**MSSNY**
**Committee on Bioethics**
**Friday, October 23, 2020**
**Draft Minutes**

1) **Welcome**

2) **Adoption of February 7, 2020 committee minutes –** approved

3) **Discussion of ethical issues that arose due to COVID 19 –**

a) **Ventilator Distribution/Allocation across NYS –** the committee was directed to the minutes included in the meeting packet of minutes from the Bioethics Committee dated May 9, 2014. In it, there was a presentation by Ms. Susie Han, from the NYS Task Force on the Life and the Law. This presentation offered, among other things, policy regarding ventilator distribution during a pandemic. Regarding the COVID Pandemic. There didn't seem to any guidelines. People seemed to be looking elsewhere to see what other locations/states were using for guidelines. It was suggested that the committee or a subcommittee of this committee should get together to go over these old guidelines for 2014 to see if they need to be revised. We did not have to use them at this point in time, but we should use this time to prepare in case the guidelines need to be used in the future. It was pointed out that if a physician practices in a hospital that has religious affiliations, the guidelines may differ. There is a concern that there could be agist discrimination. If the state isn't going to do anything with these guidelines, then perhaps MSSNY should come up with its own. It is disappointing that the NYS Department of Health did not do anything despite urging from MSSNY. Also concern for decisions that were being made on behalf of people with developmental disabilities. Hospitals have an obligation to make their guidelines known to their population so the population can choose if they want to go there. This isn't possible if they don't have guidelines. Some hospitals took the task force guidelines, revised them and used them in accordance with their hospital policies and their ethics committees. Asking HANYS and Greater New York how they used the guidelines is an important part of how the committee decides to move forward. MSSNY was in constant contact with the governor's office and the department of health during this crisis. There is an ethical imperative that all hospitals have one set of guidelines and treatment should be uniform throughout. MSSNY made it a priority to provide as much information as they could to their physicians including the directive to use these guidelines. The instructional iniquities that were compounded by COVID are many. Some of the ethical issues that physicians faced during the pandemic are on the agenda. Certainly, these are some, but not all.

**b) The reallocations of ventilators from upstate to downstate and across NYS**
Questions – is it ethical to leave some ventilators unused in case they are needed for patients that arrive later? In some hospitals there were blind panels that determined how equipment and supplies were to be rationed between patients. How do you get the information to the person who decides who get the ventilator in real time, in order for them to make a decision? How did certain institutions deal with this? One member commented that there was a member of the blind committee available 24 hours a day in case they were needed to make a decision. There were problems with decisions in the

beginning regarding ventilators with patients with IDD because they lacked capacity. It was almost impossible to do it correctly. There were problems in particular with the 1750B. In working with MHLS and the consumer advisory board, the SCMD committees when OPWDD could not be reached and get their input, they were able to put some guidance together and put it on MOST.org including a was to reach MHLS attorneys throughout the state 24/7; numbers to reach DD when needed. It improved a sense of the process. There are extra considerations to be made under normal circumstance when dealing with people through OPWDD, then decision making during COVID was another story. When people who were able to leave the hospital and go to an LPAC setting where there is a fairly high level of care there were no beds. The impact that COVID 19 had on the department of health itself, made it extremely difficult to get help in this area? Where do these patients go? LPAC beds are hard to come by in normal settings. There is a need to take a look at this and ask the question – "where are these patients going to go?" People working outside of their competencies had to learn in real time how to manage their patients. There was a departure from the norms of clinical practice. There was desperation-based medicine instead of evidence-based medicine. There was a departure from the "norms" or clinical based practice. During COVID, entirely new standards were established, Is it defensible to established to standards are care during desperation moments? That's the question. These questions are being asked in the ethics literature "what constitutes a standard of care during times of crisis? There are two dilemmas. First in an emergency there is less time to plan. Second in a novel disease process, there is no evidence to go with.

c) **Rationing of Renal Replacement -** Many hospitals were surprised across the state at the prevalence of renal failure. They did not anticipate the need for dialysis, the need for the filters to run CRRT because of the clotting due to the inflammatory response of COVID. They were unable to anticipate the nurses that would be required to staff the CRRT.

d) **Rationing of ECHMO** - There was no anticipation how ECHMO was going to be used. The normal length of ECHMO is five to seven days, but the use of ECHMO in the treatment of COVD, physicians found that being on ECHMO for several weeks even as long as a month was survivable. The hospitals ran out of ECHMO supplies very quickly because patients got on ECHMO and stayed on ECHMO. Medications were jury rigged, due to lack of supplies.

**e) Adequacy of Palliative Care Services –** if the guidelines for Palliative Care during a pandemic are reviewed, you receive palliative care when patients are not going to receive a life saving intervention. The need for palliative care services in New York State tripled during COVID. A lot of goals of cure conversations, symptom management. Not just the patients that were coming off life support, but patients that were on life support helping to make decisions on treatment intensity and when to change courses of care. Palliative care wound up being far more than taking care of patients that were dying and coming off life support. One committee member mentioned trying to make sure patients coming into the emergency room were not making decisions for their care under duress. The decisions were necessary in order to provide care, however, physicians felt that was an ethical issue for them. Part of how they resolved that was expanding the palliative care services to the Emergency Department. Palliative Care didn't really function in the emergency room before the pandemic. Expanding the palliative care allowed someone to assist a patient in decision make especially because they were alone. There was mention that Columbia Presbyterian Hospital is creating a pilot program to create Palliative Care Services in the ER.

