

# Ethics Talk Videocast Transcript – Rationing Critical Care During COVID Surge

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TIM HOFF: Welcome to another special edition of *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. This episode is an audio version of a video interview conducted by the Journal's Editor-in-Chief, Dr. Audiey Kao, with Dr. Matthew Wynia, a Professor of Medicine and Public Health at the University of Colorado School of Medicine and the Director of its Center for Bioethics and Humanities. Dr. Wynia joined us to discuss implementation of crisis standards of care in response to the dramatic surge in COVID-19 cases that is pushing the limits of U.S. hospitals' critical care capacity. To watch the full video interview, head to our site, [JournalofEthics.org](http://JournalofEthics.org), or visit our [YouTube](#) channel.

DR. AUDIEY KAO: Matt, welcome back to *Ethics Talk*. [music fades out]

DR. MATTHEW WYNIA: Nice to see you again, Audiey.

KAO: So, the U.S. is currently experiencing a surge in COVID cases and hospitalizations that is larger and broader in scope than the one we faced in April or July. Some states and counties have reported zero or near-zero ICU capacity. Given how important decisions are about allocating limited critical care resources, such as ICU beds and staffing the care for patients on ventilators, states and hospitals seem hesitant to formally activate standards of care that can guide decision making during this health crisis. So, what is contributing to the seeming hesitancy to activate crisis standards of care, and how can we overcome these barriers?

WYNIA: Yeah. I mean, there are some obvious reasons why I think leaders in a state might want to not sort of take responsibility for the activation of crisis standards of care, because that implies that they're planning to avoid crisis, standards of care didn't work. Unfortunately, it also implies a lot of other things. And so, you know, if we could take the pressure off of the leadership of states to say, "Look, this doesn't necessarily mean that your leadership failed." Many states are now seeing this kind of tremendous surge in the numbers of COVID-19 cases across the political spectrum, right? Red states, blue states, they're all seeing this right now. So, if we could do anything, I think that would help in terms of allowing the leadership of states to recognize that implementation of crisis standards of care, when that is necessary, is appropriate and will, in fact, improve the quality of care that you're able to deliver to the largest number of people.

Leaving folks in clinical situations without that level of guidance and protection doesn't mean that they don't have to operate under crisis standards of care, right? That's the misconception here, is that if you don't label it that, it won't happen.

KAO: Right.

WYNIA: But that's just putting your head in the sand, right? I mean, [chuckles] crisis standards of care are not something you choose. They are thrust upon you. And the question is, how well are you going to manage your crisis? And trying to manage at crisis-level conditions without crisis-level authorities and protections and guidance is not going to get you a better outcome than if you implement crisis standards of care and say to the providers in your state, "We recognize the stress that you are under right now. Here's the best guidance we've got. Here are the protections we can offer to allow you to make the best possible decisions under catastrophically tragic circumstances." So, I understand why a governor would not want to acknowledge the reality of their situation. It feels bad. It looks bad. It is bad. But failure to acknowledge the reality of a situation does not change the reality of the situation. And that's unfortunately where some localities and states are at right now.

KAO: So, in that context, in late December, the National Academy of Medicine, along with nine other national organizations—including the American Medical Association and American Nurses Association—called on governors, health departments, and health care providers to take action and implement crisis standards of care during this current COVID surge. So, given what you just said, what more should the federal government be doing to support states and counties that are facing unprecedented resource challenges to their health care system?

WYNIA: You know, that's a really interesting question, because, as you know, the U.S. health care system is quite fragmented. A lot of health care regulatory functions are at the state level, for example. So, many of the things that we usually talk about in terms of crisis standards of care, allowing folks to operate outside of their usual scope of practice, for example, is not a federal issue. That's a state issue. So, the question of what can the feds do? There are federal regulatory steps that the federal government could probably take that would alleviate some of the stress on hospitals and health systems.

So, for example, CMS, the Centers for Medicare and Medicaid Services, do surveys and have documentation requirements and so on, some of which could be pulled back during implementation of crisis standards of care, right? And that would alleviate some of the stress that is arising now on the staff and on doctors and nurses who are actually struggling to keep up with caseloads right now. So, there are probably some regulatory relief that could be offered again just during the crisis, right? So, this would be one of the advantages of saying, of acknowledging, "Look, we are in a crisis in our community, and we're doing the following things to try and alleviate that crisis, to try to work our way through it." The federal government could come in and help.

The other thing that the federal government could really do— Because it's just tragic that we have doctors' offices that have furloughed their workers. We have health care professionals who are out of work or underemployed right now. And simultaneously, we have hospitals and health systems that are completely swamped.

KAO: Yeah.

