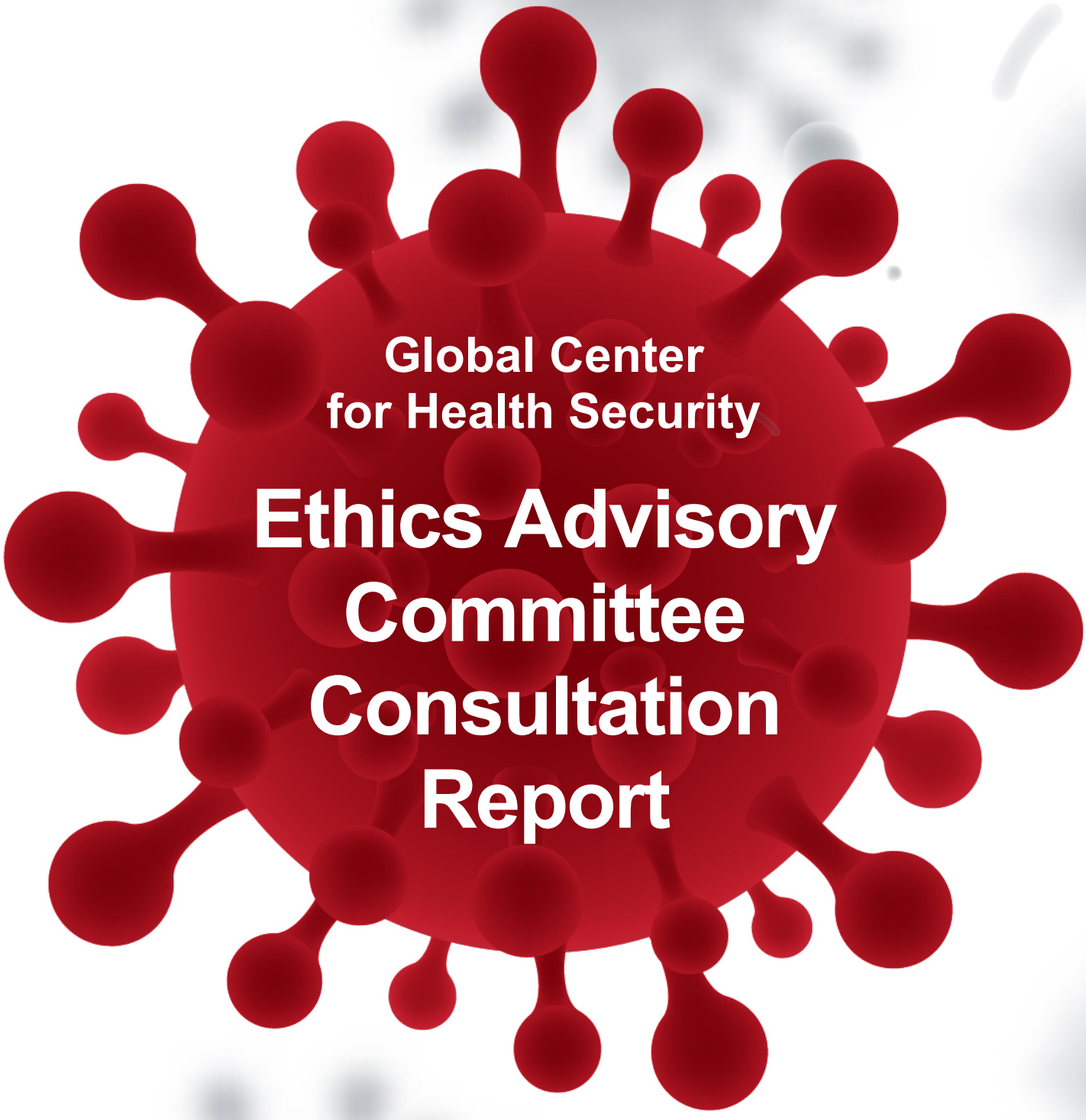
University of Nebraska Medical Center

Nebraska Medicine



Global Center for Health Security

Ethics Advisory Committee Consultation Report

05/06/2020

Cohorting COVID-19 and non-COVID-19 Patients in a Comfort-Only Care Unit

Abigail E. Lowe, Kelly K. Dineen, Nneka Sederstrum, and Matt K. Wynia with the Global Center for Health Security's Ethics Advisory Committee

Background

LL hospital is currently working to create a 30-bed unit for Comfort Care in a vacant clinic space. The unit would not be staffed as a hospice or palliative care unit and would be used only in the event that local hospice and palliative care resources are overwhelmed or otherwise unavailable. The Palliative Care team is creating admission criteria to this unit, which is intended only for patients for whom death is imminent (i.e., expected within 48-72 hours). The clinical administrator is now asking for advice on whether it is ethically acceptable to cohort COVID-19 positive and negative patients together in this unit, assuming all fit the criteria for admission.

