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Alerts

# Picking and Choosing COVID-19 Patients: Health Care Providers Face Ethical and Legal Dilemmas When Following State Triage Guidelines

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*Health Care Alert*


## Attorneys

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Hospitals, physicians, and other health care providers are facing unprecedented ethical and legal challenges related to the shortage of critical-care resources for patients during the coronavirus pandemic (COVID-19). Some triage protocols adopted by hospitals and states have been criticized for devaluing people with disabilities and excluding them from "equal" treatment opportunities. Other protocols have hospitals and health care providers turning from a patient-centered approach to a "public health as a whole" approach. These protocols raise the question of whether they provide the necessary ethical and legal framework for health care providers to make these decisions.

## Triage Guidelines

A handful of states—including New York, Maryland, Alabama, Washington, Pennsylvania, Arizona, Kansas, Louisiana, Michigan, Tennessee, and Utah—have issued triage guidelines in response to the COVID-19 crisis. Alabama, for instance, issued an emergency protocol which stated that health care providers are not to offer mechanical ventilator support for patients "with intellectual disability, complex neurological problems, dementia, severe or profound mental retardation, individuals with motor neuron disease, glioblastoma multiforme, and children with severe neurological problems." Meanwhile, New York's clinical ventilator allocation protocol directed physicians to assess patient's needs based on their "underlying disease or medical conditions that may hinder recovery." The Kansas Department of Health and Environment (KDHE) created a guideline of pediatric ventilator allocation that includes an exclusion criteria list denying admission or transfer to critical care if the patient has "metastatic malignant disease with poor prognosis, or severe and irreversible neurological event or condition." Another exclusion criteria list was issued in Louisiana, which excludes patients with "known severe dementia" from being admitted to a hospital. Washington State's triage guidelines state that health care providers should consider "baseline functional status" of patients which includes their cognition and physical ability.

In response to these guidelines, disability rights advocates have filed a significant number of complaints with the U.S. Department of Health and Human Services (HHS) for perceived discrimination against disabled patients. In response, the HHS Office for Civil Rights (OCR) issued a bulletin reminding

hospitals and health care providers of their obligations under the law to treat all patients notwithstanding the COVID-19 pandemic, and not to deny medical care to persons with disabilities based on their "relative worth."

Going a step further, the OCR announced the resolution of a compliance review of the State of Alabama after the state removed ventilator rationing guidelines that "allegedly discriminated on the basis of disability and age." As to other state triage guidelines, OCR has yet to take enforcement action.

## Ethical Considerations

The core ethical principles for health care providers include: fairness, the duty to care, duty to steward resources, transparency in decision-making, proportionality and accountability. These principals are heavily tested during a crisis, such as a pandemic, when doctors are expected to follow state guidelines or pick and choose patients to receive treatment.

David Magnus, Director of the Stanford Center for Biomedical Ethics, outlined three theories about how ethical triage decisions should be made so doctors don't feel burdened by moral guilt: egalitarianism, utilitarianism, and prioritarianism. As Magnus explains, each theory has its own moral logic. Egalitarianism is focused on treating the patients equally, using a lottery approach and selecting patients randomly. Utilitarianism, on the other hand, aims to "maximize total benefit," essentially favoring those who have more "high-quality years" left to live. Finally, prioritarianism emphasizes the treatment of the sickest patients. While something may seem theoretically easy to implement, the reality is that implementing guidelines for allocating limited resources can be extremely difficult and distressing. Unfortunately, this is the reality that many hospitals, doctors, and other health care providers face.

Authors of a recent article published in the *New England Journal of Medicine* (NEJM) take issue with Magnus' utilitarianism theory, referring to it as a form of "morally and legally unacceptable discrimination" against disabled individuals that health care providers are not immune from. The article further notes that withdrawal of care morally distresses health care providers, and argues care should be withdrawn only "when the gap in prospects for patients is large," and that the measure of prognosis should not be based on subjective perspectives, quality-of-life, or greatest years of life saved, but on "empirical evidence."

Similarly, a separate *NEJM* article, emphasized that quality-of-life considerations are addressed by HHS, which finds it ethically and legally problematic to deny medical care on the basis of stereotypes, and limits use of quality-of-life assessments in Medicaid benefit design. The article goes on to address the phenomenon of "near-term prognosis," where patients who are expected to die within a year from an end-stage condition—even if they survive the acute illness—are assigned a lower priority. Interestingly, near-term prognosis is accepted in medical ethics and clinical practice.

## Legal Considerations

The implementation of triage guidelines and protocols which exclude disabled individuals from care and treatment based on their disability may result in a violation of the Rehabilitation Act of 1973 (Rehab Act); hospitals and physicians should be aware of the corresponding legal consequences. The Rehab Act prohibits exclusion of individuals with disabilities from the participation, benefits under any program or activity receiving Federal financial assistance. Importantly, the Rehab Act applies to hospitals and health care providers receiving federal funds indirectly through the state, via programs like Medicaid. Hospitals and physicians who receive federal assistance through Medicare and Medicaid payments are subject to §504 of the Rehab Act.

Implementing such guidelines in public or private hospitals may also result in a violation of the Americans with Disabilities Act (ADA), which exists to address discrimination "against individuals with disabilities in such critical areas as health care." The ADA is not limited to programs receiving federal funding. Rather, it applies to all public entities, including state and local governments, as well as the private sector.

Even during unpredictable circumstances such as the COVID-19 pandemic, federal regulations help ensure that the distribution of supplies and assistance activities are conducted in an equitable and impartial manner, without discrimination based on disability. Guidelines which consider a patient's disability as criteria for excluding care are neither

an equitable nor impartial way of allocating resources or assistance.

