasis on treating and advocating for individual patients (autonomy and fidelity) to what is best for the largest number (justice)
The Trauma of Triage

- A terrorist attack
  - The difficulty of shifting from assigning priority to the sickest patients to assigning priority to those most likely to survive

- James F. Childress PhD
- Calabresi G, Bobbit P. *Tragic Choices*
  WW Norton & Company, 1978
Setting Rules of Triage

- Need to be set in advance of emergencies to prevent confusion and chaos
- Should be based on medically acceptable and ethically defensible rules
- Justified to the public in advance of emergency
Rules of Triage (2)

- Process of setting rules should be transparent and open with all relevant stakeholders offering input (including local government officials & the public).
- Rules must be medically acceptable and ethically defensible. (issue of “fairness”)
- Must create and maintain public trust: especially if isolation and quarantine needed to control an infectious disease.
Rules of Triage (3)

- Importance of providing CARE to all patients so that there is not a sense of abandonment
What setting(s) do YOU work in?
Ethical Framework for Allocating Ventilators (New York State)

- Duty to care for patients
- Duty to steward resources
- Duty to plan
- Distributive Justice
- Transparency
  - www.health.state.ny.us/diseases/communicable/influenza/pandemic/ventilators/
A Growing Consensus

• Utah State plan
• VA system plan 2010
• Institute of Medicine Report 2012
• North Texas Regional Plan
• Texas State plan
From IOM report 2012: Crisis Standards of Care

- a strong ethical grounding that enables a process deemed equitable based on its transparency, consistency, proportionality, and accountability;
- integrated and ongoing community and provider engagement, education, and communication;
IOM (2)

- the necessary legal authority and legal environment in which CSC can be ethically and optimally implemented;
- clear indicators, triggers, and lines of responsibility; and
- evidence-based clinical processes and operations
Issues of Balancing the Public Good and the Care of the Individual Patient
• Ethics related to Scarce Resources
  • Vaccines
  • Antivirals—if available
  • Ventilators
  • Hospital beds
  • Personnel

• Ethics related to quarantine and Isolation
Assumptions

• It is best to have thought about the ethical implications of these issues before the crisis
• It would be preferable to develop a community wide standard of how scarce resources will be handled
• It will NOT be business as usual.
Planning: Preparation and Prevention

- Triaging the distribution of vaccines and antivirals:
  - Who gets preference? Health care workers? Police and public health officials and garbage collectors?
  - Who is needed to keep an orderly society?
- Public education to prevent spread of disease:
  - may be better to stay at home than to go to ER.
  - Social distancing
Mandatory Vaccinations

• Another issue to consider if we have a new virus AND a new vaccine: what are the overall risks and benefits
Ethics related to Quarantine and Isolation

- SARS experience in Toronto
- CDC work group on ethical guidelines for a pandemic: PanFluEthics@cdc.gov
  - Respect for individual autonomy requires that any restrictions be considered carefully
  - Legitimate restrictions may be placed if exercising one’s freedom places others at risk
The ethics of isolation and quarantine: Must consider the balance of individual interests and community interests

- Adopt the least restrictive practices that will allow protection of the common good
- Attempt to ensure that those impacted by restrictions receive support from the community
Quarantine & Isolation (3)

• Process to be thought out well in advance
• Specify the decision makers and the criteria
• Transparency is essential
• Public should be clearly informed
What would happen if…?

- 1/3 of your city were to become ill?
- 1/3 of your employees did not come to work?
- Schools and childcare centers were closed for an extended period of time
- Food supplies, prescription drugs…were in short supply
Transmissibility by Number of New Infections Caused by each Sick Person

Effect of $R_0$ on Epidemic Curves

- $R_0 = 3.2$
- $R_0 = 3.0$
- $R_0 = 2.7$
- $R_0 = 2.4$
- $R_0 = 2.1$
- $R_0 = 1.1$
Break Cycle of Transmission

- Cover your cough
- Handwashing
- Social distancing (stay at least 3 feet away from other people—especially if they are sick)
- Vaccines and antivirals if available
- Personal protective equipment (masks and gloves)
- Community mitigation: closure of schools, canceling public gatherings, etc.
A Tale of Two Cities

