

The Massachusetts Crises Of Care Guidelines Need Re-Thinking

by Barbara Anthony

Background and Introduction

Doctors in the northern Italy have faced a critical shortage of lifesaving ventilators. Too many very sick people and not enough ventilators; how did they decide who got a ventilator and who did not? How did they decide whom to take off a ventilator to provide it to another patient with a better chance of survival?

The insidious nature of COVID-19 means that those who need ventilation to breathe and who have no access to the equipment will most likely die. If you are on a ventilator and are then taken off, you suffocate, while another patient may survive because of your sacrifice. Even though only a small percentage of the population gets to this critical point, those are the cruel facts for such victims. These are not hypothetical questions, but very real decisions faced by Italy's doctors.

So how were decisions made in Italy? An article in *The Atlantic* described the extraordinary and painful decisions Italian doctors faced. What they did, according to *The Atlantic* report, was allocate equipment to those who not only were more likely to survive but who also had many years ahead after survival. In other words, if you were over a certain age and likely to survive COVID-19, but someone a lot younger was in a similar circumstance, the decision would be made on the basis of who likely had the most years ahead of him or her.

These Italian guidelines were published by the Italian College of Anesthesia, Analgesia, Resuscitation and Intensive Care in response to the COVID-19 crisis that hit Italy like a tsunami and likened the moral choices facing Italian doctors to the forms of triage required in wartime. The authors, all of whom are medical doctors, provide concrete recommendations, and offer that "it may be necessary to establish an age limit to intensive care." The document advises doctors and nurses to take a patient's overall health status into account, which, it explains, means considering pre-existing health conditions. The Italian guidelines did not come from the Italian central or regional governments, they came from a medical society most impacted by COVID-19. The guidelines seem to reflect the reality of what was happening on the ground in a country caught off-guard but doing its best under extraordinary circumstances.

If you find the Italian guidelines unsettling, look no further than the Massachusetts Department of Public Health Crises Standards of Care to see what could be in our future.



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If you find the Italian guidelines unsettling, and we cast no moral judgment on the decisions Italian doctors had to make quickly in the midst of an overwhelming pandemic, look no further than the Crises Standards of Care (CSC) issued by the Massachusetts Department of Public Health (DPH) on April 7, 2020, to see what could be in our future.

The Massachusetts CSC Guidelines

Where Did They Come From?

While it appears that these guidelines for CSC were just issued for the COVID-19 pandemic, in fact, they have been in development since at least 2009, and appear to have been finalized in 2016. The information on the state's COVID-19 website says

that the state's CSC guidelines were created at the request of "leaders in the healthcare system" to inform the process of providing acute care during the pandemic. The website also says that the CSC guidelines "are not mandatory." The guidelines themselves are silent as to whether they are mandatory and certainly read in a very prescriptive fashion. These guidelines have been around for years and the Commonwealth of Massachusetts has had ample time to vet and improve them

before COVID-19 hit. *Unfortunately, they have not been vetted in recent years, especially among the vulnerable populations most likely affected.* This is a substantial and serious flaw of this document, which is being released under the imprimatur of state government.

The CSC is directed to hospitals and it would appear, upon close reading, that their release may have been inspired, in part, by a desire to provide legal cover for the tough decisions that hospitals may have to make when there are insufficient life-saving resources for all who are in need. The document is full of dated references spanning 1985 to 2013, with one reference source taken from 2015.

Most of the document appears to take its direction from a 2011 report prepared by the Centers for Disease Control's (CDC) Ventilator Working Group. Interestingly, the CDC report repeatedly rises the need for community input and transparency in the development of such guidelines, a process that the DPH seems not to have adopted before releasing them. In one part of the DPH guidelines, legal counsel is required to be present when a triage appeals board makes decisions to take a patient off lifesaving treatment. There is no mention of the role of legal counsel in the CDC guidelines.

