Responding to Covid-19 as a Regional Public Health Challenge

Preliminary Guidelines for Regional Collaboration Involving Hospitals

Nancy Berlinger, PhD; Matthew Wynia, MD, MPH; Aimee Milliken, RN, PhD, HEC-C;
Felicia Cohn, PhD, HEC-C; Laura K. Guidry-Grimes, PhD; Lori Bruce, MA, MBE; Grace Oei, MD, HEC-C;
Hannah I. Lipman, MD, MS; Carla Cheatham, MA, MDiv, PhD

The Hastings Center • April 29, 2020

Supplement to
Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19) with Guidelines for Institutional Ethics Services Responding to COVID-19: Managing Uncertainty, Safeguarding Communities, Guiding Practice
Nancy Berlinger, PhD; Matthew Wynia, MD, MPH; Tia Powell, MD; D. Micah Hester, PhD; Aimee Milliken, RN, PhD, HEC-C; Rachel Fabi, PhD; Felicia Cohn, PhD, HEC-C; Laura K. Guidry-Grimes, PhD; Jamie Carlin Watson, PhD; Lori Bruce, MA, MBE; Elizabeth J. Chuang, MD, MPH; Grace Oei, MD, HEC-C; Jean Abbott, MD, HEC-C; Nancy Piper Jenks, MS, CFNP, FAANP
The Hastings Center • March 16, 2020
https://www.thehastingscenter.org/ethicalframeworkcovid19/

CONTENTS

Summary

This supplement to The Hastings Center's *Ethical Framework* aims to help structure discussion of significant, foreseeable ethical concerns in responding to Covid-19 as a regional public health challenge and to support collaboration across institutions throughout pandemic response and recovery. It is designed for use by hospitals and other health care organizations serving the same geographic region, such as a municipality, county, metropolitan area, state, or multistate area.

This document may support formal and informal convening by state and regional hospital associations, state medical societies, and public health authorities. Its method is to

- explain how ethical duties apply across institutions serving the same communities and populations, drawing on the duties outlined in the Ethical Framework;
- offer preliminary guidance concerning ethical challenges arising in collaboration among hospitals and other health care institutions and with public health authorities; and
- share resources supporting regional collaboration.

This document is not intended to be, and should not be considered, a substitute for clinical ethics consultation or other medical, legal, or other professional advice on individual cases or for particular institutions. It reflects an evolving public health emergency and the rapid development and updating of public health and clinical practice guidance and institutional protocols; references are current as of April 27, 2020. This rapid-response work is made possible by the Donaghue Impact Fund at The Hastings Center.

Ethical Duties of Health Care Leaders Responding to Covid-19 across Institutions

Effective response to Covid-19 acknowledges the tension between the patient-focused duty of care familiar to clinicians and new or urgent public health duties to the community and the health care workforce. These public health duties include and are not limited to the fair allocation of limited or scarce resources (staff, stuff, space).

Health care leaders have a duty to plan for the management of foreseeable ethical challenges during a public health emergency.

- Ethical challenges arise when there is uncertainty about how to "do the right thing" when duties or values conflict. These challenges affect the health care workforce, health care operations, and a health care institution's communication with the public.
- Planning to meet the needs of patients with severe Covid-19 illness includes explicit attention to critical care, palliative care, and institutional ethics services and resources.
- Planning for the possibility of crisis standards of care (CSC) includes the development of triage protocols to allocate scarce resources, such as critical care beds and ventilators, and ensuring adequate palliative care for patients opting for or triaged to receive comfort care.

Health care leaders have a duty to safeguard the health care workforce and vulnerable populations in the community.

- The health care workforce includes clinicians caring for Covid-19 patients, such as physicians, nurses, and respiratory technicians, and other essential workers, such as janitors and housekeeping staff, who are at increased risk of occupational harms during an infectious illness outbreak. A community's health care workforce is not limited to the employees of a single institution or system, nor to those working in hospitals and clinics. The health care workforce includes those providing home health services, caring for residents of long-term care facilities, and responding to emergency medical needs in the field as first responders.
- Vulnerable populations include people at risk of severe Covid-19 illness due to factors such as age or underlying health conditions, people facing barriers to health care access, and those at increased risk of infection due to working or living conditions.
- Persons who live in the same household as a member of the health care workforce may also make up a vulnerable population due to increased risk of infection or because health care workers' obligations require alternative housing or create a need for childcare.

