

# **Minnesota Crisis Standards of Care Framework**

ETHICAL GUIDANCE

Updated: 01/10/2020

## **Minnesota Crisis Standards of Care Framework: Ethical Guidance**

Minnesota Department of Health  
Center for Emergency Preparedness and Response  
PO Box 64975  
St. Paul, MN 55164-0975  
651-201-5700  
[health.epr@state.mn.us](mailto:health.epr@state.mn.us)  
[www.health.state.mn.us](http://www.health.state.mn.us)

*To obtain this information in a different format, call: 651-201-5700. Printed on recycled paper.*

## Contents

Introduction .....	4
Overview .....	4
Purpose and Scope.....	4
Process .....	5
Annotated Ethical Framework .....	5
Existing Ethical Guidance and National Recommendations.....	5
Ethical Commitments.....	6
Ethical Objectives.....	7
Ethical Strategies.....	8
Conclusion.....	26

# Introduction

## Overview

Establishing crisis standards of care requires addressing complex ethical issues. The National Academies of Sciences, Engineering and Medicine, Institute of Medicine (IOM)—now the National Academies of Medicine (NAM)—(referred to as the IOM/NAM in this document) asserts that this ethical framework forms the “bedrock” for crisis standards of care preparedness.<sup>1</sup> In 2016, the Minnesota Department of Health (MDH) contracted with the University of Minnesota Center for Bioethics to develop ethical guidance for the Minnesota Crisis Standards of Care (CSC) Framework. It emphasizes IOM/NAM’s importance of equity and the protection of those who are most vulnerable during disasters.<sup>2</sup> This includes groups experiencing health disparities and those with access or functional needs. Minnesota’s CSC ethics guidelines embraces IOM/NAMs position about the need for clear guidance for health professionals about how to stay true to their essential ethical commitments in catastrophic contexts.<sup>3</sup> Additionally, it outlines the fundamental ethical commitments for CSC development and presents the ethical objectives that must be met, so that fundamental ethical commitments can be honored in a time of crisis. Finally, it offers strategies to achieve the stated ethical objectives, and specific case scenarios to illustrate its application.

## Purpose and Scope

This guidance may be useful to both public and private providers—such as health care systems and facilities, ambulatory care centers, clinics, emergency medical services and others—in planning for disasters and times of critical resource shortages. In some communities and organizations, local ethics advisory groups may be established (proactively or improvised during a response) to also serve as a resource in guiding ethically sound decisions on controversial cases. This ethical guidance in MDH CSC Framework aims to support these varied groups during the planning and response phases in a crisis standards of care disaster.

Public and private systems alike have a duty to plan for CSC, not only to minimize the risk for moral distress and improvised decision-making during a crisis, but also to provide the best care possible within context. Executives and leadership of these entities should adapt their plans to the specific circumstances of the event as necessary. Thus, context-specific analysis will be required to implement the ethical framework during a pervasive or catastrophic public health event.

In addition, certain recommendations—like those associated with triage—depend heavily on medical, logistical, or other factors. This guidance does not seek to address those issues. It offers ethical guidance for how to implement triage when it is needed; it does not offer the medical criteria necessary to predict or prioritize patients based on expected short-term outcome. Data must be collected and medical/scientific guidelines or best evidence applied to

---

<sup>1</sup> IOM/NAM 2009, p.5.

<sup>2</sup> IOM/NAM 2012, p1-72.

<sup>3</sup> IOM/NAM 2012, p1-72.

utilize ethical guidance offered. In general, the presented ethical considerations are meant to guide the development and implementation of CSC plans at the local (facility/agency) and state levels, not usurp operational and logistical planning activities, nor that of other public or private health care systems.

## Process

The CSC Ethics Workgroup, a multidisciplinary group of stakeholders including ethicists, emergency regional coordinators, health care professionals, health systems administrators, clergy, advocates for populations with access and functional needs, tribal coordinators, and other subject matter experts (SMEs) was formed by MDH in 2016. To assist in the research involved, MDH and the workgroup contracted with the University of Minnesota Center for Bioethics. They first conducted a systematic review of academic and practice-based literature, focusing on documents released after the 2012 Institute of Medicine's (IOM)—now the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (HMD)—(referred to as the IOM/NAM in this document) landmark report on CSC. Highlighted in the [literature review](#), are ethical issues CSC plans should address and influence the development of an ethical framework for CSC.

