Pandemic Triage: Pausing for Reflection

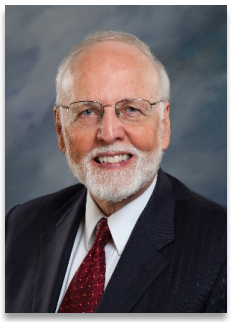
Leaders from three health systems reflect on what we have learned thus far.

Mark Carr, MDiv, PhD

Region Director of Ethics, Alaska
Providence Health and Services

Gina Mohr, MD

Director, Center for Palliative Care
Chair, LLUMC Ethics Committee
Loma Linda University Health



Gerald Winslow, PhD

Director, Center for Christian Bioethics
Professor, Religion
Loma Linda University Health

Ted Hamilton, MD

Chief Mission Integration Officer
Sr. VP, Mission & Ministry
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Grace Oei, MD, MA

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The **webinar and the slide deck** will be available for future viewing under "Webinars" within the "Resources" tab on the ABC Website.

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Questions and Answers

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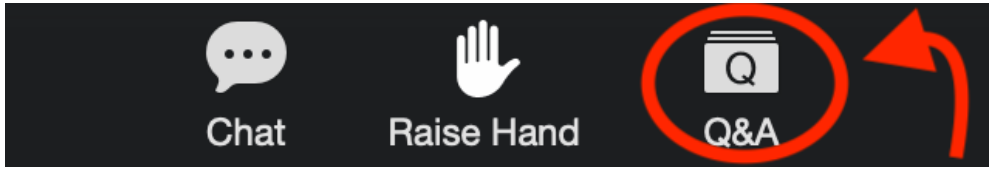

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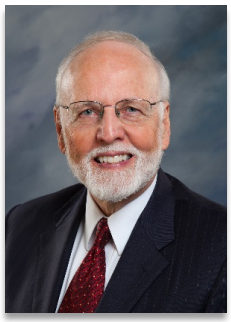

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Session Objectives

1. Identify the healthcare-related moral or ethical difficulties concerning triage that have come to prominence because of the COVID-19 pandemic
2. Identify ways to balance competing moral interests as ethical challenges associated with COVID-19 continue to arise

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A Closer Look At…

- Allocation Policies
- Triage Protocols
- Implementing Allocation Policies
- Changes to Clinical Medicine Because of COVID-19

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A Closer Look At Allocation Policies

- **Ted Hamilton, MD**
- Chief Mission Integration Officer
- Senior Vice President, Mission & Ministry
- AdventHealth

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A Closer Look At Triage Protocols

- **Grace Oei, MD, MA**
- Director, Clinical Ethics
- Associate Director, Center for Christian Bioethics
- Loma Linda University Health

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Triage Protocols

- Strictly utilitarian intent to save most life-years
  - Broad inclusion criteria
  - Limited exclusion criteria
- Unequal playing field (Millet et al, 2020)
  - How can we build in exceptions to utilitarianism in a way that does not render triage moot?
- Within the allocation scheme – how to account for co-morbidities
  - Long term / short term outcomes
  - Do we prioritize younger patients?

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Triage Protocols

- How should emerging knowledge about COVID-19 alter our original triage allocation protocols?
  - Preferential treatment for patients with higher risk factors of dying?
- Have we been transparent enough?

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A Closer Look At Implementation

- **Mark Carr, MDiv, PhD**
- Regional Director of Ethics, Alaska
- Providence Health and Services

