Call Participants:

Applewhite, Megan
Aulisio, Mark
Aultman, Julie
Baker, Jeffrey
Bolton, Jonathan
Bulger, Jeffrey
Carney, John
Case, Gretchen
Clay, Maria Castillo
Davis, F. Daniel
Demme, Richard
Derse, Arthur
Doukas, David J
Dudzinski, Denise
Eberl, Jason
Faber-Langendoen, Kathy
Gallagher, Colleen M
Garrett-Bell, Jamila (notetaker)
Gibb, Tyler
Grady, Christine
Green, Michael
Henriksen, Joan
Hester, D. Micah
Illes, Judy
Jagsi, Reshma
Jones, Nora
Juknialis, Barbara (notetaker)
Kahn, Jeffrey
Kao, Audiey
Kinlaw, Kathy
Kogan, Claudio
Krohmal, Benjamin
Kuczewski, Mark
Lee, Sandra S.
Lipman, Hannah
Marks, Jonathan
McGuire, Amy Lynn
McLeod-Sordjan, Renee
Meador, Keith
Mercurio, Mark
Michelson, Kelly
Mitchell, Christine
Parker, Lisa Suzanne
Racine, Eric
Rhodes, Rosamond
Rosenthal, M. Sara
Sharp, Richard
Solomon, Mildred
Streiffer, Robert
Tabor, Holly
Tolle, Susan
Waitzkin, Michael (Buz)
Wilfond, Benjamin
Wolf, Susan
Wolpe, Paul Root

1. Welcome
   55 participants. Attendance recorded for those who identified themselves on Zoom; Those who signed in with telephone numbers or other abbreviations should email Barb Juknialis (bwj@case.edu)

2. The meeting is being recorded to facilitate note taking. Once the minutes are finalized, the recording will be erased.
   All callers will be muted. Amy McGuire will be calling on people who “raise their hands.” Use chat to indicate you have a substantive comment. Send chat information to Amy McGuire.

Please enter information about upcoming conferences and events into the chat. The chat file will be sent to everyone.

3. President's Report
ABPD has become extremely important as a source of information by acting as a clearinghouse for policies, new information, etc.
The original agenda included several topics that will not be covered today:
Career development towards leadership—finding potential leaders, mentoring, knowing when someone is ready, locating a position.
Process of creating repositories for information—e.g., regulatory.
Best practices for social media
Best practices for managing leadership responsibilities without being overwhelmed.
Christine Mitchell – Plannded to present Harvard program.
We will send out the planned formal agenda and ask for suggestions for the fall meeting.

   a. Fall meeting: workshop, session ideas The 2017 grants writing workshop was the most well-attended of the three we have presented. We are planning to do another grants workshop this fall. The economic aftermath of COVID-19 will make fundraising and securing grants an even greater challenge. Please let Paul know if there is any feedback or comments on this plan.

      Paul reminded everyone about the resources on our website. The education section needs to be updated. Please check out the website and help contribute. The list of graduate programs should be checked by each member to be sure the information is still accurate.

   b. Affinity Group Reports: (and leaders)
      Administrator Group: Joseph Sayegh. A list serve was created and will be used to conduct surveys. The survey on remote work has been delayed. If your administrator is not on the list, please let us know.
      Graduate Program Directors: Gerard Vong. A mission statement and an updated contact list of directors have been created. The mission statement has been circulated. Once it has been finalized, the group will explore collaboration with ASBH, ABPD, etc. There is a planned in-person meeting at ASBH in 2020. Please be sure your director is a member of the group.
      Clinical Ethics Program Directors: Colleen Gallagher. An e-mail soliciting names was sent out. Issues to be discussed: working with faculty; input into policies. Volunteers are needed for the survey committee. The next survey will focus on salaries. Please contact Colleen if you want to help.
      Clinical Ethics Fellowship Directors: Janet Malek This group was a new suggestion from Baylor.