Next, the CSC Ethics Workgroup was tasked with providing input on the ethical framework. The contractor from the University of Minnesota Center for Bioethics led a series of meetings during which the Workgroup offered feedback on the structure and content of the proposed framework, as well as on questions about its implementation. The proposed Ethical Framework was also presented to MDH's Science Advisory Team (SAT) and CSC Steering Committee for their input. Throughout the development of the Ethical Framework SMEs (e.g., scientific or legal advisors) were consulted as needed.

## Annotated Ethical Framework

### Existing Ethical Guidance and National Recommendations

The ethical guidance offered here builds upon the previously conducted [Minnesota Pandemic Ethics Project \(MPEP\)](#). The CSC Ethics Workgroup included members of the MPEP team from the University of Minnesota. MPEP developed ethical guidance for rationing scarce resources in a severe influenza pandemic through a complex process involving extensive expert analysis, stakeholder consultation and community engagement. The project produced two major reports that offered substantial, operational ethical guidance for an influenza pandemic. They are:

- [For the Good of Us All: Ethically Rationing Health Resources in Minnesota in a Severe Influenza Pandemic](#),<sup>4</sup> which presented ethical frameworks for rationing, and

---

<sup>4</sup> Vawter, DE. (2010) Retrieved from [For the Good of Us All: Ethically Rationing Health Resources in Minnesota in a Severe Influenza Pandemic](#)

- *Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic*,<sup>5</sup> which identified and analyzed issues relating to the implementation of those ethical frameworks.

Of course, Minnesotans may face other pervasive or catastrophic public health events that results in crisis standards of care. The 2012 IOM/NAM report emphasizes a duty to plan for CSC under catastrophic conditions. The IOM/NAM outlines a broad ethical framework for CSC, based on two key concepts:

*“First, groups that are most at risk before a disaster are those most vulnerable during a disaster. Ethically and clinically sound planning will aim to secure equivalent resources and fair protections for these at-risk groups. Second, some health care professionals question whether they can maintain core professional values and behaviors in the context of a disaster.”*<sup>6</sup>

The IOM/NAM maintains that an ethical framework for CSC must thus include these key features: fairness, the duty to care, the duty to steward resources, transparency, consistency, proportionality, and accountability. The report offers preliminary analyses of these norms.<sup>7</sup> Each section of the framework is explained in detail below. After a health care system or facility or agency creates their own CSC plan, MDH recommends they cross reference their plan with the below ethical framework.

## Ethical Commitments

### Pursue Minnesotans’ common good in ways that:

- **Are accountable, transparent and worthy of trust;**
- **Promote solidarity and mutual responsibility;**
- **Respond to needs respectfully, fairly, effectively and efficiently.**

These fundamental ethical commitments ground the ethical framework for CSC; they constitute the most basic ethical obligations for disaster planning and response. These ethical commitments largely mirror those embraced by MPEP given its extensive process of expert analysis, stakeholder consultation and community engagement.<sup>8</sup> However, while MPEP focused

---

<sup>5</sup> Debra A. DeBruin, Mary Faith Marshall, Elizabeth Parilla, Joan Liaschenko, J.P. Leider, Donald J. Brunnquell, J. Eline Garrett, Dorothy E. Vawter (2010) Retrieved from [Implementing Ethical Frameworks for Rationing Scarce Resources in Minnesota during Severe Influenza Pandemic](#).

<sup>6</sup> Dan Hanfling, Bruce M. Altevogt, Kristin Viswanathan, and Lawrence O. Gostin, Editors; Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations; Institute of Medicine. “Volume 1: Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response” p. 1-72.

<sup>7</sup> Dan Hanfling, Bruce M. Altevogt, Kristin Viswanathan, and Lawrence O. Gostin, Editors; Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations; Institute of Medicine. “Volume 1: Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response” p. 1-72.

<sup>8</sup> Garrett, J. E., D. E. Vawter, K. G. Gervais, A. W. Prehn, D. A. DeBruin, F. Livingston, A. M. Morley, L. Liaschenko, and R. Lynfield. "The Minnesota Pandemic Ethics Project: sequenced, robust public engagement processes." J Particip Med 3 (2011).

on rationing scarce resources during influenza pandemic, this project aims to develop a broader ethical framework for crisis care situations.