Goals of the Guidelines and Methodologies

So what exactly does the Massachusetts CSC provide? First, the goal is to calculate with numerical precision a score for each

patient that aims to establish the patient's chances of surviving the virus. The principle behind this exercise is to maximize the number of lives saved. To calculate a patient's chance of survival, the clinician is given a list of factors with predetermined numerical values. For example, one of the indicators that is scored upon intake is a patient's creatinine level, which is a measure of kidney function. A number even slightly above normal will earn a point against that patient, even though there are, in fact, many reasons, such as temporary dehydration and the use of antibiotics, that could cause an above normal creatinine level. There are several other factors that have to be scored with a precise number for each patient. Once the scores are established, they become infallible absent mathematical error or revision due to change in health status, which is then captured by another set of calculations.

The second goal is to estimate with numerical precision the number of years a patient may live after surviving COVID-19. In other words, after determining a patient's chance of survival, the guidelines require that a second estimate be made that measures the number of years a patient may live once cured of COVID-19. That said, underlying health conditions or comorbidities are applied to these scores. Of course, many people, especially disabled and older adults, have some kind of pre-existing condition. It is not clear from the guidelines how pre-existing conditions that are under control through medication or lifestyle are evaluated. For example, a person may have severe asthma, but due to advances in pharmaceuticals not available even a few years ago, is able to enjoy a normal life without restrictions. Decisions are then made on the basis of these scores. Lower scores win; higher scores lose. In case of ties between or among patients, younger patients are given preference over older ones, with precise scoring systems allocated to various age groups.

The goal is to calculate a precise numerical score establishing a patient's chances of survival and length of life after surviving COVID-19.

Implementing the Goals of the Guidelines

Responsibility for implementing the guidelines and determining who receives treatment and who does not is given to a "Triage Team" or "Triage Officers," who are not the same personnel as the clinical staff. The guidelines are clear that clinical, treatment staff are to be separate from the triage staff and that clinical staff are not to be involved in decisions regarding initiation, continuation or withdrawal of treatment.

It is not clear from the guidelines who will be performing the initial assessment calculations. Clearly the treating doctors and nurses who are attending the patient would be in the best position to evaluate a patient's condition. Whether they have time to perform the very specific formulaic calculations required is not addressed. But the guidelines do not specify and in

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some cases say that Triage Officers perform assessments. That remains somewhat unclear.

Both the initial triage decision and the decision to withdraw resources can be appealed. The initial decision not to provide care is appealable to the triage team that made the decision in the first place and the basis of appeal is restricted to mathematical errors in the scoring system. The decision to withdraw care is done by the “Triage Review Group,” which is made up of new triage personnel, including legal counsel. What medical expertise legal counsel adds to these decisions is not clear. All decisions made by the triage teams or review boards are final.

It must be noted that it is extremely unlikely that any family or advocate for the patient would be involved on behalf of the patient in these appeals processes. It seems incomprehensible that a process that produces such finality would include no advocate or family member, let alone the actual treating physician.

The Controversial Role of Age and the Failure to Account for Social Determinants of Health

A patient loses points depending on how old the patient is. Things start getting really dicey in the 65 to 80 and over 80 age ranges. In fact, seniors or those with disabilities or underlying health issues—even if they are under control—appear to be in a no-win situation. Even if you have a good chance of surviving the virus, the Massachusetts DPH wants the triage team—as opposed to your doctor—to take into account how long you are likely to live. Is there anyone over 65 who doesn’t have some underlying health issue?

So, for example, your mother, father, or you, if you are over 65, would never be able to score high enough to survive folks in the 40 to 65-year-old range. And it is the triage team which, based on data most likely retrieved by the treatment team, who will be making life and death decisions. In fact, the DPH guidelines instruct hospitals to secure the necessary administrative apparatus and computers to keep track of all these patient scores, appeals, and outcomes. One thing is clear: the treatment team takes no part in these decisions. The life and death decisions are made by the triage team, which is unlikely to ever actually see the patient.

Although the guidelines issued by the state DPH are loaded with compassionate and flowery caveats—there is even a section on how to break the news that your 70-year-old mother will be coming off a ventilator—the bottom line appears to be that older folks, regardless of post COVID-19 prognosis, are expendable.

