Editorial Comments—Pandemic Influenza Triage in the Clinical Setting

Jennifer E. Miller, MS (Bioethics)

Executive Director, Bioethics International, New York, New York USA

Correspondence:
E-mail: jmiller@bioethicsinternational.org

Web publication: 29 March 2010

There have been great efforts on the federal and local levels to prepare for the specter of a severe influenza pandemic, however knowledge gaps and operational challenges remain. It is critical to assess if current top-down efforts actually are improving and/or likely to improve the ability of on-the-ground clinicians to respond effectively, efficiently, and ethically to the formidable healthcare challenges of a severe influenza pandemic. Because severe pandemics involve acute *shortages of resources*, such as ventilators, beds, and clinical staff, a formidable challenge will include planning for and responding to the ethical questions of *who will receive resources and care, when and under what conditions?*[1] Hospital clinicians, and in particular, emergency physicians, will be at the forefront of these decisions which will require more than mere technical consideration of survival probabilities and resource capabilities.[2–7] Rottman and co-authors of the study, "Pandemic Influenza Triage in the Clinical Setting" are to be commended for recognizing the need not only to study the efficacy of current planning efforts on the hospital level, but to particularly focus on the preparedness and willingness of hospital clinicians to make the necessary ethical decisions.

The study results are striking. By surveying 46 healthcare professionals, Rottman and co-authors highlight that hospital clinicians are unaware of the general and ethical challenges that occur during a pandemic. Moreover, the study shows that when hospital clinicians are made aware of the potential challenges, including triage and resource allocation decision scenarios, they are "quickly overwhelmed" and unable to reason through the scenarios and/or draw upon cohesive and consistent response action plans. This study is immensely helpful in that it demonstrates the acute preparedness and knowledge gaps regarding ethical decision-making, although the results would be statistically stronger with a larger respondent pool. This information is highly relevant because a failure by the clinical community to make ethical decisions in a pandemic not only exposes the clinician and his or her hospital to legal liability, but also is likely to lead to a failure to save the most amount of lives possible. For example, without preparedness in ethical decision-making, a clinician may decide to allocate resources and provide care on a first-come, first-served basis or lottery system. Although these two systems might seem superficially fair, this type of decision-making is not likely to maximize the total number of lives saved. Additionally, because select survey responses extend beyond pandemics to include bioterrorism and disasters generally, the study results may be applicable for consideration in multiple hazard disaster planning.

A significant strength of this study is that it highlights the necessity for developing a national, standardized, ethical framework that may be consistently applied, taught and communicated. The authors highlight this knowledge gap by concluding that although particular ethical challenges "have been identified, the necessary clinical and ethical guidance for the emergency department triage of large numbers of variably ill patients remains elusive." It is correct that a select number of preparedness initiatives have made efforts to discuss and identify ethical issues and values, however, these same initiatives also have, to varying degrees, generated ethical frameworks. The issue is not so much that no ethical frameworks exist, but rather no single, nationally adopted ethical frame-

work has emerged. In fact, the New York State Pandemic Workgroup, the Task Force for Mass Critical Care, the Institute for Medicine, and the University of Toronto all have promulgated ethical frameworks. However, the ethical frameworks, though partially convergent, differ in their overall recommended ethical principles as well as their target audiences. For example, the Task Force for Mass Critical Care recommends a comparatively streamlined set of three ethical commitments.[8] The New York State Workgroup includes a more expansive five-element ethical framework.[6] The Institute of Medicine's ethical framework provides a total of seven ethical norms[9] and the University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group identifies 15 necessary ethical values.[10] These four prominent planning guides yield a list of 18 different precedent ethical values.[11] The multiplicity of ethical frameworks and values presents a potential challenge to developing and promulgating a standardized national framework that may be applied to multi-level decision-making. Nonetheless, survey results, which includes comments such as "I don't really feel we would do anything different for any kind of disaster…" and "whether our patients are urgent or non-urgent, they all get the same type of care", clearly demonstrate a need for efforts in this area.