Proposals that health care providers should consider subjective factors in picking and choosing patients during a pandemic potentially exposes health care providers and hospitals—through vicarious liability or apparent agency—to a variety of legal risks, including claims of negligence, gross negligence, assault or battery, as well as other criminal offenses including homicide, resulting from intentionally withdrawing or withholding a ventilator from a patient requiring such support.

Typically, to prove medical negligence, you need to show that: (1) the health care provider failed to exercise the degree of care, skill, and learning expected of a reasonable, prudent health care provider in the profession or class to which he belongs within the state acting in the same or similar circumstances; and (2) such failure was a proximate cause of the injury. The "prudent doctor standard" requires that the physician exercise reasonable care "as measured against the conduct of his or her peers." Health care providers should keep this in mind while deciding whether to withdraw or withhold care from a patient during the pandemic. Moreover, withdrawing care without consent, even in emergency situations, can form the basis of civil negligence involving health care providers.

"Gross negligence is more than just an egregious form of negligence and can more appropriately be defined as willful misconduct or intentional wrongdoing." Disconnecting a disabled patient from a ventilator for the purposes of allocating that resource to other patients to save "more life-years" could potentially qualify as intentional wrongdoing.

Medical battery consists of the intentional act of a health care provider that results in offensive contact with the patient, without consent to the health care provider's conduct. More importantly, treatment against the patient's will constitutes battery even when an emergency exists. A health care provider who intentionally withdraws a ventilator without a patient's consent can be charged with criminal homicide. Because the crime of homicide must be proved "beyond a reasonable doubt," convicting a health care provider of homicide would be very challenging, but health care providers are not shielded from prosecution. However, some argue defending health care providers from battery or even murder may be more difficult than defending against civil liabilities. Importantly, very few states, if any, provide criminal liability protections to health care providers during a disaster, due to worries of "sheltering intentional misconduct."

Allocation of scarce resources among patients during a pandemic should be based on evidence-based predictions and near-term prognosis, and not on subjective criteria or disabilities. These approaches seem to be supported by the case law.

## Recommendations

Applicable law mandates that hospitals, physicians, and other health care providers treat patients equally, irrespective of their disabilities. Health care resources can be allocated in a manner that does not disproportionately disadvantage persons with disabilities and complies with our justice system.

Below, we identify four recommendations which conform to ethical and legal considerations:

1. Design objective guidelines that do not discriminate against disabled people and allocate resources among patients solely based on the potential for survival. Mortality prediction tools such as APACHE II, SAPS II, SOFA and PELOD may be ethical and legal, if modified to eliminate impermissible discriminatory considerations.
2. Because limited availability of personal protective equipment (PPE) and ventilators has a significant effect on patients other than those who are at the hospital due to COVID-19 fairness and justice requires that no special priority be given for COVID-19 patients versus patients with other medical conditions and survival rates.
3. Hospitals should establish Clinical Triage Teams which are responsible for the practical evaluation of triage decisions to eliminate unduly biased decision making against particular groups or patient populations.
4. Use hospital near-term prognosis—e.g., death expected within a few years despite treatment—but not long-term life expectancy.

## Conclusion

As health care providers focus on ensuring the health of society as a whole, they should adopt triage guidelines that address a variety of pertinent issues, including which patients get access to resources like ventilators and the objective criteria used to make such decisions. However, those guidelines need to be both ethical and legal, in order to retain the trust of the communities health care providers serve and avoid harsh legal consequences. Specific demographics or patient characteristics, such as individuals with disabilities, should not be isolated or treated in a discriminatory manner because of their pre-existing medical conditions. To avoid potential civil and criminal liability, health care providers should seek legal guidance to ensure their adopted guidelines use objective criteria to allocate resources, rather than discriminating against a specific class of people.

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*See* 29 U.S.C. § 794.
James Lockhart, Annotation, *Who is recipient of, and what constitutes program or activity receiving, federal financial assistance for purposes of § 504 of Rehabilitation Act (19 U.S.C.A. § 794), which prohibits any program or activity receiving financial assistance from discriminating on basis of disability*, 160 A.L.R. Fed. 297 (Originally published 2000)
*See* U.S.C. § 12101 (a)(3)
42 U.S.C. § 5151(a)
*See* e.g. Ariz. Rev. Stat. Ann. § 12-563
Valerie Gutmann Koch, J.D. & Beth E. Roxland, J.D., M. Bioethics, *Unique Proposals for Limiting Legal Liability and Encouraging Adherence to Ventilator Allocation Guidelines in an Influenza Pandemic*, 14 DePaul J. Health Care L. 467, 474 (2013)
Wash. Rev. Code Ann. § 7.70.050 (July 22, 2011)
26 Ill. Law and Prac. *Medicine and Health Care Professionals* §5 (January 2020 Update)
Valerie Gutmann Koch, J.D. & Beth E. Roxland, J.D., M. Bioethics, *Unique Proposals for Limiting Legal Liability and Encouraging Adherence to Ventilator Allocation Guidelines in an Influenza Pandemic*, 14 DePaul J. Health Care L. 467, 499 (2013).
*Sumes v. Andres*, 938 F. Supp. 9, 12 (D.D.C. 1996). Also *see*: Persad G. Why disability law permits evidence-based triage. Yale Law J Forum (April 8, 2020)
*See* American College of Surgeons, ACS: COVID-19 and Surgery, Ethical Considerations, (March 30, 2020)
Michelle M. Mello, J.D., Ph.D., *Govind Persad, J.D., Ph.D., and Douglas B. White, M.D., Respecting Disability Rights – Toward Improved Crisis Standards of Care*, N. Engl. J. Med. 4, (May 19, 2020)