WYNIA: And that's just nuts, and it reflects a lack of coordination and a lack of funding, right? So, you're talking about states. Well, states operate under very strict fiscal constraints. States can't run a deficit, right? So, the states have limitations in what they can do in terms of paying people to do work, but I think the federal government could

actually do that, right? So, you could see something like the CARES Act, like the kinds of supports that have come in and will be coming in to provide vaccinations, for example. Funding could come from the federal level to help states with the fiscal implications, basically, of having to operate under crisis standards of care and allow them to hire up in situations where staffing shortages are a real problem.

KAO: Yeah. So, many crisis standards of care protocols incorporate clinical scoring systems such as the Sequential Organ Failure Assessment or SOFA scores to triage patients for critical care. However, SOFA scores have not performed well prognostically in respiratory failure patients. How, if at all, should scoring systems be applied in crisis standards of care protocols, especially from a racial equity perspective?

WYNIA: Yeah. So, I'll take that in a couple chunks. It is true: SOFA scores do not perform particularly well in viral respiratory illness, but they don't perform terribly either. And so, the question is, is there something that's better than a SOFA score at predicting who is likely to die from this illness even if they are given full respiratory supports, full ICU care? Because that's what you're...that's sort of what you're looking for in terms of avoiding using scarce resources to provide care to someone for whom it's not going to do them any good. So, that's what you're sort of looking for when you're using these different scoring systems, is who can we provide lower levels of care to, because providing them higher levels of care is not going to benefit them.

KAO: Yeah.

WYNIA: So, these clinical scoring systems have been a big piece of the thinking around how to allocate scarce resources in a crisis circumstance. And a number of people now have argued that they have been too much of a big piece, that we've spent too much time thinking about clinical scoring systems. There was a piece in *Jama Network* opened just last month that looked at a couple different scoring systems, just the clinical scoring system components, and essentially showed that—and this, in retrospect, should not have been too surprising—but they essentially showed that those types of clinical scoring systems don't end up finding a whole lot of people who are going to die no matter what you do. There's just a very small number of people that are truly going to die no matter whether or not they get this and that we can predict accurately in advance that that's what's going to happen. So, unfortunately, even the best scoring system is probably not going to find us a lot of extra resources because you can say, "Well, this person is going to pass away no matter what we do, and therefore, we can allocate them to just comfort services for now. Because we need to keep those critical care resources and use them for others who have a chance of survival." Unfortunately, or fortunately, the good news is that's a small number of people. We can save many, many people.

The other implication of that, though, is that just using clinical scoring systems is not going to get us where we need to go if we, in fact, are overwhelmed and cannot offer full critical care to everyone. And that means we are going to have to start thinking about using other aspects of decision making, other values beyond just how do we use these resources most efficiently. And that gets to the second component of your question, which is we also have worried that these scoring systems, which take into account things like underlying comorbidities and the creatinine level and things that can be affected by race, ethnicity, that some of these things may end up exacerbating disparities by race and ethnicity in health care outcomes.

And in so far as that may be true, we have an obligation to look at other things like equity, like are there ways to ensure that we are giving adequate services to people who are in the hardest hit communities?

KAO: Yeah.

WYNIA: Where they're seeing really high rates of COVID-19 and where mortality rates have been as much as five or six times higher than in other communities in the U.S. So, I think the next step in terms of crisis standards of care is moving beyond the scoring systems, these clinical scoring systems, and thinking very clearly about how do we ensure equity in the allocation of these resources.

KAO: So, as we're talking today, Los Angeles County, where I am today actually, is an epicenter of COVID cases and hospitalizations. To reduce demand on hospitals, the L.A. County Emergency Medical Services Agency recently issued a memo directing ambulance crews to not transfer to hospitals most patients who have virtually no chance of survival. Not surviving cardiopulmonary arrest in the community raises the dilemma of how hospitals should respond during a so-called code blue situation. So, how should physicians and the health care team handle the agonizing dilemma of a hospitalized patient suffering cardiopulmonary arrest when critical care resources to support potential resuscitation are unavailable?

WYNIA: Yeah. That's such a difficult question. And I think in the moment, when someone is having a code blue arrest in your hospital, unless that person starts out with such a poor likelihood of survival that doing CPR would be futile to begin with, which, by the way, if that's the case, then you probably shouldn't be doing CPR regardless, right? Whether you're in a COVID situation or not, we shouldn't be doing CPR on people for whom it is objectively not going to provide any benefit. And there are a few patients like that. And those patients, I think, we try hard, and especially during COVID, we've tried even harder, to have the difficult conversation with the patient and the family in advance to say, "Look. At this point, if there were to be an event where your mom or your dad's heart were to stop, it would no longer be a valid intervention for us to try to restart the heart. Because in circumstances like these, the odds of recovery are so incredibly low, that it is essentially a non-beneficial and only causes harm to do that intervention." And so, we try to have those conversations in advance so that doesn't arise.