These commitments also reflect the most fundamental of the key features in the IOM/NAM's ethical framework: transparency, accountability, fairness and consistency (characterized by the IOM/NAM as "one way of promoting fairness" because it requires "treating like groups alike"<sup>9</sup>). Finally, the commitments in this CSC ethics framework give rise to a duty to plan for disasters. IOM/NAM maintains that both government and private providers have such a duty, which will be explained in more detail in the strategies section of this framework.

## Ethical Objectives

Below are the three (3) equally important and overlapping ethical objectives that should be met in all CSC planning and response to honor the fundamental ethical commitments noted above.

### Protect the population's health by:

- Reducing mortality and serious morbidity from the public health crisis; and
- Reducing mortality and serious morbidity from disruption to basic health care, public health, public safety and other critical infrastructures.

Planning must address the needs of individuals in the communities with injuries or illnesses that are directly related to the disaster: e.g., injuries related to building collapse or flying debris in tornado, cases of anthrax or influenza in bioterrorist attacks or pandemics. Planning must also attend to health needs related to the impact of the disaster on critical infrastructures as well as consideration of how to fairly and effectively manage more routine health care needs in the context of a disaster that overwhelms the health care system. These related needs also include concerns about public health consequences of disaster on critical services other than health care, including clean water, reliable power, sanitation services, etc.

While emergency and disaster preparedness focuses on protecting human life and health, planning should also attend to risks disasters pose to animals. For example, if disaster evacuation plans do not address needs of animals, owners may refuse to evacuate without their pets or return to care for their pets before it is deemed to be safe, leading to failed evacuations and an increased health risk for these owners.<sup>10, 11, 12</sup>

### Respect individuals and groups by:

- Promoting public understand of, input into, and confidence in CSC planning and response;
- Supporting a duty to promote the best care possible in crisis circumstances; and

---

<sup>9</sup> Hanfling et al., Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response, p 1-75.

<sup>10</sup> Blendon, R. J., Benson, J. M., DesRoches, C. M., Lyon-Daniel, K., Mitchell, E. W., & Pollard, W. E. (2007). The public's preparedness for hurricanes in four affected regions. *Public Health Reports*, 167-176.

<sup>11</sup> Glassey, S., & Wilson, T. (2011). Animal welfare impact following the 4 September 2010 Canterbury (Darfield) earthquake.

<sup>12</sup> Heath, S. E., Voeks, S. K., & Glickman, L. T. (2001). Epidemiologic features of pet evacuation failure in a rapid-onset disaster. *Journal of the American Veterinary Medical Association*, 218(12), 1898-1904.

- Ensuring burdens imposed by crisis response are minimized and justified by the benefits gained.

Duties of respect require that individuals and groups receive critical information and provide input on plans that may ultimately affect them. Duties of respect also help ground the duty to care, which honors both those whose health is affected by disaster and those who provide care. Finally, duties of respect protect individuals and groups when public health interventions may restrict their rights and liberties.

### **Strive for fairness and protect against systematic unfairness by:**

- Utilizing strategies for public education and public engagement that are inclusive and culturally sensitive;
- Promulgating standardized crisis standards of care response protocols that are publicly available, revised regularly, and become tailored to specific crisis responses;
- Ensuring that burdens and benefits associated with crisis response are equitable;
- Making reasonable efforts to remove barriers to access and address functional needs;
- Stewarding resources to:
  - Reduce significant group differences in mortality and serious morbidity; and
  - Appropriately reciprocate to groups accepting high risk in the service of others;
- Using decision-making processes that consistently apply only ethically relevant (non-discriminatory, non-arbitrary) considerations.

Duties of fairness apply at all phases of disaster planning and response, and require both fair processes and substantively fair treatment of individuals and groups. Public health ethics demands a focus on the needs of populations with health disparities and/or access and functional needs, since these populations consistently suffer the worst public health outcomes. While disproportionate impacts may not be intentional consequences of public health activities, they are nevertheless inequitable, and thus violate duties of fairness. This attachment provides more detail about duties of fairness and those of respect in discussions of ethical strategies below.

