Battlefield Triage During a Public Health Emergency or Infectious Disease Outbreak

Amundsen Davis Health Care Alert
April 6, 2020

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Public Health Emergencies (PHE), particularly those involving disease outbreaks, present significant ethical challenges relating to the provision of medical care. Currently, as Illinois and the nation confront an escalating crisis that is COVID-19, health care providers (HCP) are being challenged in unprecedented ways to make critical lifesaving decisions with limited resources.

As the stress on resources builds, HCPs debate about prioritizing the survival of the many over the one. Illinois' Do-Not-Resuscitate (DNR)/Practitioner Orders for Life-Sustaining Treatment (POST) orders have come front and center to the debate of whether DNR orders for COVID-19 infected patients can be implemented regardless of the wishes of the patient or their family members. Currently, Illinois' DNR statute requires consent from the patient, or the patient's legal guardian or surrogate decision maker.

What are the duties of health care providers in emergencies?

The American Medical Association Code of Medical Ethics offers opinions and recommendations for HCPs and institutions responding to the COVID-19 pandemic. **Opinion 8.3**, "Physicians' Responsibilities in Disaster Response and Preparedness," sets out physicians' ethical obligations in situations of epidemic. Physicians have an obligation to "provide urgent medical care during disasters," an obligation that holds "even in the face of greater than usual risk to physicians' own safety, health or life." However, Opinion 8.3 recognizes that the physician workforce itself is not an unlimited resource. It provides that when providing care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future.

Who receives medical treatment or equipment and in which order?

Opinion 11.1.3 sets out criteria for allocating limited resources among patients in various contexts, including triage situations -- for example, ventilators during a pandemic:

- Urgency of (medical) need;

- Likelihood and anticipated duration of benefit; and
- Change in quality of life.

Opinion 11.1.3 further calls on health care professionals and institutions to:

- Give first priority to patients for whom treatment will avoid premature death or extremely poor outcomes;
- Use an objective, flexible, transparent mechanism to determine which patients will receive recourse when there are not substantial differences among patients;
- Requires that allocation policies be explained both to patients who are denied access to limited resources and to the public.

When faced with a PHE and the process of triage is utilized, can you consider denying or delaying medical care for the old, the disabled, persons with HIV/AIDS, etc.?

While the realities of the COVID-19 crisis require HCPs to adjust policies and protocols, on March 28, 2020, the U.S. Department of Health and Human Services Office for Civil Rights (OCR) published a **bulletin** relating to COVID-19. OCR warns that "persons with disabilities should not be denied medical care on the basis of stereotypes, assessments of quality of life, or judgments about a person's relative 'worth' based on the presence or absence of disabilities." OCR advises that "decisions by covered entities concerning whether an individual is a candidate for treatment should be based on an individualized assessment of the patient based on the best available objective medical evidence."

Section 302 of the Americans with Disabilities Act provides that:

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

It also qualifies the mandate not to discriminate by providing:

Nothing in this subchapter shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.

The HHS Secretary issued a Declaration under the Public Readiness and Emergency Preparedness (PREP) Act, which provides liability immunity to certain individuals and entities against claims of loss caused by, arising out of, relating to, or resulting from the manufacture, distribution, administration, or use of

medical countermeasures, except for claims involving willful misconduct. This Declaration and application to Illinois is discussed further in a previous alert, titled **Liability Immunity for Health Care Workers during the COVID-19 Crisis**. This Declaration applies to civil liability for traditional concepts of medical negligence. It should be noted that it does not include immunity from criminal or administrative/regulatory liability.

Although the Secretary's Declaration may make it difficult to assert claims under the Rehabilitation Act or the ADA, it does not necessarily immunize requirements to comply with federal regulations. A plaintiff would need to prove that the alleged wrong was due specifically to their disability instead of general exigent circumstances and that the defendant could have made accommodations without undue hardship despite the crisis.

In emergencies, especially public health emergencies, scarcity of resources, quick decision-making, and increased risks of exposure to health care providers are realities. Policies and protocols have to be reconsidered in a PHE, which may require changes in practice and rationing. Rationing of limited medical treatments and equipment can be achieved ethically and legal challenges can be mitigated with appropriate planning and documented sound medical decision-making.

When the COVID-19 crisis subsides, the plaintiff's bar will be scavenging to find ways to pierce the federal and state immunity laws enacted by PREP and the Illinois Emergency Management Act to file claims for willful misconduct. As an example of a claim arising out of a public health emergency, after Hurricane Katrina in 2005, a large health care system paid $25 million to settle a class action suit by families of patients who died in a New Orleans hospital. In that case, plaintiffs claimed the hospital failed to adequately prepare for the storm. Attempts by the plaintiff's bar to test these non-traditional bases of liability can likely be expected

In each case, whether immunity is applicable will depend on the particular facts and circumstances. To avoid inviting claims during the COVID-19 crisis, hospital systems and health care providers should consider the following:

- Re-evaluate current triage policies. Modify policies to describe clear and unambiguous goals for resource allocation decisions, such as which types of patients receive particular resources during a crisis.
- Ensure medical services and equipment are allocated in a non-discriminatory way. Don't discriminate or single out patients based on age, gender, race, or other protected classes.
- Document all medical decision-making, including what measures were taken for patients that were denied other lifesaving care.
- Document all objective data used to arrive at clinical decisions, not just age or the presence/absence of disabilities.

- Excuse bedside clinicians from making triage decisions. Establish triage officers not involved in the treatment of individual patients to be responsible for decisions to limit treatment, using triage protocols.
- Educate the public that during a PHE, treatment options unlikely to benefit patients may be made unavailable to patients if the public health impact is substantial. Explain that response time to critical problems, such as cardiopulmonary arrest, may be limited by lengthy PPE donning procedures.