



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

**PUBLICMASSACHUSETTS MEDICAL SOCIETY
COMMENTS TO THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
RELATIVE TO THE CRISIS STANDARDS OF CARE DRAFT PLANNING GUIDANCE
OCTOBER 12, 2020**

The Massachusetts Medical Society is a professional association of over 25,000 physicians, medical residents, and medical students across all clinical disciplines, organizations, and practice settings. The Medical Society is committed to advocating on behalf of patients, to improve the health care delivered to them, and on behalf of physicians, to help them provide the best care possible. The Medical Society acknowledges that various inequities have long stood as impediments to reaching those ends. Although the Medical Society has advocated to eliminate injustice and inequity in health care, the COVID-19 pandemic has highlighted myriad issues with health care delivery in our Commonwealth. This pandemic has stressed how important anticipatory planning and preparedness are to the public's health in such uncertain times. **The Medical Society would like to thank the Massachusetts Department of Public Health for taking this opportunity to develop a contingency plan for situations of severe medical resource scarcity that we all wish never to encounter. We further wish to applaud the continuing efforts of the Department to refine and revise these Crisis Standards of Care (CSC) toward more equitable and just guidelines that respect the differences amongst the people within Massachusetts while drawing on sound moral and ethical foundations to suggest processes that strive for distributive justice and clinical utility in the context of severe resource scarcity.**

The COVID-19 outbreak has posed many novel and difficult challenges to the Massachusetts health care system, not least of which is how to respond to a highly transmissible disease, which has disparate impact on various populations, while working with limited resources. The Baker Administration acted quickly to quell the tide of coronavirus, and many of the measures taken have proven to be quite effective. As a result, the Commonwealth has been afforded the benefit of additional time to revise the Crisis Standards of Care guidelines that were initially released and revised for the first time back in April. It is clear that the DPH has heard many concerns regarding the CSCs from various patient populations and that they are endeavoring to address these issues of allocative justice in a considered and reasoned fashion. The

Medical Society appreciates the revisions that have been made thus far and is grateful for this opportunity to continue engaging in the conversation to ensure equitable CSC guidelines result therefrom.

To that end, the Medical Society would first like to commend the expansion of the CSC guideline Working Group to include individuals with lived and learned experience with various issues of inequity in American society that must be considered in such an undertaking. The new voices in the Expanded Working Group are demonstrably present in the most recent CSC guidelines and represent one step forward for the implementation of these guidelines. As the guidelines continue to be revised, it is the diverse voices from Massachusetts communities that must carry great weight in this iterative and deliberative process.

The current draft CSC guidelines show greater attention to representation within the teams engaging in the decision-making processes. The guidelines suggest that the demographics of the members on the triage teams and oversight committees reflect the diversity of the hospital's patient population. It is vital that these decisionmakers represent the community as much as possible to mitigate implicit bias and promote equitable practices in implementing the CSC guidelines. Further working toward that end, the suggested training for all triage team members is a beneficial addition to the guidelines, as it will help team members recognize unconscious biases that may affect their decision making. We would, however, urge further clarification on the expected timelines for triage team assembly and training to encourage that the teams are created and receive proper training prior to the invocation of CSCs. This guidance would help ensure the benefits of these provisions are most effectively realized once the time of need arises. The Medical Society is appreciative of these inclusions working toward promoting a diverse and representative triage team and supports continued efforts to ensure that the implementation of these ideals is fulfilled in practice if such CSCs are ever required.

This theme of promoting health equity in the CSC guidelines by mitigating implicit bias is additionally furthered by the reduced period of survivability used in calculating a patient's priority score. A reduction from five-year survivability to a one-year prognostication certainly works to limit the potential error that may be caused by subjective unconscious bias. Further reduction in this time period may be appropriate in order to align with six-month standards for hospice referral or, even further, to align with predicted survivability of the acute illness. The Medical Society supports continued efforts to ensure that irrelevant biases and subjective medical information are eradicated from the priority score calculus, while preserving the utility of these guidelines and affording adequate deference to clinical judgment in these most unique and complex situations. With that end in mind, the Medical Society further commends the change providing an upper limit for scoring the presence of chronic kidney disease, as this condition and the elevated creatinine levels associated with it disproportionately affect people of color.

