Medical Decision Making During the COVID 19 Pandemic

- FOCUS: Ethics, Advance Directives (POLST), Crisis Standards of Care

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Hippocrates 400 BC

The definition of medicine:

"To do away with the suffering of the sick, to lessen the violence of their disease, and to refuse to treat those who are overmastered by their disease, realizing that in such cases medicine is powerless."

Medical Professional Centered Ethical Principals

- Beneficence
- Nonmaleficence

Patient Centered Ethical Principals

- Autonomy
- Autonomy After Loss of Mental Capacity
  - Substituted Judgement
    - AD
    - HCA
  - Best Interests

Society Centered Ethical Principals

- Justice:

  Individuals and groups should receive fair, equitable, and appropriate treatments during a health crisis

Patients' Absolute Rights

- Patients with decision making capacity have a common law and constitutional right to refuse life sustaining treatment.
- This right is extended to patients who lack decision making capacity through surrogates.
- This right does not depend on prognosis, it is a basic right.

Hastings Center Guidelines, 2013

Informed Consent

Discussion of the following elements

- Assessment of patient capacity
- The name of the decision/procedure
- Alternatives to proposed intervention
- Risks and benefits of each
- Decision by patient

AMA Code of Medical Ethics

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

1. The diagnosis (when known)
2. The nature and purpose of recommended interventions
3. The burdens, risks, and expected benefits of all options, including forgoing treatment

(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

Minnesota Patient Bill of Rights

Information about Treatment

Patients shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the patients can reasonably be expected to understand. Patients may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a patient's medical record, the information shall be given to the patient's guardian or other person designated by the patient as his or her representative. Individuals have the right to refuse this information.

AMA Code of Ethics

Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians' own safety, health, or life.

However, the physician workforce is not an unlimited resource. Therefore, when providing care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future.

Public Health Ethics

Individual Rights (Autonomy)

vs.

Community Rights (Population Health)

Harm Principle

Competent adults should have freedom of action unless they pose a risk to others.

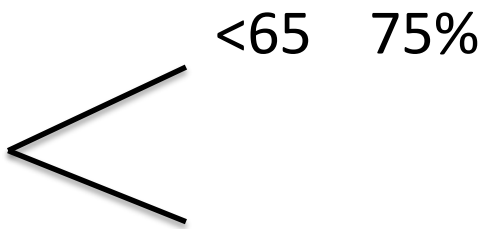
PANDEMIC DATA

1918 Influenza Pandemic	50 million deaths/5% of world's population
2020 Corona Pandemic	3.5 million cases/7% fatality rate
2020 U.S. Pandemic	1.2 million cases/6% fatality rate
2020 Minnesota Pandemic	7000 cases/ 6% fatality rate

New York Corona Fatality Rates

All Patients 7.6%

Ventilator Patients 88%



2020 Corona Fatality Rates by Age

Age 70-79	7-10%
Age >80	15-20%
Minnesota SNF/AL	28%

Differences Between AD and POLST

Legal Advance Directive

- Often created before serious illness
- Used to communicate person's wishes to family, physician and other providers
- Completed and signed by person and witnessed or notarized
- Used to prevent legal and moral problems
- Person can assign a Health Care Agent to speak on person's behalf should they not be able to communicate

POLST

- Used for patients who are elderly or have been diagnosed with a serious illness
- Used to discuss specific end-of-life treatment options
- Signed by provider (physician, NP, PA)
- Used to ensure that persons' wishes are known, communicated, and honored across all health care settings

Minnesota POLST / COVID 19

- Value of POLST
- Who should have a POLST?
- Completing a POLST

Goals of Care → POLST

Would you (your loved one) like all medical treatment used to prolong your life?

OR

If your mother was sitting here with us as she had been 5 or 10 years ago, what would she have told us to do?

Would she have wanted us to focus on comfort here at the Nursing home and told us not to send her back to the hospital?

OR would she have told us that she would go back to the hospital but no heroics: no ICU, no surgery, no CPR, and no ventilators?

More nurses and IVs would be OK.

Completing a POLST During a Pandemic

- In SNFs and ALs: POLST conversation with RNs and SWs
- Remote completion of the POLST
- In the home and clinic: RNs and SWs

The provider must sign the form

POLST Conversations

It’s always important for us to know the medical treatments that you (your mom) would want. Some people want all treatments used to prolong their lives. They would go to the hospital, the ICU, they would want CPR, a ventilator – all the tools we have in the hospital. Other people want treatment focused on comfort; they do not want to go to the hospital. Most people hope to die at home.

Some people because of the pandemic have decided they do not want to go to the hospital. Others have decided that they do not want to go on a ventilator.

If you decided (or if your mother would have decided) to avoid the hospital and receive comfort care at home (or nursing home or assisted living), then we’ll complete a POLST form that I will sign so that everyone will know and honor your wishes.