## **Ethical Strategies**

Below are multiple strategies to achieve the ethical objectives outlined above. It includes considerations regarding the duty to plan; promoting ethical decision-making among private partners; public engagement, understanding, and communication; the duty to care; proportionality and equity in liberty-limiting interventions; removing barriers to access; and fairly and consistently stewarding resources. The first two strategies—duty to plan and promoting ethical decision-making among private partners—affect achievement of all three ethical objectives because they address the planning and coordination required for ethically appropriate disaster response. The remaining strategies offer guidance about how to accomplish the three ethical objectives listed above.

### **Planning and Coordination Strategies**

#### **DUTY TO PLAN**



- **Prospective planning**
  - MDH, local/tribal health departments, private providers and other partners should engage in prospective planning for CSC, taking expert stakeholder and community input into account as they do so.
  - Standardized CSC response protocols should be made publically available to promote transparency, accountability and public understanding.
- **Process for review and tailoring**
  - Processes should be developed to periodically review and revise CSC plans, as well as to tailor them to the specific context of particular disasters encountered.
  - Consultation with the state and/or local CSC ethics support teams may be sought to support these processes.

The duty to plan relates to the position both governments and private providers hold in disaster and emergency response, and the potential harm to individuals if these organizations elect not to plan prior to an emergency or disaster.<sup>13</sup> Impromptu decision-making during a disaster—when resources are tight, demand is high, and other logistical challenges arise—significantly risks undermining the fundamental ethical commitments stated above. State, local, and tribal governments, as well as private providers and other partners, must acknowledge a duty to plan for emergencies and disasters, recognizing plans will periodically need to be reviewed and revised, as well as tailored to the particular circumstances of disasters when they occur. This provides a moral foundation for CSC planning and response.

#### PROMOTING ETHICAL DECISION-MAKING AMONG PRIVATE PARTNERS

- **Partnerships**
  - MDH will continue to treat private entities, such as health care organizations, as partners in planning disaster response, recognizing the shared planning and response roles of private providers and health care systems as necessary for effective response.
  - MDH will continue to work with other governmental entities and engage non-health private partners (e.g., faith-based organizations or nonprofit service providers) in planning for a disaster.
- **Coordinating responsibilities**
  - Planning efforts should not unduly burden private partners. Those with greater or unique capabilities should accept equivalent responsibilities in response, and MDH and other private partners should support these organizations in doing so.
- **Patient transfer and care transition plans**
  - The health care sector should work with MDH to create patient transfer and care transition plans and maps for disaster response.
  - These plans should allow lower levels of care to occur outside of the hospital setting so as to minimize the burden on hospital services, especially critical care.
  - Scope of practice should be expanded so the majority of care may be shifted to community clinics, primary care or specialty offices, and other providers.

---

<sup>13</sup> Powell, T., Christ, K. C., & Birkhead, G. S. (2008). Allocation of ventilators in a public health disaster. *Disaster Med Public Health Prep*, 2(01), 20-26.

- State and local government should be prepared to support these non-traditional responses both from a financial and regulatory standpoint.
- **Increasing response capabilities**
  - MDH will support public and private actions aimed at increasing capabilities of health care providers who do not have the infrastructure to meet their accepted roles in disaster response. This may include offering technical support, increasing the availability of telemedicine, and creating helplines for private actors during disaster response and recovery.

Private entities, such as health care organizations, benefit from government efforts in disaster planning and response. These organizations thus have an obligation to contribute to a societal response. Health care organizations, in particular, have deeper obligations, including the duty to care and duty to plan. These obligations exist due to benefits accrued to these organizations by virtue of their place in society, special training and capacities housed within these organizations, and because everyday obligations of the duty to care do not evaporate when a disaster occurs.<sup>14, 15</sup> Minnesota is fortunate to have robust engagement of health care provider communities in disaster planning and response through our health care coalitions. Non-health private organizations may be critical to response, as well. These include logistically useful sectors like transportation. Large employers and small businesses may also be necessary to a broader response, depending on the disaster and should therefore be considered during planning efforts. At the same time, the government and its citizenry must recognize private organizations have additional obligations—to their owners, directors or shareholders—that justifiably drive different incentives and priorities.

