Crucial Conversations During the COVID-19 Pandemic

Discussion Outline

- Introductions (Sabine von Preyss-Friedman, Kevin Henning, Laurent Adler)
- Kevin intro and :"There is no more fundamental ethical tension than the tension of the distribution of scarce resources," said Emory University bioethics expert Paul Root Wolpe, president of the Association of Bioethics Program Directors.
- Although the stress of the health system in Western Washington appears to have moderated in recent days, it is increasing in many areas of the country and has the potential to recur in the coming weeks and months.
- Moderator - goal of the session - is to arm our WA PALTC workforce with decision-making tools and conceptual frameworks for the challenge of caring PA and LTC residents in a potentially resource-limited environment. We will do this by walking through a real clinical case and reflecting on how to think through the challenges
- Moderator: Question – What ethical principles or conceptual frameworks exist in healthcare for approaching care during resource- limited times?
- Response – (Laurent, Kevin)
    - Principle-based ethics. Philosophers, ethicists, religious leaders agree on four ethical principles.
    - Autonomy – patient self-determination
    - Beneficence – promoting the patient's well-being.
    - Non-maleficence – avoid doing harm
    - Justice – fair allocation of resources
- Moderator: Summary (optional) - Our society has moved away from the paternalism and more towards patient autonomy over the years with the more recent ethical principle of shared decision-making being emphasized over the past 10 years. This is when the healthcare team, patient and family participate in figure out the best path to go down. In addition, our society has traditionally not needed to ration resources. Now let's discuss a case, Kevin.
- Case presentation (Kevin)

Commented [LA1]: For many years this has meant patients and families being autonomous medical decision making. In recent years there has been a trend away from that model and towards sharing decision-making with the healthcare team.

Commented [LA2]: While the US has long had sufficient resources to provide high-intensity care to all its residents, in the face of the global pandemic we are facing shortages and perhaps the need to ration.

Commented [LA3]: By adding this summary paragraph to the principle-based ethics section (above) I think we can get rid of this paragraph.

96 yo female at a SNF in a community with widespread COVID-19. PMHx – dementia with dysphagia, total care including feeding, aphasia, anxiety, CKD, GERD. The NP managed the patient by phone since 3/1 since due to the prevalence of COVID.

Goals of Care – DNR, comfort measures only.

- STOP here to reflect (prompted by Moderator)

The NP checked in with the nurse by telephone on 3/5. The patient developed SOB, poor oral intake and weakness. Roommate had similar symptoms. Ordered CBC, Flu swab, viral panel with COVID, UA and CXR. WBC was normal. 9.5. Lymphocyte count 4.9 (high). Neutrophils normal.

Thought she had aspiration pneumonia. Treated with Rocephin 1 gram. Ordered droplet precautions. Checked WBC on 3/6, WBC was 6.8. Lymphocyte count 1.4 (normal).

3/7 - CXR showed RUL opacity. Antibiotics seemed to be helping.

3/8 – O2 sat was 35-45%. The nurse was panicked. T101.8, BP 83/43, RR 26.

- <u>STOP here to reflect</u> (prompted by Moderator – how would you approach this to address family panic → empathy, acknowledge "difficult times", fear,)

The NP called the family and explained COVID was in the differential. The family was panicked by COVID-19 and wanted her send her to the hospital. Our NP explained the code status and that the hospital wouldn't help because the prognosis is so poor. Family wouldn't listen. "We can offer morphine to make her comfortable". Daughter said, send her to hospital.

The COVID test results were positive and available on day 2 of the hospitalization. The patient died the following day. She was not intubated.