4. Treasurer's Report (Micah Hester)
We have ~$86,000. We need to keep about $40,000 in reserve, but the balance can be used for relevant expenses. Expenses come from meetings, workshops, administration, accounting, etc. We currently have 83 members. The Board will create a small budget for the affinity groups, to be used for administration, refreshments for in-person meetings, and other relevant expenses.

Suggestion: Expand the Fall meeting to accommodate all the recent events.

5. Update on ABPD's National Role in the COVID-19 Crisis

Please continue to use the ABPD listserve to submit questions, suggestions, materials, etc. Many resources have been sent out. If you have a major resource, please let us know. Paul set up a COVID ethics page on Facebook; 400 subscribers in under 2 days

Project on COVID Policy Analysis
We have collected policies, and Jason Eberl will report on where the analysis is and the future of this project.

Jason Eberl:
The sample size for this survey is 77 (some members were excluded because they don't have clinical activities.) We collected 70 responses and selected 25 policies for analysis. The policies are being examined for commonalities, divergences, etc. Armand Antommaria and Matt Wynia developed the codebook used to evaluate policies. There are14 people coding. The goal is to code the data, write the paper, and submit it to a wide-impact medical journal ASAP.

One issue is the lack of policies from free-standing children's hospitals. It's possible that there are no policies yet or that they can't be shared.

The major goal of this project is to provide a service. This is a snapshot, not a full-blown study. Although we have started analysis, we can add more policies. If you have something to share, please send it to us. We have collected over 50 policies but are only analyzing the 25 that are most relevant to ABPD. Please continue to send policies, which serve as a resource for ABPD members.

Jason will share the codebook.

Primary Drafting Committee of article:
Jason Eberl
Amy McGuire
Matt Wynia
Paul Root Wolpe
Tyler Gibb
Armand Antommaria

Additional Coders:
Art Caplan
Tamar Schiff
Renee McLeod-Sordjan
Doug Diekema
Holly Tabor

Micah Hester
Megan Applewhite
Lisa Lehmann

Question: Is there any advocacy for a particular framework? The goal is to be descriptive and let people draw their own conclusions.

Jason created a google site for all the policies and shared it on the list serve. Some policies were removed because of concerns from institutions. Send an e-mail to Jason if your institution is willing to share and it will be made available. State policies should be sent to Jason.

Google drive link: https://drive.google.com/open?id=1ewmo9BT8aN8WxqlOAWo4BioeMsmwwfSD

Please let Jason, Amy, or Paul know if you are interested in working on a follow-up paper.

Open Discussion

This is not only about how ethicists cope with difficult issues. It is also about how we manage our Centers as we cope with the pandemic.

Note: Discussion themes discussed fell into the following categories; individual comments are below

a. Issues Related to Triage and Allocation of Scarce Resources:
    i. Should children be treated differently?
    ii. Should healthcare providers be prioritized?
    iii. How do we define “likely to benefit”?
    iv. Non-critical triage policies for non-COVID- 19 patients – incidental morbidity and mortality associated with those policies/practices
    v. Consent – consent for research (e.g., splitting vents), consent to/notification of allocation protocol (e.g., under general consent to treat mention that if they need a vent they will be part of allocation protocol if activated), unilateral DNRs
b. Other Issues:
    i. Legal liability issues
    ii. Need for community engagement and patient/community education about triage/allocation of scarce resources and end of life planning\ Special issues related to rural and remote communities

a. Sarah Rosenthal; legal barriers to triage; if national policy that can be used for malpractice suits or standard triage allocation framework; triage committee with macro policy, physician command group for bedside
b. Bob Klitzman: New York and Texas are giving clinicians immunity for crisis standards
c. Susan Wolf: Policies that use age or disability as discriminating factors are the subject of emerging lawsuits; lawsuit in Washington State re: disability and OCR guidance issued Saturday; Susan posted OCR guidance

d. https://www.hhs.gov/about/news/2020/03/28/ocr-issues-bulletin-on-civil-rights-laws-and-hipaa-flexibilities-that-apply-during-the-covid-19-emergency.html
e. Jeff Kahn: Governor of Maryland will issue executive order for framework across all hospitals in Maryland; will be public shortly

Questions, comments, issues:

What is being asked of members of triage teams?