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1) Minnesota POLST www.polstmn.org

2) Center to Advanced Palliative Care (CAPC)

CAPC COVID 19 Response Tool Kit

www.capc.org

CRISIS STANDARDS OF CARE

Allocation of scarce resources during a medical crisis:

PPE, ICU beds, Ventilators, Blood Products, Drugs

Fundamental to CSC: PALLIATIVE CARE

Jennifer L. Welsh, MD Fairview
Homecare and Hospice

Symptom management for COVID-19

FAIRVIEW

Symptom management in COVID 19

By the end of the presentation, you will be able to

- **Prescribe opiates for dyspnea management**
- **Prescribe benzodiazepines for management of anxiety related to end of life/COVID**
- **Know when to consider referring patients who are PUI/COVID-+ for hospice care**

Caveats

- Focus on outpatients and patients in congregate living facilities
- Oral regimens
- Focus on management of dyspnea, anxiety, secretions, cough
- Appropriate for frail, ill patients who want symptom palliation and to avoid hospitalization/ER use
- Lots of time for questions at the end of the presentation

Dyspnea Management

- **Positioning: sitting up**
  Hospital bed
- **Oxygen for management of hypoxia; 1-5 LPM.**
  Higher flow rates may increase the risk of aerosolization of the virus
  Titrate oxygen to comfort more than a particular O2 saturation
- **Wheezing with known asthma/COPD**
  Albuterol MDI with spacer and mask, 2-4 puffs q 4 hours prn
  NO nebulizer due to concern over aerosolization

Dyspnea management: opioids

Morphine

- 2.5 mg PO/SL/rectal for mild dyspnea q 2 hours prn SOB or pain.
- 5 mg PO/SL/rectal for moderate to severe dyspnea q 2 hours prn SOB or pain.

If ineffective after one hour increase the dose

- 5 mg for mild dyspnea q 2 hours prn SOB or pain
- 10 mg for moderate to severe dyspnea q 2 hours prn SOB or pain.

Dosage forms immediate release:

Commercially available: 10mg/5mL solution , 20mg/mL concentrate (Intensol), 15 mg tab

Compounding pharmacy: 2.5mg solutabs, 5mg solutabs

Dyspnea management: opioids

Hydromorphone

- 1 mg PO/SL/rectal for mild dyspnea q 2 hours prn SOB or pain.
- 2 mg PO/SL/rectal for moderate to severe dyspnea q 2 hours prn SOB or pain.

If ineffective after one hour increase the dose

- 2 mg for mild dyspnea q 2 hours prn SOB or pain
- 4 mg for moderate to severe dyspnea q 2 hours prn SOB or pain.

- Preferred opiate for renal disease

Dosage forms:
Commercially available: 2 mg tab, 4 mg tab, 8 mg tab
Compounding pharmacy: 0.5 mg soltab, 2 mg soltab, 10 mg/mL

Dyspnea management: opioids

Oxycodone

- 2.5 mg PO/SL/rectal for mild dyspnea q 2 hours prn SOB or pain.
- 5 mg PO/SL/rectal for moderate to severe dyspnea q 2 hours prn SOB or pain.

If ineffective after one hour increase the dose

- 5 mg for mild dyspnea q 2 hours prn SOB or pain
- 10 mg for moderate to severe dyspnea q 2 hours prn SOB or pain.

Dosage forms immediate release:
Commercially available: 5 mg tab, 1 mg/mL, 20 mg/mL
Compounding pharmacy: 0.5 mg soltab, 2 mg soltab, 10 mg/mL

Anxiety management

Lorazepam

0.25 PO/SL/rectal q 4 hours prn mild anxiety
0.5 mg PO/SL/rectal q 4 hours prn moderate to severe anxiety

If not effective in 2 hours, then
0.5 mg PO/SL/rectal q 4 hours prn mild anxiety
1 mg PO/SL/rectal q 4 hours prn moderate to severe anxiety
Dosage forms: 0.5 mg tab, 1.0 mg tab, 2 mg/mL

Less preferred:
Diazepam
2 mg PO/SL/rectal q 4 hours mild anxiety
4 mg PO/SL/rectal q 4 hours severe anxiety
Dosage forms: 2 mg tab, 5 mg/1 mL, 5 mg/5 mL

Secretions

- **Scopolamne patch: 1.5 mg , change q 3 days**
- **Glycopyrrolate 1 mg tablet**
  1 mg PO/SL tid prn
  if ineffective after 4 hours may increase to 2 mg tid prn
- **Atropine (1% Ophthalmic Solution)**
  2 drops PO/SL every 4 hours prn
  if ineffective after 4 hours may increase to 4 drops every 4 hours prn

  All are anticholinergic and can cause dry mouth, urinary retention, overdrying and thick mucus

Cough/Expectorants

- **Guaifenesin 100 mg/5mL**
  400 mg/ 20 mL every 4 hours as needed

- **Opiates are also cough suppressants**

Dysphagia

- Occurs at the end of life, sometimes earlier (for example, stroke)
- Can complicate medication administration
- Oral immediate release opiate and benzodiazepine pills can be given in slurry form for patients having difficulty swallowing
- Oral immediate release opiate and benzodiazepine pills can be given rectally
- Opiates and benzodiazepines are available in concentrated liquid forms via compounding pharmacies to allow sublingual/buccal dosing

Does my COVID +/PUI qualify for hospice?

- **Respiratory symptoms (*dyspnea or tachypnea and/or O2 sat under 90%; worse than baseline in patients with underlying respiratory symptoms*)**
- **Mostly bed to chair existence due to acute illness.**
- **Patient has one or more chronic health conditions that would increase their morbidity and/or mortality.**

  advanced or metastatic cancer, class 3 or 4 CHF (*short of breath with minimal activity or at rest*), Atherosclerotic Heart Disease, COPD, Diabetes with renal or cardiovascular complications, CKD stage 4 or 5, severe protein calorie malnutrition, and/or advanced neurodegenerative disease (*Alzheimer's Disease or other Dementia, Parkinson's Disease, CVA with significant functional impairment*).

Questions

- Contact me at jwelsh3@Fairview.org
- Cell: 612-272-5963
- Online version of Acute Symptomatic Management for SNF Patients with Dyspnea/Anxiety/Chest Pain/Secretions

  Minnesota Network of Hospice and Palliative Care

  https://www.mnhpc.org/assets/docs/COVID%2019%20ASM%20v.Final%20Accessible%204.17.20%20%281%29.pdf