The DPH guidelines come with a number of compassionate and flowery caveats, but...

Another very serious flaw in the guidelines is their failure to acknowledge, let alone take into account, the fact that certain racial and ethnic populations are disproportionately represented in COVID populations. A letter to Governor Baker written by 250 healthcare professionals, referenced in the *Boston Globe* on April 12, contains the following statement by Dr. Lana Habash, a long-time family physician, “Patients who historically have experienced health disparities because of racial injustice or economic injustice or disability are going to be penalized through [that] the scoring system.” The health care providers suggest that, among other measures, the state needs to make sure that hospitals with less demand are sharing their resources with harder hit providers and, importantly, they want the input of those most affected to be included in the CSC.

In addition, the *Globe* reports that 18 organizations had already written to the Governor asking him to revisit the guidelines so as to prevent discriminatory rationing.

The Role of Treating Physicians and Family

These guidelines take away from doctors the kinds of decisions they make every day. Because this is an emergency, we are told to accept the notion that only objective triage team members, and not treating doctors, are capable of making life and death decisions based on a mathematical formula and further, that these decision makers do not need to see the patient.

If you have ever been on a cancer floor when doctors know that no further treatment will make any difference, you won’t see them take out their calculators. Based on their experience, and moral and ethical judgment, they know when, whether young or old, there is no point in continuing treatment. After consulting with family, IVs are discontinued, and the morphine drip is brought in. But, if your grandfather is on the road to recovery, they don’t calculate how many years he has left and then pull the plug. They continue to treat until he goes home.

We concede that in a worst-case scenario, U.S. doctors will have to make gut wrenching decisions too and there will not be time for the usual sit-down conversation with family or guardians. But if there is time for review boards and sit downs with legal counsel, is there no way to involve family or guardians? Is there no time for a quick cell phone call to a parent or children? There is plenty of verbiage in the guidelines on how to approach, explain, and comfort family *after* decisions are made. If there is time to perform those functions after the fact, why not include family or advocates as decisions are made. In shooting wars, family or advocates can be thousands of miles away and national security impedes disclosing treatment locations. Those factors are not present in the current crisis.

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We don't know if we will have enough lifesaving equipment. But don't we have enough trust that our front-line doctors know their moral and ethical obligations to do no harm and make decisions in the best interests of the patients they serve, knowing that the overall public health is also at stake? Do we not trust our doctors to know when further treatment is futile? But if the doctor sees recovery ahead, do we really want her consulting a life insurance actuarial table to see if dad should be pulled off his ventilator? What if dad is likely to survive and to do just fine for many years? Is medicine such an exact science that we know precisely how long someone will live based on current age after surviving COVID-19?

In fact, without hard indicators, medicine can't predict what conditions any of us, young or old, may develop. A 70-year-old may live another 20 to 25 years—at least, they do in one author's family!—while a strapping 45 year old in the same family can suddenly succumb to an aneurism or heart attack and die in an instant.

The Role of the State

These guidelines place the state in the godlike position of setting forth mechanisms for making life or death decisions about its citizens. Why would we want a bureaucracy, as opposed to medical staff on the ground, making such decisions? There are so many variables involved that no mathematical formula could ever forecast with accuracy the lifespan of any one of us. What's most disturbing is that the Commonwealth—*without vetting these guidelines among those affected*—has assumed the role of decider. It is disingenuous to say these are only guidelines. Their adoption by hospitals is the most likely outcome and those physicians who do not comply will likely be pressured to do so.

These are indeed trying times, but dealing with them requires that we not abandon core principles. All Americans have the inalienable right to life. Physicians have a duty to care for patients and also to make decisions also the greater benefit to public health. There are laws that protect people of color and ethnic minorities, the disabled and laws against age discrimination. Hospitals are being told how these protections and duties can be evaded under the guidelines issued, but “not mandated” by the Commonwealth. There was no vetting process in recent times for these “guidelines” and they bear all the markings of state bureaucracy. The guidelines need re-thinking and a thorough vetting with the citizens of Massachusetts.

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