Medical Xpress

How can hospitals address scarce resources during COVID-19?

April 8 2020, by Hoag Levins

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After reading Julia Lynch's latest draft paper, a typical layperson would likely be surprised to realize that despite decades of national concern about terrorists, biological warfare attacks, and dirty bombs, hospitals don't have an actual how-to guide for deciding how to allocate scarce resources during such catastrophic incidents.

Lynch, Ph.D., an associate professor of political science at Penn's School of Arts and Sciences and an LDI Senior Fellow, realized this a few weeks ago. A colleague from a Michigan health system called her trying to find—or have her create—step-by-step instructions for how to make ongoing scarce resource allocation decisions in hospitals during emergencies like the current coronavirus pandemic.

"The call came in because political scientists like myself set up decision-making rules, and these decision rules were what was absent from existing guidance," said Lynch. "Most hospitals have contingency plans designed to guide decision-making about scarce resource allocation during crises like a pandemic. But most of these plans start from abstract bioethical principles and then jump to detailed plans for triaging particular forms of treatment."

The missing piece

"What's missing," she continued, "is the in-between step that says when hospital staff are confronted with a shortage that wasn't foreseen in the triage guidelines, or that provokes a conflict between bioethical principles that we haven't accounted for, or that prompts a conflict between different stakeholders in the hospital setting, what do we actually do in that case? How do we come to a decision about how to deal with that scarcity? And that is the hole that our guidance was designed to fill."

Working with Isabel Perera, Ph.D., her former Ph.D. student and a current bioethics post-doc at the Perelman School of Medicine and LDI Associate Fellow, Lynch began researching and writing Procedural Guidelines for Scarce Resource Allocation Teams (SRAT) Under COVID-19: Promoting Fairness, Transparency, and Accountability. The resulting guidance has been made available online, and Lynch and her collaborators are working to publicize it via social media.

"As far as we are aware, this is the first guidance of its kind," said Lynch. "When I started researching, I reached out to a lot of contacts and cast a really wide net to see if there was anything being done elsewhere on this. Some people said "Yeah, we have something' but what they sent me would either be a statement of abstract bioethical principles or the triage instructions their hospital had adopted for allocating patients to ventilators, for example. Nobody seemed to have the middle piece, the operational guidance on how to set up a scarce resource allocation team and what procedures it should follow for actually making allocation decisions."

Organizing the committee

Among the issues covered in the guidance developed by Lynch are things like who should sit on the scarce resource allocation committee, how they should resolve conflicts when disagreements arise, or how to handle unexpected scarcities in equipment, medication, or staffing such as those now plaguing every aspect of the clinical response to the COVID-19 pandemic.

"Hospitals desperately need guidance that explains how to set up systems that can fairly, transparently, and efficiently implement the abstract bioethical principles that guide most scarce resource allocation plans," Lynch said. "As we can see all around us, hospitals are struggling to establish decision-making structures, and are instead pushing these decisions off onto bedside clinicians. This creates a huge amount of moral distress for health care workers, and also puts hospitals at risk. Clear, transparent processes that allocate responsibility for decision-making allow systems to apply rules consistently and fairly. On the flip-side, ad hoc decision-making can easily result in decisions that fail to resolve the fundamental conflicts between general principles or stakeholder values that often arise when you're trying to allocate scarce resources."

One example of conflict she cited involved how to allocate nursing resources, which are becoming increasingly strained as the COVID-19 pandemic wears on. What happens, for example, if half of the critical care night shift staff becomes infected by COVID-19 and is unable to come to work because they need to go into 14-day self isolation?

Conflicting agendas

"The triage team might try to reallocate nursing staff from the emergency department to the critical care unit, preserving the ability to treat ICU patients," Lynch said. "But ED staff might argue that such an approach would leave far more patients languishing and under-triaged. And a nursing staff representative might question the wisdom of trying to rapidly re-skill nurses for work in the ICU, and prefer to reinstate retired or student nurses. A hospital administrator might express concern about the ability to adequately license or certify the safety of any of these changes. So staff are in conflict about how to proceed, but a decision has to be made within six hours before the next night shift begins. The problem we were trying to solve as we developed these guidelines was who should do what, and how, to come to a decision in a situation like this?"

Lynch's guidelines explain how to set up and staff a SRAT team, and what rules the team should follow when making decisions both under true emergency conditions and in the case that a decision can be deliberated for 12 or 24 hours.

Before that can happen, though, said Lynch, "clear decisions need to be made about what kinds of decisions the SRAT should not be making. What allocation decisions could be made by triage teams which are closer to the floor level of the hospital, or by individual clinicians? And what kinds of decisions would be referred to a scarce resource allocation team? So, clarifying what kinds of decisions get made where and by

whom is an important first step in setting up an SRAT."

Staffing the committee

"The second thing that needs to happen," she continued, is staffing. Hospitals need to decide who are the clinicians and non-clinician staff who would sit on the committee, who will occupy the role of the chairs, and who are the staff people who can take care of things like setting up a system for keeping records about decision-making and processes."

"Then the third piece that is important for getting a system like this fully operational is practice," Lynch said. "SRAT teams really need to practice because this kind of decision-making is actually really, really hard. So, teams need to practice on a set of scenarios, to figure out how the decision-making is going to play out in practice and get comfortable with the processes. To the extent that teams can start doing that now before the real brunt of the resource allocation crunch hits, the teams will be able to function much more smoothly. In the case of COVID-19, it's already hitting but it's going to get a lot worse—so if they can start practicing now, they'll be ready to roll as that happens."

Provided by University of Pennsylvania

Citation: How can hospitals address scarce resources during COVID-19? (2020, April 8) retrieved 27 April 2024 from https://medicalxpress.com/news/2020-04-hospitals-scarce-resources-covid-.html

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