Mt. Sinai, NYC: There is a team of 20 people to cover 7 hospitals. Critical care people are primarily involved, but Rosamund Rhodes is the only "bioethicist." Triage teams are available 24/7. policy largely recommended by NY State, plans shared ventilators; will be studied. Data are being collected on all kinds of things. Patients may be asked if they consent to being part of a study. There are facilities being set up in lobbies, and tents are going up. There is no plan at the moment to have a separate policy for children.

Denise Dudzinski in Seattle shared a plan for triage teams of 2 clinicians (ICU, EM) and an ethicist.

Ben Krohmal—Acting Director, MedStar Washington Hospital Center: Are there policies for giving priority to health care workers?

Sara Rosenthal: We will be prioritizing health care professionals. They are looking after us, so we will reciprocate. If PPE protections are not adequate, they will receive priority benefits should they become infected. This approach is similar to 9/11 policies regarding military personnel.

Kathy Kinlaw – Emory: We prioritize health care workers in patient areas that involve increased risk of exposure. If a "tie," the tie-breaker goes to individuals working in health care working with high exposure; principles = fidelity and solidarity

What about prioritizing immediate families of HCP? Discussed briefly without conclusion.

Jonathan Bolton: How do you define health care workers for reciprocity arrangements?

Rosamund Rhodes: At Sinai, anyone involved in patient care is considered a health care worker and receives priority only for experimental treatments. The rationale is based on the ability to get them back to work to help save lives. She is troubled by reciprocity argument; it is a fiduciary responsibility to treat patients over self-interests

Denise Dudzinski: There is concern about being viewed as prioritizing our own and creating a discriminatory policy. It is best to emphasize the probability of successful treatment.

Christine Mitchell: Our policy is being held up because of questions of priority for health care providers. The soldier argument about sending people back to work doesn't really apply. The course of treatment is too long.

John Carney re: Kansas and Missouri: In 2009, it might have made sense to have such policies. Now it is indefensible.

Sara Rosenthal: The reciprocity protocol started in Toronto in response to SARS. those on front lines ha 20-30% higher risk for health threats in 911; It is ethically problematic to not offer priority to front-line first responders.

Millie Solomon: The rationale is still relevant for people who get sick but recover.

Kelly Michelson: This pandemic is not going away in a month or two. We are going to need HCP for the long term, so there may be justification in that respect.

Mark Aulisio: The pandemic will be cycling for 12-18 months, so it makes sense to focus on long-term outcomes for HCPs.

Rosamund Rhodes: It's really dangerous to say that we are worth more than anyone else.

Jonathan Marks: Expressed concerns about the substance of policies and procedures for drafting. Any policies should be considered transitional and need to be revised in consultation with those whose lives depend on them.

Mark Aulisio: What constitutes a front-line responder can change, depending upon the situation. There is a significantly increased risk in pandemics. Returning to the workforce is plausible as a need. Workforce morale matters. It looks like the general public is much more comfortable with prioritizing HCP than the HCPs themselves.

Bob Klitzman: There is a problem with people calling in sick because of fear. Would that justify giving HCP treatment priority?

Rich Sharp: There is the same issue with research and clerical staff reassigned to different kinds of clinical positions.

Sara Rosenthal: We will be starting virtual rounds. Morale is very important.

Ben Wilfond: There is a policy at Seattle Children's to prevent physicians over 70 from having direct patient contact.

Rosamund Rhodes: Those over 60 or with a pre-existing condition need to be cleared by Employee Health. If cleared, they will be asked to come back.

Judy Illes: There is a movement to recall people over 65. How do we protect the individuals being recalled?