In 1918
# 1918 Outcomes by City

<table>
<thead>
<tr>
<th>City</th>
<th>First Cases</th>
<th>Death Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>8/27/18</td>
<td>5.7</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>By 9/11/18</td>
<td><strong>7.4</strong></td>
</tr>
<tr>
<td>New Haven</td>
<td>Week of 9/11/18</td>
<td>5.1</td>
</tr>
<tr>
<td>Chicago</td>
<td>9/11/18</td>
<td>3.5</td>
</tr>
<tr>
<td>New York</td>
<td>Before 9/15/18</td>
<td>4.1</td>
</tr>
<tr>
<td>Pittsburgh</td>
<td>Mid-9/18</td>
<td>6.3</td>
</tr>
<tr>
<td>Baltimore</td>
<td>9/17/18</td>
<td>6.4</td>
</tr>
<tr>
<td>San Francisco</td>
<td>9/24/18</td>
<td>4.7</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>“Last days 9/18”</td>
<td>3.3</td>
</tr>
<tr>
<td>Milwaukee</td>
<td>9/26/18</td>
<td>1.8</td>
</tr>
<tr>
<td>Minneapolis</td>
<td>9/27/18</td>
<td>1.8</td>
</tr>
<tr>
<td>St. Louis</td>
<td>Before 10/3/18</td>
<td><strong>2.2</strong></td>
</tr>
<tr>
<td>Toledo</td>
<td>“First week 10/18”</td>
<td>2.0</td>
</tr>
</tbody>
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Excess P&I mortality over 1913-1917 baseline in Philadelphia and St. Louis

Liberty Loan Parade
Sept 28, 1918
Mayor closes “theaters, moving picture shows, schools, pool and billiard halls, Sunday schools, cabarets, lodges, societies, public funerals, open air meetings, dance halls and conventions until further notice”

Closing order withdrawn
What about the hospitals?

- An overwhelming surge of cases:
  - ER triage: who gets admitted
  - Who gets ICU beds and ventilators
  - Elective cases cancelled
  - Early dismissals
  - A clean wing for non-epidemic cases: acute surgical emergencies, delivery of babies, heart attacks?
  - Do you keep the hospital open if short staff, short supplies, failing infrastructure?
Hospitals: Altered standards of Care

• If 30% of the work force does not show up for work, or if other resources are short, we do the best we can:

  ❖ Hospital personnel may be shifted to tasks that are not usually in their licensure standards/scope of practice.
  ❖ Charting will not be the same. Minimally acceptable levels of documentation of care may need to be established
Hospitals: Altered standards of care (2)

Family members or friends who have been exposed may stay “for the duration” to help care for patients.

When are the usual standards of care suspended? Declaration by the Governor can suspend any usual regulations. Changes should be temporary and for the shortest time possible.
A duty to care?

• If pregnant women have a 50% death rate, can we reassign their duties or create “safe” parts of the hospital for them to work in?
• Who cares for young children if schools are closed?
• What is the duty of doctors and nurses to care for patients at the risk of their own lives?
Competing Obligations for Health Care Workers

- Duty to serve patients: abandonment
- Duty to protect/care for self: access to preventive/protective/treatment resources (Duty of employer to provide?)
- Duty to protect/support family: community and insurance to help during and after
- Duty to not transmit disease: quarantine and travel bans
PHYSICIAN’S DUTY: AMA code of medical ethics

• “...that a duty to serve overrides autonomy rights in societal emergencies, even in cases that involve personal risk to physicians.

  - Clark.CC In harm’s way: AMA physician and the duty to treat. J Med Philos 2005: 30: 65-87
Hospital Beds and Ventilators

• In day to day usual operations, the sickest people get the most resources.
• In the case of a public health emergency, the standard changes to attempt to save the MOST lives—therefore the resources are used for those most likely to survive.
• How do we decide?
Some standards to consider

- Evidence based protocols
- Consistency in the application of triage
- Transparency in the development of policies and protocols
- Community input
- Flexibility to meet changing needs as new information becomes available
Ethical Issues with Allocation of Ventilators

• Not first come first served
• The patient most likely to survive
• Who decides when someone does not meet criteria and must come off a ventilator:
  ❖ Conflict between fidelity and an attempt to save the most lives
  ❖ Someone not involved in care? An ethics team or a “supervisor”
  ❖ Would the New York State plan fly in Texas
Current Draft Plans
Exclusions for Ventilator Access

- Cardiac arrest: unwitnessed arrest, recurrent arrest, arrest unresponsive to standard measures; Trauma-related arrest
- Metastatic malignancy with poor prognosis
- Severe burn: body surface >40%, severe inhalation injury
- End-stage organ failure:
  - Cardiac: NYHA Class III or IV
  - Pulmonary: severe chronic lung disease: FEV1<25%
  - Renal: dialysis dependent
  - Neurologic: severe, irreversible neurologic event
  - Hepatic: MELD score >20
Draft plans: Time trials

- Patients would be assessed in ER for inclusion and exclusion criteria for ventilators
- If placed on a ventilator would be reassessed at 48 and 120 hours to see if they still met criteria
- Use of SOFA scores, mSOFA and Adapted OHPIP triage tool.
### Critical Care Triage Tool
**(Initial Assessment)**

<table>
<thead>
<tr>
<th>Color Code</th>
<th>Criteria</th>
<th>Priority/Action</th>
</tr>
</thead>
</table>
| **Blue**   | • Exclusion Criteria  
  • or  
  • SOFA > 11* | Medical Management +/- Palliate & d/c |
| **Red**    | • SOFA ≤ 7  
  • or  
  • Single Organ Failure | Highest |
| **Yellow** | • SOFA 8-11 | Intermediate |
| **Green**  | • No significant organ failure | Defer or d/c, reassess as needed |

*If exclusion criteria or SOFA < 11 at any time from the initial assessment to 48 hours change triage code to Blue and palliate.

d/c = discharge
Everyone Receives Care

• “Every human life is valued and every human being deserves respect, caring and compassion. However, this does not mean that all patients will or should receive critical care. Those who do not receive critical care will not be abandoned; rather they will continue to be cared for with alternative levels of care”

from OHPIP
What Would an Ethics Consult Look Like?