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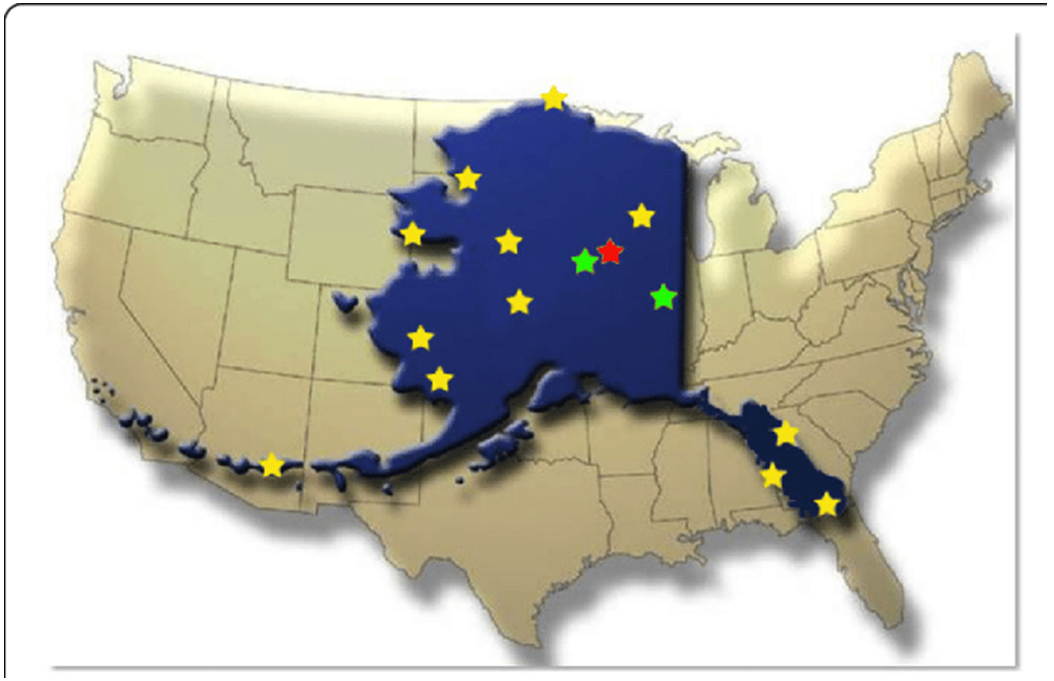
Providence Health Alaska:

Five hospitals, nineteen clinical locations, in six Alaskan communities:

- AK population: ~735,000
- Anchorage population: ~288,000
- Patients serve by PHA: ~108,000

Our Anchorage hospital is the State hub for all things medical.

At the prompting of two members of a local physician group, I hosted a conference call on the narrow focus of triaging patients for ventilator support in the event of an overwhelming surge of patients. With surgeon co-chair, Kenneth Thomas, we went on to conduct about one dozen calls that gathered over forty providers across many locations and systems of healthcare in Alaska, both non-profit and for profit. We established scoring protocol and a battery of triage officers with multi-disciplinary support committees. We made specific recommendations to the State regarding our hoped for management of the Triage protocol and practice.



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What Did I Learn?

1. **We don't work well together in American healthcare; not among corporations (regardless of profit orientation) and not between public and private entities**
   a) Our/my work is proprietary → it belongs to the corporation that pays me.
   b) It is never appropriate to talk to the competition regarding our work.
   c) My Regional Corporate Compliance officer, facility Risk Management officers, and a facility CEO spoke to me about the work I was initiating across Systems within Anchorage and around the State.
   d) My Point: **we should/ought to collaborate and cooperate better than we do.**

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What Did I Learn?

2. **Ethical standards in public health emergencies are not popular in America**
   a) Utilitarianism reigns supreme. We don't like it.
   b) We do not serve the public well by debating triage criteria in the midst of a pandemic.
   c) State agencies should depend upon private companies but maintain strict and comprehensive oversight.
   d) Emergency preparedness documents need clinical interpretative scoring algorithms.
   e) Chaos is not a strategy.

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What Did I Learn?

3. **Human Nature is universally frightened of an invisible enemy**
   a) We should allow science to lead the way, not media, not politics, and not religion
4. **Americans don't really care about healthcare disparities**
   a) We should

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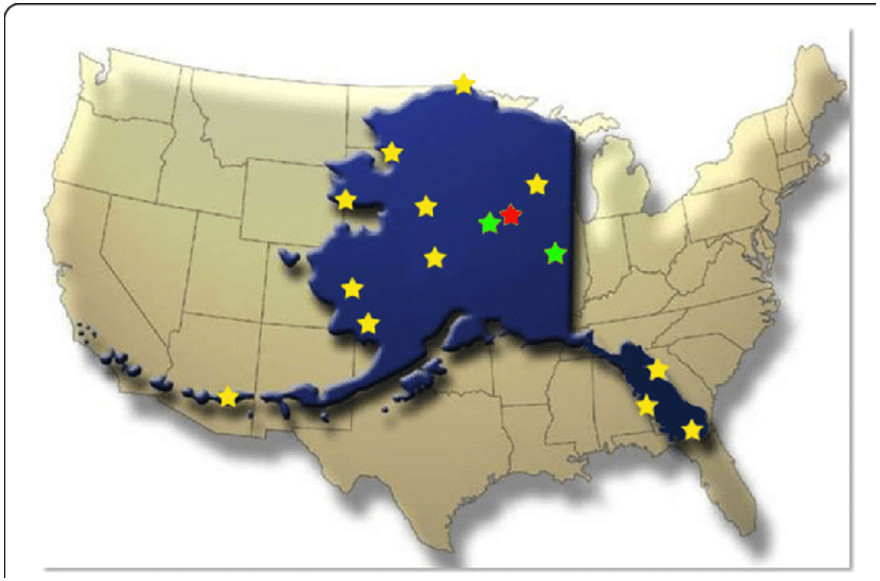
Finally, a Question to Prompt Discussion