Considerations of equity apply to the involvement of private organizations in disaster response. Private organizations ought not to be unduly burdened during response or recovery. Health care systems should share relative risks and benefits in line with their capabilities and roles in response. As with infringing on individual liberties among the public, governmental entities have an obligation to use the least restrictive means of responding to a disaster. For corporate entities, this translates to minimally impinging on their financial, economic, or other interests during disaster. Moreover, as with individuals, actions that burden private organization must be justified by public health interest.

An ethically appropriate CSC plan requires coordination of responsibilities and collaboration in patient transfer and care transition plans across private organizations in the state. Large systems tend to have greater staff capacity, specializations, and offer higher levels of care than smaller systems or individual facilities. However, in the event higher-level hospitals become overburdened or must be evacuated, patient care may need to be dramatically reorganized. Transports and transfers to other similar level facilities is a reasonable first step. However, during a crisis standards of care situation, obligations to patient care may not be satisfied without transitioning patients to lower level providers and expanding their scope of practice. Disaster response may call on other types of providers to accept less acute or complex patients.

---

<sup>14</sup> Prehn, Angela W., and Dorothy E. Vawter. "Ethical guidance for rationing scarce health-related resources in a severe influenza pandemic: Literature and plan review." (2008).

<sup>15</sup> "Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report" Report Brief. September 2009, p.3

This may require response from community health centers, but also private general practice and specialty providers that would not typically be involved in emergency response. MDH, as well as private provider systems, will engage in planning for patient and care transition in the event major facilities (e.g., Level 1 Trauma) are overburdened or unavailable.

Additionally, it may not be practical for smaller or more rural organizations to maintain the staffing or technical expertise necessary to respond to disasters. As part of the duty to plan, these organizations have an obligation to maximize their readiness and competency for disaster response. This is tempered by other obligations, e.g., fiduciary obligations to shareholders. MDH, then, will support these organizations in planning for disaster response. This largely occurs through planning for technical assistance provision or logistical support within their health care coalition or by request to jurisdictional emergency management. This may include offering technical support, increasing the availability of telemedicine, and creating helplines for private actors during disaster response and recovery.

MDH will treat private organizations as partners in planning disaster response, recognizing the shared planning and response roles private providers and health care systems play are necessary to effective response.

## Strategies to Accomplish Ethical Objectives

### PUBLIC ENGAGEMENT, UNDERSTANDING, AND COMMUNICATION

- **Public Engagement**
  - Initiatives should reach out to communities and not rely on a standard public comment period for soliciting feedback on CSC planning.
  - Reasonable efforts should be made to consult with populations with health disparities as well as those with access and functional needs. Input should be gathered on culturally appropriate planning and how to minimize the impact of health disparities, access barriers and functional needs in the context of crisis response.
- **Public Understanding and Communication**
  - Strong communication is critical to an ethically appropriate disaster response.
  - Information regarding a mass casualty incident and crisis response plans should be disseminated as widely as possible, in different languages, using a variety of approaches, materials, and venues for distribution of information.
  - Care should be taken to adequately inform the public without creating fear and to avoid dissemination of misinformation.

The fulfillment of the ethical commitments to transparency and accountability necessitate a strong focus on community engagement, open and honest communication, and the promotion of public understanding during both the CSC planning phase and crisis response. This begins with community engagement regarding CSC planning, including the ethical guidance presented here. MDH will work with private provider systems, nonprofits, and other stakeholders to accomplish this task of seeking input from lay community members, including members of populations with health disparities and those with access and functional needs. Since, as the IOM/NAM contends, “groups that are most at risk before a disaster are those most vulnerable

during a disaster”<sup>16</sup>, fairness demands that these groups be included in public engagement activities. In addition, community engagement activities will address questions about how to make plans culturally appropriate, as well as potential limits to cultural accommodation given demands of fairness across groups and the limits of what can be possible in the challenging context of disaster response. Community engagement activities have two goals: to gather input to assess the acceptability of the norms and standards proposed in CSC plans; and to ensure the guidance is clear and accessible to all Minnesotans.

The state will offer educational campaigns concerning crisis standards of care plans. Once plans have been developed, prior to a crisis, information about the plan will be publicized to promote transparency and public understanding. During a crisis, MDH has an obligation to be accessible and provide clear, consistent information about the incident and response. Communication should be culturally appropriate, offered in the diverse languages of populations in the state, and take into account functional challenges such as unequal access to the internet or other media or the need for interpreters. While dissemination of information should occur within communities, such as at neighborhood “hubs,” the media also merits special attention as it will play an important role in disclosure of information to the public.