Health care leaders have a duty to guide health care workers experiencing demanding work conditions, ethical uncertainty, and moral distress during a public health emergency.

- The devastating nature of severe Covid-19 illness and the operational demands of caring for large numbers of Covid-19 patients add tremendous stress to clinical work.
- Further sources of workforce stress include shortages of personal protective equipment (PPE or "gear") during an infectious disease outbreak, staff redeployment to compensate for staff shortages or surge conditions, and restructured staff-to-patient ratios in critical-care nursing and other areas.
- Moral distress—the feeling of being unable to "do the right thing" or being helpless to avoid wrongdoing or harm—is foreseeable during a prolonged public emergency featuring high mortality, visitor restrictions, resource limitations affecting patient care and health care workforce safety, and the potential need for triage decisions.

These duties apply *across* health care institutions regionally as well as within institutions.

- **Regional collaboration can support the duty to plan** by clarifying regional challenges, sharing resources, identifying consensus, and reducing duplication and unilateral approaches in the development of policies and processes, including triage protocols.
- **Regional collaboration can support the duty to safeguard workers and vulnerable populations** by facilitating PPE allocation across institutions and care settings (including home health and residential care facil-

ities) and identifying trustworthy ways to communicate with and concerning the needs of vulnerable populations within a region.

- **Regional collaboration can support the duty to guide** through joint workforce training reflecting regional priorities; processes for consultation and referrals across institutions, including among ethics committee leaders and palliative care professionals based in hospitals and in hospice programs; and identification of behavioral health services available to Covid-19 health care workers and other caregivers, such as family members and volunteers.

Promising Practices Supporting Regional Collaboration

Regional collaboration may be initiated by a state or regional hospital association, state medical society, state hospice and palliative care organization, municipal public health system, academic medical center, or regional or statewide clinical ethics network. Discussions and other exchanges can support Covid-19 preparedness and response by

- providing a reliable, confidential venue (e.g., a scheduled online meeting or conference call, list-serve, or document repository) to identify, discuss, and make progress on regional challenges in caring for Covid-19 patients;
- encouraging transparency and mutual support in planning;
- sharing template documents for adaptation;
- supporting institutions where ethics services are limited or staffed by redeployed clinicians;
- providing updates on state-level legal and policy developments;
- clarifying legal concerns related to provision of care under contingent and crisis conditions;
- exploring development of and consensus concerning regional standards of care if state-level guidance for crisis standards of care is unavailable; and
- identifying emerging concerns that may call for joint communication to a state's governor, public health authorities, or the public.

Health care ethicists participating in regional discussions in different parts of the United States have identified ethical challenges arising within regions as well as within institutions. The Preliminary Guidelines below reflect nonconfidential insights supplied by contributors.

Preliminary Guidelines for Regional Collaboration Involving Hospitals

Hospitals serving the same region should aim to confer with each other concerning policies, processes, and practices to

- **safeguard the regional health care workforce, not limited to an institution's employees;**
- **safeguard vulnerable populations in a region, drawing on data concerning social inequalities and health inequities regionally and on existing efforts to mitigate health inequities and serve populations facing barriers to health care;**
- **ensure medically appropriate care for Covid-19 patients, including under contingent levels of care and crisis standards of care; and**
- **communicate with patients, families, and the public about foreseeable medical decisions and care limitations during a public health emergency.**

Hospitals should include community-based hospice and palliative care programs in regional planning and collaboration concerning anticipated surges in Covid-19-related palliative care needs and capacities.

Relevant policies, processes, or practices include the following:

- coordinated efforts to promote equity in PPE allocation across Covid-19 care settings, e.g., inpatient and outpatient clinical settings, residential care facilities, hospice programs, and home health agencies, including non-Covid-19 hospital settings (e.g., obstetrics), where health care workers and hospitalized patients are at risk of Covid-19 exposure;
- creation of a resource allocation system for hospital and intensive care beds that can be activated when one health care system within the region is nearing capacity, with attention to suspension of preexisting health care contracts as needed;
- communication among hospitals concerning effective regional management of contingency levels of care, with attention to resource allocation systems to avoid unilateral triage outside of CSC;
- communications with patients, families, and the public about care limitations during a public health emergency and about foreseeable medical decisions arising for critically ill Covid-19 patients, with attention to communicating with diverse populations in terms of language, culture, and health literacy and to barriers to health care experienced by different populations;
- consultation among hospital-based and community-based hospice and palliative care professionals to share knowledge of best practices for symptom management in Covid-19 patients and to establish processes for comfort care and end-of-life care in hospital and other settings, including contingency plans if first-line medications are unavailable;
- agreement concerning modification of CPR practices, such as PPE donning, limiting the number of staff members present, and limiting interventions to compression until an advanced airway is in place, with attention to balancing workforce protection and procedural effectiveness;
- agreement concerning whether health care settings responding to Covid-19 should adopt the do-not-resuscitate (DNR) code status for critically ill patients in view of benefits to patients/survivability, risks to workers, resource constraints, and equity across institutions; and
- agreement concerning whether and how health care workers should be prioritized in the allocation of scarce resources under crisis standards of care, including consequences for the larger community and for equity across hospitals and other health care settings.