One specific concern raised is that medical centers caring for COVID-19 patients generally do not allow in-person visitors because of the current shortage of PPE and infection control concerns; therefore, unit leadership is planning for a no visitor policy in this comfort care unit. Instead, they will provide reports to a designated patient contact and try to facilitate virtual visits at least once a day via telephone or other devices. However, in the extreme conditions under which this unit would be used, staffing would be very limited so facilitating virtual visits may be limited as well.

Response in brief: It may be necessary, and therefore ethically acceptable, to house COVID-positive and negative patients in the same unit, if this is the only way to provide appropriate compassionate care at the end of life. We recommend a number of adjustments however, to ensure the COVID-negative patients are provided opportunities for contact with family, clergy, or others that would otherwise have been possible.

Introduction

Pandemics such as that caused by COVID-19 can lead to a surge in demand for health care services, including palliative and end-of-life care. Some people who become seriously ill will have advance directives in place that stipulate comfort measures are to be emphasized if they become seriously ill. And in conditions of absolute resource scarcity, some patients may be triaged to receive comfort-focused care, including some who may have not improved with mechanical ventilation and are subsequently extubated to focus on comfort care. As a result, during disasters, the potential need for palliative and comfort care services might increase very substantially, potentially far outstripping capacity.[1]

Contingency and crisis levels of care under emergency conditions can gradually reduce quality of care as limits on staff, space, and supplies are reached and exceeded.[2] Unfortunately, even under normal conditions palliative care services are often more limited than critical care resources. In the event that crisis standards of care were

needed due to critical care resource shortages, palliative care services would likely be overwhelmed as well. This could undermine one of the key principles of the triage process—the idea that all patients will receive some level of compassionate care, even if everyone cannot receive usual care. Still, in conditions of overwhelming scarcity that limit practitioner and patient choices, it is especially important that health care professionals adhere to ethical norms. Planning for such circumstances should emphasize core ethical values, including fairness, proportionality and the professional duties to care for patients, and steward resources - and adherence to these substantive values can be supported through attention to several procedural norms, including transparency, consistency, accountability and inclusion.[3]

While the potential for mass mortality is often considered in planning for major disasters (CDC Preparedness and Response Capability 5: Fatality Management), the issue of mass palliation is often neglected.[4] But the goals of disaster preparedness and response apply to end-of-life services as well. These goals should include maximizing benefits and reducing harms during the crisis, and they should also include ensuring that dying people are treated equitably and with respect, which are necessary for long term social cohesion and so that the people whose loved ones die will be able to trust the health care system in the aftermath of the crisis.

In response to potential shortages in end-of-life care capacity during disasters, palliative care, hospice care and hospital teams must respond and work together to develop new ways of delivering end-of-life care.[5] One proposed way to rapidly expand capacity to provide comfort care to dying patients has been to create short-term, specialized inpatient comfort-only care units (COCU). These units may be inside hospitals, or in specially created locations adjacent to a hospital, or in separate locations if transportation is available. For hospitals considering options for comfort care units to accommodate an anticipated surge in the need for end-of-life care, and if staffing resources require cohorting positive and negative COVID-19 patients, the following analysis examines key points for consideration prior to operation.

Is it Ethically Acceptable to Cohort COVID-19 Positive and Negative Patients in a Comfort-Only Care Unit?

Since all patients in the COCU would be very near to death, the risk of transmission of illness from COVID-19 positive to COVID-19 negative patients is not clinically relevant (i.e., even if transmission were to occur, it would have no clinical implications since any patient acquiring the infection would die well before symptoms could arise). Instead of clinical concerns, the primary concerns in cohorting COVID-19 positive and negative patients in a CCU relate to potential harms arising from the restrictive visitation policies adopted for COVID-19 positive patients. These restrictive policies are being implemented to protect visitors and staff, reduce spread of the illness, and preserve limited PPE. By cohorting positive and negative patients together, the same restrictive visitation policies would need to be applied to all patients, thus increasing the harms associated with these policies and raising potential concerns about fairness for the COVID-19 negative patients.

Harms from restricting visitation arise from the fact that patients die in isolation and family members are denied opportunities to be with their loved one in their final moments. A ‘no visitation’ policy could also have the unintended consequence of deterring ill individuals from seeking medical attention, which could increase morbidity and mortality and factor into the spread of the disease.