#### DUTY TO CARE—OBLIGATIONS TO PATIENTS

- **Best care possible**
  - Fundamental norms of good care carry over from conventional care standards during a crisis situation. Patients should be provided the best care possible given available resources.
  - The plan for care should be based upon the CSC plan and explained to patients and their families throughout the process in which decisions concerning care are made.
  - Patients should not be abandoned.
- **Palliative and hospice care**
  - CSC planning should address how to meet palliative and hospice care needs during an incident, including:
    - Recommendations for stockpiling;
    - Distributing and securely storing palliative care resources;
    - Promulgating symptom management protocols and algorithms;
    - Developing caregiver educational programs for laypersons and clinicians;
    - Developing a process for ongoing community engagement and communication;
    - Planning for support of the dying and their caregivers.
- **Mental and behavioral health care**
  - CSC plans should address how to meet mental/behavioral health care needs during an pervasive or catastrophic public health event., including:
    - Identifying disaster mental health providers and means of access (local and national mechanisms)
    - Incorporating disaster mental health into crisis planning and response processes;

---

<sup>16</sup> Dan Hanfling et al., *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* (National Academies Press, 2012), p 1-72.

- Assuring triage protocols fairly triage patients suffering from both mental and somatic ailments;
- Creating a parallel triage protocol for those requiring mental health resources if rationing is required;
- Providers should minimize disruptions in continuity of care during disasters through planning for alternative treatment modalities, e.g., tele-psychiatry.
- **Appropriate care for the dead**
  - As part of community engagement during CSC planning, solicit public input regarding expectations for appropriate care for the dead during a pervasive or catastrophic public health event. Special efforts should focus on Minnesota’s major immigrant populations, tribal communities and faith communities.

Health professionals have a responsibility to provide care in crisis circumstances by virtue of their position, training, and professional norms.<sup>17, 18</sup> Disasters triggering CSC strategies and/or plans, by definition, involve “substantial change in the usual health care operations and the level of care it is possible to deliver....”<sup>19</sup> Nevertheless, providers have an ethical obligation to provide the best care possible under the circumstances. This includes not only preventive care (such as vaccines in influenza pandemic) and curative treatment, but also palliative care and mental/behavioral health care. Failing to plan to meet these very predictable needs constitutes abandonment of patients.

The demand for palliative care in crisis circumstances will be much higher than in conventional or contingency care. This means that both the state and private providers including hospital systems and physician practices should have adequate supplies of palliative care medications. This must be done with the recognition that stockpiling opioid or other types of painkillers poses risks in the current environment of prescription and other drug abuse and may have operational storage and management constraints. Safeguards must be taken when creating stockpiles. However, these drugs are relatively inexpensive, have a considerable shelf life, and will be critical to crisis response. A mechanism for distributing comfort care kits for home and alternative site use should also be considered. MPEP includes more detailed discussion of planning strategies concerning palliative care needs.<sup>20</sup>

Similarly, officials charged with CSC planning and preparedness have an obligation to plan to meet mental health needs of health professionals, patients directly affected by disaster-related injuries or illness, and other members of the public. As with palliative care, the need for mental/behavioral health care in crisis circumstances is greater than during conventional or contingent care. This need poses significant planning challenges, given that some communities routinely experience shortages of some mental/behavioral health resources, especially

---

<sup>17</sup> [IOM 2012](#), p 1-73.

<sup>18</sup> Prehn, A. W., & Vawter, D. E. (2008). Ethical guidance for rationing scarce health-related resources in a severe influenza pandemic: Literature and plan review: Minneapolis, MN: Minnesota Center for Health Care Ethics and University of Minnesota Center for Bioethics.

<sup>19</sup> IOM 2009, p 3.