A further helpful aspect of the Rottman study is that it posits the need for ethics training that fosters greater clinician comprehension, willingness, and ability to meet the demands entailed during a severe pandemic. For example, one study responder states, "I don't think we have that kind of experience... I don't think we have the training to understand what decisions might need to be made." This evidence contribution is critical because merely developing a standardized, national ethical framework is insufficient to guarantee the clinician community's ability and willingness to adhere to the framework. Ethics education is needed to help operationalize the ethical framework. Additionally, although not referenced in the study, hospital ethics training programs are of further value in that they offer means for refining a nationally implemented ethical framework by providing opportunities for clinician feedback. Experts and limited literature support this need for ethics training, however, greater evidence was needed, which this study contributes.[11,12]

A further forte of this study is that it highlights potential emotional and psychological challenges for clinicians as necessary pandemic planning concerns. The authors discover this necessary planning step through an emergency department nurse survey response stating that his or her "biggest concern is the emotional wear and tear on the staff…." This finding relates to the finding of the necessity for greater ethics education because it not only creates awareness of the types of ethical questions that will arise, but by explaining the 'why' behind the 'what' to do, it can assist in providing the necessary conviction for clinicians to adopt what could be psychologically overwhelming protocols, as well as avoid potential crisis of conscience. This study result is supported by general disaster medicine literature; for example, the 2005 Hurricane Katrina disaster forced clinicians to make emotionally and psychologically challenging decisions for which they were unprepared.[13]

Rottman and co-authors are to be praised for identifying the need, and for providing preliminary supportive evidence for, the development of a standardized national ethical framework and policies. The authors conclude their paper by stating that, "such actions, (the creation of clinically applicable guidelines) perhaps in concert with public health, medical society, and legislative authorities will help clinicians, define, adopt, and communicate to the public those practice standards that will be followed in a mass population infectious diseases emergency." Interestingly, although study survey responses indicate a need for ethics training, the need is not emphasized in the study conclusions as a means for fostering adoption and communication of national policies and frameworks. Nonetheless, the study is immensely valuable in that it evidences a need for the development, adoption, and communication of a national ethical framework and policies that may be applied at the hospital level. The creation and operationalization of such a framework will greatly assist in minimizing disparities in quality of care and applied ethics, unethical personal or system biases, loss of public trust, legal liability hazards for clinicians and hospitals, and most importantly, failures to maximize the number of lives saved.

References

1. Foltin GM, George L (eds): American Academy of Pediatrics: *Pediatric Terrorism and Disaster Preparedness: A Resource for Pediatricians*. 2006;06(07)-0056.
2. Christian MD, Hawryluck L, Wax RS, *et al*: Developing of a triage protocol for critical care during an influenza pandemic. *CMAJ* 2006;175(11):1377–1381.
3. Hick JL, O'Laughlin DT: Concept of operations for triage of mechanical ventilation in an epidemic. *Acad Emerg Med* 2006;13(2):223–229.
4. Rubinson L, Hick JL, Curtis JR, *et al*: (2008). Definite care for the critically ill during a disaster: A Framework for optimizing crtical care surge capcity: from a Task Force for Mass Critical Care summit meeting, January 26-27, 2007, Chicago, IL. *Chest* 133(5 Suppl):18–31.
5. Bielajs I, Burkle FM Jr, Archer FL, Smith E: Development of prehospital, population-based triage-management protocols for pandemics. *Prehosp Disaster Med* 2008;23(5):420–430.
6. New York State Workgroup on Ventilator Allocation in an Influenza Pandemic: *Allocation of Ventilators in an Influenza Pandemic: Planning Document*. Albany: New York State Department of Health, 2007.
7. United States Department of Health and Human Services and the Centers for Disease Control and Prevention: Health Insurer Pandemic Influenza Planning Checklist, 2008
8. Devereaux AV, Dichter JR, Christian MD, *et al*: Definitive care for the critically ill during a disaster: a framework for allocation of scarce resources in mass critical care: from a Task Force for Mass Critical Care summit meeting, January 26-27, 2007, Chicago, IL. *Chest* 2008;133(5 Suppl):51S–66S.
9. Atevogt B: S. C. Guidance for Establishing Crisis Standards of Care for use in Disaster Situations: A letter Report. Institute of Medicine (IOM), Washington, DC. Sept 2009.
10. Upshur RE, Faith K, Gibson JL, *et al*: Stand on Guard for Thee: Ethical Considerations in the Preparedness Planning for Pandemic Influenza. University of Toronto Joint Center for Bioethics–Pandemic Influenza Working Group, 2005.
11. Miller J, Burkle FM: Development of a Standardized Operational Framework to Guide Ethical Decisions During Pediatric Mass Critical Care. Pediatric Mass Critical Care Workgroup, *Pediatr Crit Care Med*, submitted to workgroup for review January 2010.
12. Thomas J, MacDonald P, Wenink E: Ethical decision making in a crisis: A case study of ethics in public health emergencies. *J Public Health Manag Pract* 2009;15(2):E16–E21.
13. Curiel TJ: Murder or mercy? Hurricane Katrina and the need for disaster training. *N Engl J Med* 2006;355:2067–2069.