Are faith-based clinical ethicists:

A. Protecting the faith
B. Joint Commission obligatory staff
C. Supporting difficult decision making
D. All of the above and more



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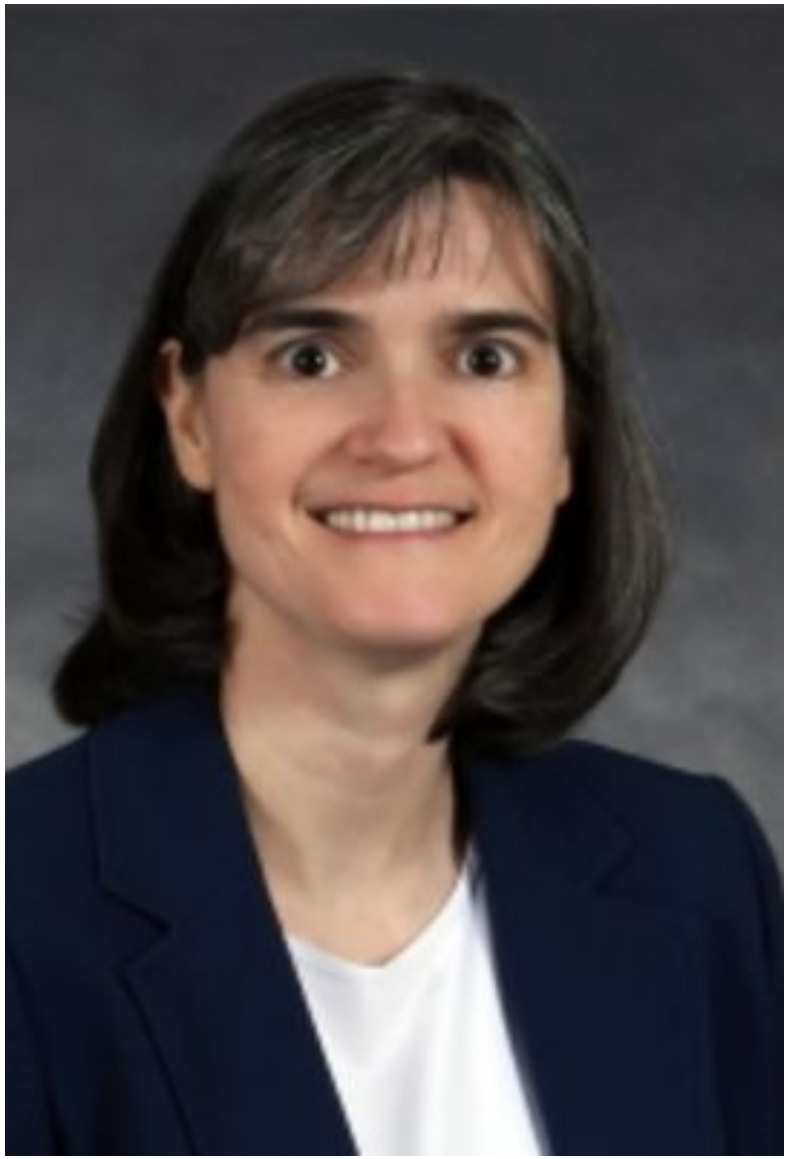

A Closer Look At Changes to Clinical Practice

- **Gina Mohr, MD**
- Director, Center for Palliative Care
- Chair, Ethics Committee, LLUMC and LLUCH
- Loma Linda University Health

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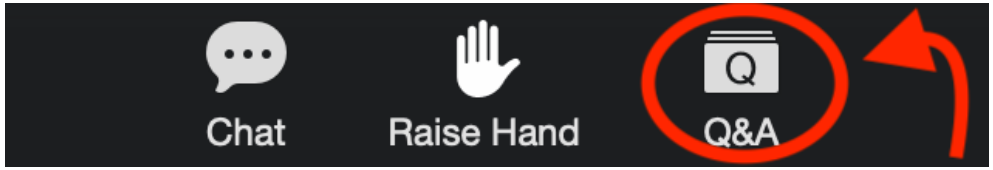

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