In addition to our concerns regarding ensuring racial equity in the implementation of CSCs, the Medical Society also wishes to express its support for measures taken to eliminate biases of many other forms. While we understand that objective medical criteria are useful in crafting decision frameworks for these most difficult and morally troubling clinical choices, we also stand against discrimination based on age or disability when those factors are not wholly relevant to the types of decisions that must be made under a CSC framework. For that reason, we commend the removal of an explicit tiebreaker based on age. We also applaud the Expanded Working Group's inclusion of provisions relative to reasonable accommodation in the calculation of priority scores for patients with a disability. Establishing baseline clinical metrics is vital to safeguard against discriminating based on disability or age, guaranteeing that diverse lives are not discounted due to problematic and subjective perceptions regarding quality of life.

The Medical Society is further pleased to see that perceived social worth is explicitly stated to be an irrelevant factor in making priority calculations and allocation decisions; however, we remain concerned with the choice not to prioritize all essential workers in these CSC guidelines. Understanding that these CSCs will only be implemented as a last resort in cases of severe resource scarcity, it must be noted that the circumstances contemplated by these guidelines are far different from those that we have experienced to date. If the CSCs ever become necessary, the context requiring their implementation very likely comes with an increased risk of infection to those putting themselves on the front line. Such individuals are often the ones upon whom society relies to maintain essential system functions that work to combat the spread of the virus. Accordingly, in such a situation, it is vital to the public's health and to the health system's operability to sustain a healthy workforce that is capable of meeting the expanded need that results in activation of CSCs in the first place. The Medical Society thus advocates for continued flexibility surrounding the prioritization processes to allow for renewed priority calculations as varying demand may suggest.

Additionally, the Medical Society would like to underscore the uncertainty we find in a few areas of the draft guidelines. Facing conditions that require CSCs, lacking the resource of certainty will further the difficulties the health care system faces when attempting to resolve the most troubling distributive decisions. To avoid future dilemmas, we find it best to anticipate and explicitly address potential areas of confusion. To that end, the Medical Society seeks further clarification on how CSCs are meant to be implemented—whether across the health care spectrum as a whole or on an individual hospital basis. In order to avoid the need for activation of CSCs, the Medical Society encourages continued preventive measures that will help to curb disease surges and other measures that will help to manage resources broadly across geographic regions. The former may be focused on community investment, targeting high-risk communities. Intentional investment centered on social drivers of health that have been found

to be most determinative of the health outcomes in question may help to prevent the need to ever implement CSCs. In situations of dire need, continuing to think creatively about avoiding true scarcity, such as through pooled resource sharing agreements between institutions and across geographic boundaries, could be beneficial, even in addition to the remarkable “load bearing” initiatives led so far by the state this Spring. Similarly, we believe that it may also be helpful to further leverage the top-notch health care resources of our Commonwealth by establishing a centralized resource consultation service that may offer specialized expertise and human resources to facilities in need.

Furthermore, the Medical Society would appreciate elucidation of who will be the arbiter determining when CSCs are activated and how best to promote consistency in activation and implementation across institutions. Although we understand that these draft guidelines are only meant to be guiding in nature, we believe it would be very helpful to have a better understanding of how the CSCs will bear on such things as liability for decisions made thereunder.

Finally, the Medical Society wishes to express strong support for continued dialogue on the subject of Crisis Standards of Care—even beyond the COVID-19 pandemic—in order to ensure that the guidelines are informed by the most accurate and current data to support their processes and prioritization calculations. Investment should be made into researching the proposed processes, such as the use of SOFA scoring, which may benefit from reassessment and revision to reflect the most effective and predictive tools that are capable of considering multiple dimensions of health while ignoring irrelevant, subjective criteria.

Thank you for this opportunity to comment on the Crisis Standards of Care draft guidelines. The Medical Society stands ready to assist in the efforts to revise these guidelines and looks forward to continuing this discussion about advancing health equity in the allocation of scarce medical resources. Lastly, we would like to remind the Department that the promulgation of these guidelines does not conclude the CSC revision process; a sound communication and education plan to patients and the health care system is imperative to ensuring optimal reception and understanding of these challenging concepts.