- <u>STOP here to reflect and summarize the case</u> (prompted by Laurent); consider why not intubated

- <u>Question</u> – What else did your team learn from this experience (Moderator)
- <u>Answer</u> – (Kevin) Serious Illness Conversation Guide or similar approach to communication
  - Much of the challenge can be addressed with accurate prognosis sharing, goals of care discussion and recommendations that match goals in the context of prognosis and the available resources
  - Ask permission to discuss goals and values in the context of the pandemic
    - "I'm hoping we can talk about where things are with your Mom's condition, particularly given where we are with the COVID pandemic. Is now a good time?"
  - Share prognosis
    - "While I hope your Mom doesn't get this infection – we're doing everything we can to keep her safe – she may, the virus can easily spread in a nursing facility. If she develops the infection, I worry she could get sick quickly and even with intensive care, she would die"
    - **Accurate prognosis sharing is key. Don't mince words. Clinicians traditionally overestimate prognosis. Now more than ever this isn't the time for that.**
  - What would be your Mom's most important goals if she were to develop a COVID infection?
  - Make a recommendation. "Based on her condition, her goals and values and where we stand right now, we recommend treating her here. Sending her to the hospital won't help her meet her goals, she'd suffer more and needlessly expose others to the virus. So, we need to plan to treat her here, OK?"

- Focus on what we can do, not on what we can't do.

Commented [LA4]: Thoughts about sharing with APCs (for them to share w pt/RPs) about public health advantages to DNR/DNH: (1) avoiding further demands on overtaxed EMS/ER/hospital/ICU resources (2) unsuccessful use of CPR and vent takes these resources from those in whom it could be successfully used, (3) every time these life-prolonging techniques are used they risk exposing personnel to COVID with all the downstream effects from that.

Moderator: Discussion of some of the issues that are raised by the case (Laurent and Kevin tie it back to your ethical principles and conceptual frameworks)

- K: Because of the current situation, clinicians will need to shift from their traditional role having only a patient-centered focus to increasing focus on public health considerations, especially given our relatively scare resources. This can be challenging because sometimes doing what we think is "the right thing" for the health of the population can be in conflict with doing what we think is "the right thing" for individual patients.
- The Hastings Center discusses three categories of resources: stuff (medication, ventilators, PPE), space (hospital beds, ER bays, ICU space, hospital hallways), and staff (primary medical staff, reserve staff, staff performing atypical roles, volunteers). Decisions regarding allocation of these resources become increasingly difficult as they become scarcer.
- Some rationing has already started in our midst: PPE and testing supplies are two examples. Overseas there are already many examples of rationing of ICU beds and ventilators, a situation we are likely to face as well.
- Some have even suggested that patients will be removed from ventilators in order to provide ventilator support to another patient who seems more likely to survive, or an individual who has more years to live, or a healthcare provider whose survival could help others to live.
- Some may be uncomfortable with the idea of healthcare workers such as us being prioritized for testing, PPE, and life-prolonging treatment.
- This situation of insufficient ventilator may result in decisions being made to withhold life-prolonging treatment against the wishes of a patient or responsible party.
- Much of the challenge for us as providers is due to the tension between the ethical principle of patient autonomy (which we are in the habit of dealing with and treating as paramount) and the principle of justice which is not often something we are made to think about.
- Justice demands that medical decisions be fair (in terms of benefit and burden) across a society. This includes the fair distribution of scarce resources. While most of us are used to working in an environment that allows for nearly any treatment requested by a patient or RP (even if we personally may disagree with it), we may be faced with having to make triage decisions regarding who will be able to access life-prolonging care.
- This is likely to cause challenges for us as we find ways to discuss this with patients and families, as we engage with facility staff who may not agree with the decisions being made.
- Recognize that participating in these decisions can cause moral injury to the healthcare provider – the trauma of violating your own moral conscience.

If you are in a community that has rationing criteria, it is important to remember the public health implications.

- Question - Any closing comments or take aways for the group? (Moderator)
- Answer (Laurent, Kevin) – use the teaching technique of enumeration (state the numbers)
  1. The principle of doing the greatest good for the greatest number…focus on maximizing the number of lives saved.
  2. Prevention via handwashing, PPE physical distancing, will help decrease the need for prioritizing.
  3. Know the status of your community's resources.
  4. Goals of care (which should now include COVID and often a statement that we may not hospitalize your loved one if they develop serious covid-19 illness)
  5. Recognize these are challenging times, not just in terms of providing care to individuals who are gravely ill, but also because you may find yourself in an ethically challenging situation. Work with your colleagues in the facilities to start addressing this now.