Of note, many hospitals have implemented uniform visitor restriction policies, regardless of the patient's diagnosis, on the 'universal precautions' assumption that some patients have undiagnosed COVID-19 infection. Where this is true, the proposed visitation policy for the COCU would not represent a change from the policy already in place in the hospital. The fact that something is already happening elsewhere is usually a weak ethical justification for a policy that can cause meaningful harm, but in this instance, it might make the visitation policy more acceptable to families by emphasizing that the policy is being applied equitably to all patients and families across the hospital and the COCU.

In the particular case at issue, the proposed COCU space includes a 6-bed area equipped for positive airflow and an adjacent area equipped for negative air-flow. To be clear, the reason for cohorting patients is not the physical inability to separate patients. Rather, the presumption is that if the COCU were to be activated, this would happen in the context of a severe staff and supply shortage requiring staff to care for patients in both areas without the ability to don and doff PPE when moving between the two areas. Therefore, segregating positive and negative patients would be a logistical impossibility. As such, *under these conditions it would be ethically acceptable to cohort positive and negative patients*, under the principle that it cannot be ethically required to do something that is impossible ("ought implies can"). That said, it is also important to reassess the situation frequently to ensure that the least restrictive means possible are being used to address the shortage (*principle of proportionality*). For example, if/when additional staff and PPE supplies become available, then separating positive and negative patients would be desirable if this would allow for a less restrictive visitation policy for the presumed negative patients.

The assumption that cohorting is not optional but would be required due to staff and PPE shortages, and that this would force the adoption of restrictive visitation policies despite the harms they can cause, raises ancillary questions about other aspects of the quality of care it would be possible to provide in the COCU. These additional considerations emphasize the *need for those establishing the COCU to minimize foreseeable harms*.

As one example, while the risk of transmission of illness to non-COVID patients might not cause clinical harm, it could affect post-mortem arrangements. Those developing the COCU should seek to mitigate post-mortem harms where it is feasible to do so, recognizing that not all harms can be avoided in a crisis. As in the rest of the hospital, the traditions of different religions, cultures and families should be honored to the extent possible, and the facility should inquire about post-mortem arrangements in the COCU admission process and seek to address concerns in advance. Hospitals often have in place processes to facilitate end of life rituals, and these regular processes should be extended to the COCU to the extent possible.

How Should LL Hospital Engage COCU Patients' Families in the End-of-Life Process?

Dying patients and their families have emotional, psychological, social, and spiritual needs, which often are best addressed by an interprofessional palliative care team approach involving a physician, nurse, social worker, spiritual care worker, and others.[6] Visitor restrictions may heighten the emotional distress of family members who wish to be present during the dying process of their loved one. If visitor restrictions are in place for a substantial period of time and are the same before and after the move to the comfort care unit, this might facilitate understanding (if not acceptance) of the restrictions, as family members will have time to develop awareness of visitation policies and the rationales for these restrictions. Even so, managing the emotional distress of patients' families might take considerable time for COCU staff, and even more so if they are not familiar with communication about palliative

care and the end of life. Assuming it is not possible to provide full multidisciplinary palliative care services in the COCU, some partial version of these services might still be feasible, such as visitations for spiritual care from volunteer chaplains and just-in-time palliative care communication and clinical training for COCU staff; such strategies may entail asking COCU staff to operate outside their usual comfort zone, or even outside their usual scope of practice, but in crisis circumstances they should still be employed if they can mitigate harms, and especially if doing so is covered under the facility-based or state CSC, where these exist and are in effect. In short, *being unable to provide full palliative care services should not necessarily mean that no services are available and strategies to provide less than optimal palliative care may be required during the crisis.*

The COCU has a plan for phoning the patient's family at least once a day, and other options are also worth considering, such as using synchronous and asynchronous video and audio communication strategies.[7] Family members could leave their iPads or other devices with their loved one. LL Hospital could also consider repurposing office computers and monitors of staff now working from home into hospital rooms to stream virtual calls for extended video visits.[8]

Importantly, consideration must be given to accommodations with consideration of disability law (see Section 1557 of ACA, Title III of ADA, and the Rehab Act). As in the rest of the hospital, people with disabilities may need visitation alternatives, e.g. someone who is deaf may require a visual option, such as via iPad, whereas a blind person may need to be assured of audio communications.