Selected Resources

N. Berlinger et al. *Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19)*. The Hastings Center. March 16, 2020.
https://www.thehastingscenter.org/ethicalframeworkcovid19/

Center to Advance Palliative Care. "CAPC Covid-19 Response Resources." 2020.
https://www.capc.org/toolkits/covid-19-response-resources/

Greater New York Hospital Association. "Critical Care Planning Resources." 2020.
https://www.gnyha.org/tool/critical-care-planning-resources/

J. Heilinger et al. "Public Health Ethics and Covid-19: The Ethical Dimensions of Public Health Decision-Making during a Pandemic." Public Health Competence Network for COVID-19, Ethics Work Group. April 22, 2020.
https://www.public-health-covid19.de/images/2020/Ergebnisse/Policy_Brief_Pandemic_Ethics_GeneralF.pdf

Kaiser Family Foundation. "State Data and Policy Actions to Address Coronavirus." April 28, 2020.
https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/

N. Krieger et al. " The Fierce Urgency of Now: Closing Glaring Gaps in US Surveillance Data on COVID-19." *Health Affairs Blog*. April 14, 2020.
https://www.healthaffairs.org/do/10.1377/hblog20200414.238084/full/

National Academies of Sciences, Engineering, and Medicine. *Rapid Expert Consultation on Crisis Standards of Care for the COVID-19 Pandemic*. Washington, DC: The National Academies Press, 2020.
https://doi.org/10.17226/25765

National Hospice and Palliative Care Organization. "Coronavirus Disease 2019 (COVID-19) Shared Decision-Making Tool." March 19, 2020.
https://www.nhpco.org/wp-content/uploads/COVID-19-Shared-Decision-Making-Tool.pdf

National Hospice and Palliative Care Organization. "Ethical Framework for Decision-Making in HPC during the COVID-19 Pandemic." March 27, 2020.
https://www.nhpco.org/wp-content/uploads/COVID-19-Ethical-Framework-Decision-Making.pdf

VitalTalk. *COVID Ready Communication Playbook*. 2020.
https://www.vitaltalk.org/guides/covid-19-communication-skills/

Contributors

Project Director: Nancy Berlinger, PhD
Research Scholar, The Hastings Center
Bioethics Committee, Montefiore Medical Center

The following individuals are coauthors of this document. Their institutional affiliations are provided for purposes of identification only.

• Lori Bruce, MA, MBE
Chair, Community Bioethics Forum, Yale School of Medicine
Associate Director, Interdisciplinary Center for Bioethics, Yale University

• Carla Cheatham, MA, MDiv, PhD
Chair, Ethics Advisory Council, National Hospice and Palliative Care Organization

• Felicia Cohn, PhD, HEC-C
Clinical Professor of Bioethics, University of California, Irvine, School of Medicine
Bioethics Director, Kaiser Permanente Orange County

• Laura K. Guidry-Grimes, PhD
Clinical Ethicist, Assistant Professor of Medical Humanities and Bioethics, University of Arkansas for Medical Sciences

• Hannah I. Lipman, MD, MS
Director of Bioethics, Hackensack University Medical Center

• Aimee Milliken, RN, PhD, HEC-C
Clinical Ethicist and Nurse Scientist, Brigham and Women's Hospital

• Grace Oei, MD, HEC-C
Director of Clinical Ethics, Loma Linda University Health
Attending Physician, Division of Pediatric Critical Care, Loma Linda University Children's Hospital

• Matthew Wynia, MD, MPH
Professor, Schools of Medicine and Public Health, Director, Center for Bioethics and Humanities, University of Colorado, Anschutz Medical Campus, Aurora, CO

Editor: Laura Haupt
Designer: Nora Porter
Digital media: Mark Cardwell, Susan Gilbert, Julie Chibbaro