https://www.nejm.org/doi/full/10.1056/NEJMsb2005114

https://www.vitaltalk.org/guides/covid-19-communication-skills/

https://www.geripal.org/2020/03/rationing-life-saving-treatments-in-COVID19.html

https://www.thehastingscenter.org/wp-content/uploads/SlideDeck-HECCEC-COVID-19-Readiness.pdf

Vital Talk COVID Guide:

How come the basketball players got tested?	I can imagine it feels unfair. I don't know the details, but what I can tell you is that was a different time. ***The situation is changing so fast that what we did a week ago is not what we are doing today.***
Why can't my 90 year old grandmother go to the ICU?	This is an extraordinary time. We are trying to use resources in a way that is fair for everyone. Your grandmother's situation does not meet the criteria for the ICU today. I wish things were different. [C]
Shouldn't I be in an intensive care unit?	Your situation does not meet criteria for the ICU right now. The hospital is using special rules about the ICU because we are trying to use our resources in a way that is fair for everyone. If this were a year ago, we might be making a different decision. This is an extraordinary time. I wish I had more resources.[C]
My grandmother needs the ICU! Or she is going to die!	I know this is a scary situation, and I am worried for your grandmother myself. This virus is so deadly that even if we could transfer her to the ICU, I am not sure she would make it. So we need to be prepared that she could die. We will do everything we can for her.[C]
Are you just discriminating against her because she is old?	I can see how it might seem like that. No, we are not discriminating. We are using guidelines that were developed by people in this community to prepare for an event like this. The guidelines have been developed over the years, involving health care professionals, ethicists, and lay people to consider all the pros and cons. I can see that you really care about her. [C]
You're treating us differently because of the color of our skin.	I can imagine that you may have had negative experiences in the past with health care simply because of who you are. That is not fair, and I wish things had been different. The situation today is that our medical resources are stretched so thin that we are using guidelines that were developed by people in this community, including people of color, so that we can be fair. I do not want people to be treated by the color of their skin either. [C]
It sounds like you are rationing.	What we are doing is trying to spread out our resources in the best way possible. This is a time where I wish we had more for every single person in this hospital. [C]
You're playing God. You can't do that.	I am sorry. I did not mean to give you that feeling. Across the city, every hospital is working together to try to use resources in a way that is fair for everyone. I realize that we don't have enough. I wish we had more. Please understand that we are all working as

	hard as possible. [C]
Can't you get 15 more ventilators from somewhere else?	Right now the hospital is operating over capacity. It is not possible for us to increase our capacity like that overnight. And I realize that must be disappointing to hear. [C]
How can you just take them off a ventilator when their life depends on it?	I'm so sorry that her condition has gotten worse, even though we are doing everything. Because we are in an extraordinary time, we are following special guidelines that apply to everyone here. We cannot continue to provide critical care to patients who are not getting better. This means that we need to accept that she will die, and that we need to take her off the ventilator. I wish things were different. [C]

Sequential Organ Failure Assessment (SOFA) score may be used to determine patients' prognoses for hospital survival. Major and severely life-limiting comorbidities are used to calculate SOFA score, and are common in our patients

Examples of Major comorbidities (associated with significantly decreased long-term survival)	**Examples of Severely Life Limiting Comorbidities** (commonly associated with survival < 1 year)
• Moderate Alzheimer's disease or related dementia • Malignancy with a < 10 year expected survival • New York Heart Association Class III heart failure • Moderately severe chronic lung disease (e.g., COPD, IPF) • End-stage renal disease in patients < 75 • Severe multi-vessel CAD • Cirrhosis with history of decompensation	• Severe Alzheimer's disease or related dementia • Cancer being treated with only palliative interventions (including palliative chemotherapy or radiation) • New York Heart Association Class IV heart failure plus evidence of frailty • Severe chronic lung disease plus evidence of frailty • Cirrhosis with MELD score ≥20, ineligible for transplant • End-stage renal disease in patients older than 75

https://ccm.pitt.edu/sites/default/files/UnivPittsburgh_ModelHospitalResourcePolicy.pdf