**f) Remote Communications/decision making with families –** how did

physicians keep families connected with their relatives when they are in the hospital and under strict isolation? What was the quality of the conversations about goals of care? How do you create new treatment plans when the physician never has a face to face meeting with a family member?

**g) Additional topics of discussion –**

**Physicians operating outside their scope of practice** during times of crisis. Many were drafted to perform outside their scope. Cardiologists were asked to perform ventilator management. Anesthesiologists as well. There were many physicians that felt they were stretching their competencies. The governor's office did issue some limited liability immunity for clinicians working under crisis standards of care.

**Emolst -** was able to assist physicians who found themselves working outside their scope of practice by providing information that they needed, especially with 1750B. With over 50,000 in the Emolst system, over 20% were viewed and reviewed during the crisis time. In addition to having people outside their scope of practice, there were practitioners' coming from out of state. Those people found the Emolst data helpful when trying to treat patients. Regarding people with advanced illness, patients were calling in to hospitals requesting that their Emolst forms be amended. Since the hospital is able to print out the patients forms and have a discussion with the patients about what they wanted to change and why, medical staff was able to make sure the decision to change was well-informed and not just a knee jerk reaction to the message to stay away from the hospital.

Additional topics discussed:

**On education -** early on there was a policy to protect learners from COVID exposure. That policy ended early in the pandemic because there really was no way to avoid COVID patients. There was an ethical question regarding professional's responsibilities to learners vs. responsibilities to patients. The idea of asking learners to take the same risk treating COVID patients and the professionals was an ethical dilemma for some institutions.

**What are the ethical obligations of the Institution to its staff?** How much can you expect your staff to take on? What is the level of risk they are taking? What level of expectation can be too much?

**What access to health care did people have that were not hospitalized?** The message was "if you're sick stay home". What level of care were these individuals able to access? Some of that was relieved by the increased use of telemedicine. Access to in office care has increased slowly over time, but in the beginning, people were being discouraged from getting care. There was a downside of people hesitating to get the care they needed including for COVID until the time came when they were beyond the ability for physicians to help them. There is information available now about the other people who were unable to get care for their diabetes, for their heart disease as outpatients because the message was "don't come in". A question that came up "was some of the increase in mortality rate due to undiagnosed COVID patients that stayed home out of fear or people who died from other issues who stayed away from the hospital out of fear of contracting COVID?

**Excess mortality in marginalized populations** – the mortality was quite profound for a variety of reasons. Structural inequities with regard to living circumstances such as multigenerational living and the inability to isolate or social distance. Having to shelter in place when they have to work in order to pay bills. Employment not being as amenable to working remotely as others are able to do. There has been a lot written on how these structural inequities, this structural racism has directly contributed to the excess mortality in the Black and Hispanic populations nationwide. This clearly is an ethical issue on a much large scale. It is a much larger topic that needs to be addressed. It is not just a medical issue, it is a social issue as well. Marginalized people are more likely to go to the poorer hospital where they are less likely to have the equipment they need. Those facilities are resource poor and that magnifies the disparities for that population. MSSNY has been looking at the impact on health in the disparate community for some time The Committee on Health Disparities has been working on this. MSSNY brought a resolution to the AMA and a commission on health equity was formed with an equity officer. Do the inequities and disparities in the health system cause distrust? Or amplifying the inequities of the health care system to dispense equitable care? Distrust of vaccinations and distrust of vaccinations that will be along soon has been documented in the disparate populations.

Because of the issues that were just raised, does the committee want to invite the Health Disparities Committee to a meeting to discuss these issues and discuss some of the ethical issues involved? Tying the health disparity issues with the ethical issues would be worthwhile endeavor. The question being “How do we make the health system more worthy of the trust in marginalized populations”? This committee might think about writing an article on “Lessons Learned” and consider submitting it to a journal. Over the course of this committee meeting many additional ethical issues have been discussed that were not on the original agenda. Dr Berger recapped countless ethical issues brought to the agenda::

- Ventilator distribution
- Rational renal replacement
- Echmo issues
- Communications issues
- Palliative Care Resources
- Scope of practice issues
- Desperation issues and panic decisions on best care
- Learners in professionalism
- Professional courage vs Martyrdom
- Hospital avoidance and excess mortality out of fear
- Marginalized patients and health disparities
- Vaccine mistrust
- Increase in the use of telemedicine raising issues of:
    a) standards of medical practice because physicians are not physically examining the patients which causes a change in the patients database and does this affect the quality of care?
    b) Patients satisfaction with the quality of care. The duration of time spent with the patients; the quality of the content of the interaction
    c) The impact of quality of telemedicine is unknown at this time
    d) It is much less costly to run telemedicine that to keep exam room and have infrastructure.

e) The need to be cautious with telemedicine to make sure it doesn't create 2 different levels of care – those that can will see a physician – those that can't will have a telemedicine session with someone other than a physician. In addition, there may be some that don't have the resources to have a telemedicine visit.

- eMOLST seems to have aided with the processing of information during the pandemic. It allowed tele-medicine to flow better in reaching out to families that would have otherwise been difficult to contact regarding patient care and medical staff had access to the patients wishes more easily.

For the purposes of this committee and for the benefit of MSSNY what does the committee think should be done now that the committee has identified an array of ethical issues? Linking with the Health Disparities Committee would be fruitful. The topic of "Lessons Learned" has been raised with the Emergency Preparedness Committee. The Bioethics Committee should reach out to them as well.

Dr. Berger will reach out to Pat Clancy to discuss ethical framework of the items mentioned above and how best it can serve MSSNY.

**4) Meeting dates for 2021**

**February 21, 2021**
**April 30, 2021**
**October 1, 2021**