Art Derse, MCW: We looked at whether we should we give priorities to HCPs. We asked who is essential in taking care of us? What about grocery store workers? Biggest obstacles for us: public wasn't asked prospectively and is problematic when looked at retrospectively. Another Question: What will ethics be doing at the bedside if allocation policies created in advance are being applied? Ethics more valuable in the

crafting and fair application of principles. Once a scoring system is developed based on clinical parameters, does ethics have a role in that process?

Nora Jones: 90% of work right now is focused on security of medications, PPE, etc. Is there space for non-medical equity concerns? If you live in a zip code that contributes to your comorbidities, should you get priority?

Bob Klitzman: Triage policies are based on the likelihood of survival.

Paul Wolpe: There are many different kinds of vulnerable populations. What social qualities allow you to get a higher value score outside of geographic location? Such policies are very complicated to put into effect.

Holly Tabor: thinking about how to balance

A question was raised about requiring health care providers to work: e.g. Having health care worker doing other work based on age

Judy Illes: we are calling in retired physicians

Amy McGuire: What about postponing or altering treatment for non-COVID patients? Oncologists are postponing surgery and using potentially less effective approaches in order to conserve resources.

Reshma Jagsi: We are seeing this. Triage policies need to be generated for patients whose care can be delayed, and for those patients who may be adversely affected by revising treatment protocols. How can we communicate our decisions to patients?

Megan Applewhite (surgeon): We are only doing surgeries for cancers and infections. Elective surgeries are being cancelled. This brings the indications for surgery into question, and it there is a tremendous amount of gray area. Outcomes are not being specifically tracked. She is doing her own tracking, but it should be done on an institutional level.

John Carney: Is there concern about who should be sent to hospitals?

Susan Wolf: There is prioritization by likelihood of benefit. What should be considered:

1) survival to discharge (easier to predict; just getting over this),
2) 1-year survival, or
3) life-years saved

Bob Klitzman: The focus should be on just getting over this, not long-term prognosis.

Christine Mitchell: We should be taking long- and short-term survival into account. We need to be very clear about considerations of age and disability in making decisions.
Mark Kuczewski, Loyola: We are looking at short-term survival to discharge. The justification for taking a ventilator from one person and giving it to another needs to be that the second person is more likely to survive.

Kathy Faber-Langendoen: Age is used as a tiebreaker. The longer the period of survival, the closer it ties to age discrimination. NY state in 2015 used age 18 as a breakpoint (not justified); farther out survival may be more important, but then must expressly deal with the age discrimination issue

Micah Hester: UAMS went with 1-year survival criterion; to get a POLST in state completed, you need to have a diagnosis of one year or less; since state recognizes that as a limit for interventions, can justify on these grounds

Claudio Kogan: Has there been a study of how other countries have reacted? We should compare different communities. What is the role of ethics centers in reaching out to communities?

Judy Illes: Are there different policies for rural and remote communities? Is short-term prognosis the right answer?

Julie Aultman: We are working with the Amish and the undocumented migrant population. We are also drafting policies for vulnerable populations. There needs to be better communication.

Christine Mitchell: For-profit hospitals in Boston are reducing physician salaries, laying people off, and eliminating retirement contributions for 3 months.

Mark Aulisio: One of our local hospital's viability is in doubt because of the cancellation of elective surgeries. We are using a Safety Officer in the ICU to ensure that responders to codes have adequate PPE. There is a need to enforce protection, particularly with junior staff.

Amy McGuire: Next steps: Let's plan publication on the high-level issues (listed above) or organize publications on each of the issues

Get a small working group together to provide a high-level overview of the main issues, or get a group for each issue?
Do we treat kids differently?
Do we prioritize HCP?
Non-critical care triage policies
Interface with federal and state laws
Community Communication

Paul Wolpe: We will ask people about their interest in publication possibilities.

Our listserve is best for issues related to Center directors—e.g., ideas for managing personnel and centers.

We will set up a Zoom meeting in two weeks. Attend if you can. (Look for a calendar invitation.)

WHO: Replace "social distancing" with "physical distancing."

Note: There is a separate transcript of chat questions raised in text online.

Thanks to all