- Usual case:
  - Individual with MSOF in ICU in whom physicians have agreed further care is futile
  - Considerations:
    - Autonomy: what would patient have wanted
    - Benefits vs. Burdens

- Pandemic Case
  - Because of scarce resources, patients are evaluated by predetermined criteria
  - Considerations:
    - Save the most people possible
    - Is there another patient whose life can be saved?
Tarrant County: a community work in progress

- Basic Assumptions:
  - Every hospital should have similar criteria and standards
  - By planning and discussing issues ahead of time, we can come to agreement of what is most likely to work best for our community
  - Community education with consistent messaging is key
Work Groups (2)

- Human Resources issues: What would it take to keep employees safe and to enable them to come to work
- EMS issues: region wide protocols re: who is transported (e.g. nursing home patients would NOT be transported to hospitals)
- Outpatient clinics/practices
Work Group (3)

• Allocation of ventilators was the most problematic:
  - The most difficult thing to consider is taking a patient off a ventilator to give it to another patient—especially if we do not really KNOW for sure that the second patient will survive
  - Any protocol adopted will need to be flexible to change as more information comes in
  - The physician at the bedside should not be left alone to make these decisions
History of North Texas Plan

One hospital system took the lead on the ICU/ventilator allocation plan.
Once it was approved at all levels, it was taken to the Dallas County Medical Society.
Now there is a North TEXAS Regional Mass Casualty Task Force.
AND that plan is being reconciled with Texas state plan.
What about NH or AL facility?

- Prepare families ahead of time re: these issues and the fact that it will be safer to keep patients in place in NH.
- Food and medication supplies
- HR policies: especially an emergency policy for compensating workers to STAY HOME if ill.
- How will you function if 1/3 of your work force is ill? What are the essential functions? Cross-training?
What about a CCRC?

- Consider locking the facility down once there is pandemic flu in the community
- Stop congregate dining and activities
- HR policies including an analysis of the essential functions for each department
- Adequate reserve stores of food, water and medications
- Resident and family education ahead of time
What about outpatient practices?

• Education of patients: practice with this year’s flu season

• A practice plan for:
  ❖ Fewer staff:
    • allowing staff to work from home
    • HR policy
  ❖ Separating ill from sick patients
  ❖ Changing your telephone message
What about your community?

- Find out what plans your hospital/EMS and health department are making
- Educate your friends, neighbors, faith community
- Consider joining the Medical Reserve Corps.
Where do Hospices fit in?

• All patients receive care—much of it will be palliative care
• Can we be prepared to mobilize resources in the community to care for flu victims in their homes?
• Medical Reserve Corps?
IOM report: Palliative Care

- Providing palliative care is an important ethical and medical imperative and, especially with regard to end-of-life care, should include a holistic and humane approach to CSC implementation. Setting the expectation that all patients will receive some care, regardless of the availability or scarcity of resources, is an important component of CSC efforts.
IOM Palliative Care (2)

- Incorporating into CSC planning the capabilities necessary to provide palliative care assures the public that even when curative acute care cannot be provided, every attempt to offer pain management and comfort care to disaster victims will be made, even if comfort care may mean nonpharmaceutical interventions such as holding a hand or offering words of comfort.
The public would likely benefit from understanding that palliative care, in ordinary times or during a disaster, prevents a sense that society or its health care professionals have abandoned the patient or deliberately caused death. Instead, palliative care respects the humanity of those who will die soon, minimizes their discomfort, supports their loved ones, and provides aggressive treatment of symptoms (e.g., pain, shortness of breath) (Domres et al., 2003; Matzo et al., 2009).
Providing a treatment category of “palliative care” for those not likely to survive will be an important service option for responders and triage officers. Acknowledging that a person is not likely to survive typically leads to discussions regarding goals of care, appropriateness of interventions, and efforts to help the patient and family begin to say goodbye.
Other Challenges for Hospices

• Hospice patients are among the most frail and vulnerable. What strategies can you develop to protect them from catching the flu?
• What can you do to protect your employees from getting sick?
Goals

• A community wide plan for dealing with a public health emergency
• A balance between our duty to care for all who are ill and our duty to steward resources
• Communication with the wider community for transparency, education and input
“Let’s hope we never have to use these plans”

But if we do:

- Can we prevent an epidemic of fear by planning ahead and by educating the public?
- Can we prevent a major surge by rapidly initiating isolation/distancing precautions if it is an epidemic?
Unfinished Business

1) Communication/transparency
2) Who declares the disaster that allows for altered/crisis standards of care
3) Liability protection