But in the moment, if someone has a massive heart attack while they're sitting in your Emergency Department, you don't know at that time whether you're going to be able to pull them back from the brink or not. And I think you have to do the CPR. You do the full code until it becomes clear that you are or are not going to be able to pull them back. And I think in defense of the move that's being taken in Los Angeles, what they have said at the moment, as I understand it, is it's only for patients for whom after CPR in the field, after ACLS in the field, if you cannot get return of spontaneous circulation, then you don't bring that person to the hospital because that person is dead.

KAO: Yeah.

WYNIA: And the data on this are very strong. If, in the field, you cannot achieve return of spontaneous circulation, you're not going to be able to achieve that once you get them to the hospital either. So, the rule at the moment is essentially, don't bring a dead body to the hospital for us to continue to try to resuscitate them. Because the odds of us being able to do that are so exceedingly low that those people should be allowed to pass and should be

treated as a death in the field, rather than having the dead body brought to the hospital to be declared dead in the hospital instead. And that strikes me as a pretty reasonable step when your hospitals are overwhelmed and there are literally ambulances waiting to deal with the patients that are alive and have a chance of survival, right? You should not have an ambulance carrying a dead body take the front of the line when there are ambulances literally waiting in line to discharge their patients into the hospital because there's no room. So, that strikes me as a very reasonable thing. Now, that is a crisis standards of care intervention. We should acknowledge that. That's not normal standard of care.

KAO: So, as we near the end of our conversation today, I want to go back to something you talked about earlier, which was the federal government helping to quote-unquote "hire up," especially among outpatient-trained staff who could support inpatient health care teams. So, regardless of whether crisis standards of care should be activated in a certain locale, the intense workload being shouldered by frontline inpatient health care teams have placed enormous strain on their health and safety. So, what more, what can and should be done to support their well-being in the immediate and longer term during this crisis?

WYNIA: So, we could probably spend the entire hour talking about that. So, I'll try to be very brief in consideration of all that could be said about workforce well-being and resilience and moral distress and burnout. So, let me just make two points. One is sometimes it's sort of assumed that, unlike ventilators where there's sort of a hard cap, right, there's only a certain number of ventilators in your hospital, that staff are an infinitely expandable resource. That you can go from a nurse taking care of three or four patients to a nurse taking care of 20 or 30 patients, and that that's just doable. And what we are learning is that's not true. That staff are not an infinitely flexible resource.

KAO: Yeah.

WYNIA: At some point, and it's a gray point I suppose, but at some point, staff have been stretched and expanded and asked to do more and work longer hours and take care of more patients, to the point where not only do you start to see staff who literally burn out and can't do it anymore, but you see staff getting sick and can't come to work anymore. And you, at some point, not only do you have to worry about the well-being of the staff and the well-being of any given patient, you have to worry about the well-being of all of the patients that they're taking care of.

KAO: Yeah.

WYNIA: And I'll give you, this is sometimes called a feeling the soup strategy for addressing shortages, right? So, with a ventilator, you can't thin the soup, or there are very limited options for feeding more people with one ventilator, if you know what I mean.

KAO: Right.

WYNIA: So, with a ventilator, one person gets it, and the other person doesn't. With staff, you can thin the soup and feed more people a thinner soup, but at some point, you're feeding everyone water.

The second piece of your question, though, is about, so what do we do for the staff to allow them to expand in these ways? And I think health systems are being very creative about this. So, we're seeing them provide free meals. We're seeing them provide child

care. We're seeing them provide carwash services and car care services. We're seeing them do a lot of things to just take the load off and allow people to work longer hours without the rest of their life falling apart. You have to do everything you can to bring them together, to create a cohesive sense of community, do debriefs, allow people time to decompress after their shifts together so that people have a chance to talk through. Because remember, some of the things we're asking people to do they know are poor quality care. And it feels terrible to provide less than high quality care to patients. Even if you are being forced into that circumstance, it still feels terrible.

And so, allowing people the opportunity to talk that out and to recognize that this was the circumstance they didn't bring on themselves, that they weren't making a choice here, they were forced into the circumstance, that's really important for the mental well-being of people experiencing what some have called moral injury from being forced into making these kind of *Sophie's Choice* decisions.

KAO: Yeah. Well, on that challenging note, I want to thank Dr. Matthew Wynia for sharing his expertise and insights on a critically important public health topic with our audience today. Matt, thanks again for being a guest on *Ethics Talk*.

WYNIA: My pleasure. Thank you, Audiey.

KAO: For more COVID ethics resources, please visit the *AMA Journal of Ethics* at [JournalOfEthics.org](https://www.journalofethics.org). Be safe and be well. We'll see you next time on *Ethics Talk*. [bright theme music plays]