In addition, should sufficient PPE become available, LL Hospital could allow family members to visit. In particular, it might be worthwhile for LL Hospital to explore creating a "family presence" policy (allowing extended visiting in which the family member assists with comfort care), which could alleviate some of the distress of families while also helping address the staff shortage.[9]

Finally, if there are exceptions to the visitor policy for end-of-life care in other areas within the hospital, then as a matter of equity these same exceptions should be allowed in the COCU.

How Ought LL Hospital Tend to Potential Inequity Issues in the Comfort-Only Care Unit?

When a health care system is strained, systemic inequities tend to escalate. Even under usual care conditions, people who have highly stigmatized conditions such as serious mental illness or substance use disorders face substantial challenges in accessing health care. Patients in need of palliative care and simultaneously living with other deficits in regard to social determinants of health also often have particular difficulty accessing palliative care.[10] Moreover, people facing poverty, discrimination, language barriers and historical trauma are least able to self-advocate, more likely to face significant exposure risks, and more likely to have co-morbidities; and for all these reasons they are more likely to experience more severe disease, which puts them at a disadvantage when difficult decisions about resource allocation must be made.

While it is unrealistic to expect structural inequities to be solved during a crisis, there are steps that can help prevent these inequities from being exacerbated. First, being deliberate and intentional in decision making, keeping an eye on the potential for inequity, can help avert worsening. Naming an individual as being responsible for tracking and addressing inequities, such as an equity and inclusion officer, can be a useful step. It is also helpful to

make clear and frequent statements about the value the organization and its leadership place on equity. And it is useful to track the effects of policies on specific populations that are at risk. Relevant populations to track will be different in different locales, but could include racial, ethnic, or language minorities; residents of rural areas; people without insurance; prisoners; and immigrants or asylum seekers.

With respect to equitable care for patients who do not speak English, the COCU should have posted the hospital's language line number (e.g., Language Assistance) or have available video interpretation equipment. If a hospital serves a large language minority population, efforts to ensure that staff of the COCU are bilingual will be of particular value.

What Should be Disclosed to the Public About the Comfort-Only Care Unit?

Transparent communication is foundational to maintaining trust during times of uncertainty and crisis. LL Hospital leadership should support open and honest communication with patient families about the need to open the COCU and if it is opened this decision should be made public as well. Disclosure about the operation of the COCU from a different source could seriously undermine institutional trust.

Health care personnel also need to be aware of the COCU when it opens. Among the critical lessons learned from the severe acute respiratory syndrome (SARS) outbreak in Toronto (Ontario, Canada) was the significance of developing redundant and reliable communication plans among healthcare providers. [11-12]

Taking a proactive stance on developing consistent communication and planning around the end-of-life is a useful strategy to overcome the stress of making difficult decisions in a moment of crisis. As such, before a patient is sick enough for intensive care, providers should review the treatment plan and determine patient preferences with the patient or their surrogate decision maker if the patient is incapacitated. They should specifically elicit the patient's values and preferences about comfort care versus invasive cardiopulmonary support and intensive care in the event of worsening and life threatening symptoms.[2] Providers should also explain that a desire for intensive care and life support might not guarantee its provision under crisis standards of care. During an epidemic, it is not uncommon for people to avoid health care facilities, so strategies may be needed to ensure that publicity about end-of-life care and restrictions on visitation do not stop individuals from coming to the hospital who might benefit from hospital level care. Appropriate use of hospital care can both reduce individual morbidity and mortality and reduce infection risk to the community.

LL Hospital might not want to encourage COVID-19 positive patients to return home for end-of-life care, to reduce the risk of community spread, but it might be helpful to clarify this in policy, including exceptions when it might be allowed. For example, if the patient's caretaker at home has recovered from COVID-19 and the patient can be safely transported home, home hospice care for a COVID-19 positive patient might be an acceptable option.

Other Alternatives to Using a Comfort-Only Care Unit

Before implementing a COCU, other alternatives that might allow for providing higher levels of end-of-life care should also be explored. For example, a 2006 report about hospice use in Taiwan during the SARS outbreak found that palliative care space was sometimes underused.[13] Crisis standards of care are not uniform—but often arise based on the surge

status of institutions, and as such, a hospital in one part of a city might be at crisis point in terms of staffing and supplies, but another facility, such as a long-term care facility, might not be.[14]

In addition, some locations are establishing acute/alternative care centers (ACCs) to serve as ancillary inpatient units during a disaster or pandemic.[14-16] These on-site or off-site units typically focus on treating patients who require basic medical care such as hydration, oxygen, or even intravenous antibiotic therapy and often function as a step-down unit from the hospital. It might be possible to have a portion of an ACC dedicated to palliative care of terminally ill patients.[15] With constrained resources, the need for appropriate and safe transportation from the hospital to the ACC, especially if it is located off-site, would need to be taken into consideration.[17-18]

References

1. Arya A, Buchman S, Gagnon B, Downar J. Pandemic palliative care: beyond ventilators and saving lives. *CMAJ Can Med Assoc J J Assoc Medicale Can*. 2020;192(15):E400-E404. doi:10.1503/cmaj.200465

2. Downar J, Seccareccia D, Associated Medical Services Inc. Educational Fellows in Care at the End of Life. Palliating a pandemic: "all patients must be cared for." *J Pain Symptom Manage*. 2010;39(2):291-295. doi:10.1016/j.jpainsymman.2009.11.241

3. Institute of Medicine (US) Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*. (Altevogt BM, Stroud C, Hanson SL, Hanfling D, Gostin LO, eds.). Washington (DC): National Academies Press (US); 2009. http://www.ncbi.nlm.nih.gov/books/NBK219958/. Accessed March 5, 2021.

4. MacIntyre CR, Heslop DJ. Public health, health systems and palliation planning for COVID-19 on an exponential timeline. *Med J Aust*. 2020;212(10):440-442.e1. doi:10.5694/mja2.50592

5. Etkind SN, Bone AE, Lovell N, et al. The role and response of palliative care and hospice services in epidemics and pandemics: A rapid review to inform practice during the COVID-19 pandemic. *J Pain Symptom Manage*. 2020;60(1):e31-e40. doi:10.1016/j.jpainsymman.2020.03.029

6. Strasser F, Palmer JL, Willey J, et al. Impact of physician sitting versus standing during inpatient oncology consultations: patients' preference and perception of compassion and duration. A randomized controlled trial. *J Pain Symptom Manage*. 2005;29(5):489-497. doi:10.1016/j.jpainsymman.2004.08.011

7. Hart JL, Turnbull AE, Oppenheim IM, Courtright KR. Family-centered care during the COVID-19 era. *J Pain Symptom Manage*. 2020;60(2):e93-e97. doi:10.1016/j.jpainsymman.2020.04.017

8. Papadimos TJ, Marcolini EG, Hadian M, et al. Ethics of outbreaks position statement. Part 2: Family-centered care. *Crit Care Med*. 2018;46(11):1856-1860. doi:10.1097/CCM.0000000000003363

9. Voo T, Lederman Z, Kaur S. Patient isolation during infectious disease outbreaks: Arguments for physical family presence. *Public Health Ethics*. 2020;13(2). doi:10.1093/phe/phaa024

10. Reimer-Kirkham S, Stajduhar K, Pauly B, et al. Death Is a social justice issue: Perspectives on equity-informed palliative care. *ANS Adv Nurs Sci*. 2016;39(4):293-307. doi:10.1097/ANS.0000000000000146

11. Naylor CD, Chantler C, Griffiths S. Learning from SARS in Hong Kong and Toronto. *JAMA*. 2004;291(20):2483-2487. doi:10.1001/jama.291.20.2483

12. Weinstein RA. Planning for epidemics--the lessons of SARS. *N Engl J Med*. 2004;350(23):2332-2334. doi:10.1056/NEJMp048082

13. Chen T-J, Lin M-H, Chou L-F, Hwang S-J. Hospice utilization during the SARS outbreak in Taiwan. *BMC Health Serv Res*. 2006;6:94. doi:10.1186/1472-6963-6-94

14. Wilkinson A. The potential role for palliative care in mass casualty events. *J Palliat Care Med*. 2013;02(02). doi:10.4172/2165-7386.1000e112

15. Kim CS, Pile JC, Lozon MM, Wilkerson WM, Wright CM, Cinti S. Role of hospitalists in an offsite alternate care center (ACC) for pandemic flu. *J Hosp Med*. 2009;4(9):546-549. doi:10.1002/jhm.509

16. Lam C, Waldhorn R, Toner E, Inglesby TV, O'Toole T. The prospect of using alternative medical care facilities in an influenza pandemic. *Biosecurity Bioterrorism Biodefense Strategy Pract Sci*. 2006;4(4):384-390. doi:10.1089/bsp.2006.4.384

17. Kripalani S, Jackson AT, Schnipper JL, Coleman EA. Promoting effective transitions of care at hospital discharge: A review of key issues for hospitalists. *J Hosp Med*. 2007;2(5):314-323. doi:https://doi.org/10.1002/jhm.228

18. Coleman EA, Williams MV. Executing high-quality care transitions: a call to do it right. *J Hosp Med*. 2007;2(5):287-290. doi:10.1002/jhm.276