<sup>20</sup> DeBruin, D. A., Marshall, M. F., Parilla, E., Liaschenko, J., Leider, J., Brunquell, D., . . . Vawter, D. E. (2010). Implementing ethical frameworks for rationing scarce health resources in minnesota during severe influenza pandemic. *Minneapolis, MN*, 121.

inpatient beds. Thus, careful planning is required to meet the duty to care in CSC. The 2012 IOM/NAM report suggests strategies for mental and behavioral health preparedness.<sup>21</sup>

Per Minnesota Statute, during declared disasters, the governor is permitted to take direct measures to ensure safe disposition of dead human bodies including “transportation, preparation, temporary mass burial, and other interment, disinterment, and cremation of dead human bodies.”<sup>22</sup> The statute states that the governor is encouraged to respect cultural customs, family wishes, religious rites, and pre-death directives to the extent possible in a disaster. The statute also outlines the process required for identification of bodies. The aftermath of Hurricane Katrina provides ample evidence of the strong moral and cultural importance of the respectful treatment of the dead, given intense community reaction when these norms were violated during that crisis by, for example, cremating remains without permission of next of kin. Given the potential for overwhelming circumstances during a pervasive or catastrophic public health event, community engagement on this issue during the planning phase is critical, especially with Minnesota’s major immigrant populations, tribes and religious communities.

### DUTY TO CARE—SUPPORT FOR HEALTH PROFESSIONALS

- **Ethically appropriate liability protections**
  - Should be drafted by legal advisors working in partnership with their ethics support team.
  - Providers who act in good faith to meet crisis standards of care must be protected, but even in the highly challenging context of a pervasive or catastrophic public health event, providers should not be fully immunized from liability. There must be safeguards and protections for patients as well as for providers (for example, review/appeals processes).
- **Reciprocity**
  - Fairness requires society to protect those who take on risk on behalf of the public, and such protections are indexed by the level of risk taken by the professionals.
  - CSC plans should include provisions for promoting safety of these professionals (e.g., appropriate personal protective equipment and training, as well as procedures for protection of staff when faced with threats such as active shooter attacks or flooding of facilities).
  - Providers’ duty to care for patients may be limited in situations that pose imminent danger to providers.
  - In some circumstances key workers should be prioritized for access to resources when illness or injury is related to provision of care in disaster or would result in maintaining their health and ability to serve.
  - Plans should also make provisions for mental/behavioral health care for professionals given the stress/trauma of working in disasters.
- **Mandates to provide service**

---

<sup>21</sup> IOM 2012, Ch4

<sup>22</sup> Minn. Stat. § 12.381 subd. 1

- Where possible, CSC plans should use incentives rather than mandates for health professionals to provide services during a pervasive or catastrophic public health event.
- Rather than relying upon state power to mandate provision of services, employers should create emergency plans with their employees prior to a disaster in order to best address issues such as absenteeism (e.g., due to illness or family obligations) and reasonable expectations about length of work shifts.
- **Process for triage/rationing decisions**
  - Separate triage/rationing decisions from bedside care by using a triage team to allow clinicians to advocate for their patients while still following CSC plans for triage/rationing.
  - It may be necessary to construct regional triage teams for greater Minnesota, depending on the nature of the disaster and given the strain on available staff.
  - Best practices should be used in a consistent manner – these may originate from MDH SAT/CSC team, national specialty societies, or agencies such as the Centers for Disease Control and Prevention (CDC).
- **Ethics support**
  - MDH will propose a system for ethics support at the state level, and require and facilitate development of ethics support mechanisms at local/regional levels as required. The primary functions of the ethics support process are to facilitate application of ethical frameworks for CSC and to help manage moral distress.
  - MDH CSC/SAT may:
    1. Provide prospective education to Local CSC ethics advisory groups regarding state and federal guidance concerning ethical frameworks, and
    2. Review of issues/challenges regarding the ethics framework.
  - Local CSC ethics advisory groups would provide support (during planning and response) when those attempting to resolve an ethical problem need prospective guidance in decision-making. The advisory group may assist with a retrospective review of policies and practices to ensure compliance with and consistency in the application of the ethical framework and to advise MDH on measures to alter or improve policies/practices.

Given that health professionals have a duty to care in crises, public health authorities and health care organizations have a corresponding duty to support those professionals in the discharge of their duty. This section of the framework outlines several strategies for supporting health professionals.

Discussions of CSC often note health professionals may be apprehensive about implementing CSC plans due to liability concerns. In MPEP, this discussion primarily focused on controversial interventions such as the removal of ventilator support from one patient to reallocate the ventilator to another in accordance with rationing protocols. However, concerns regarding liability go well beyond these particular procedures, and relate to “difficulties with providing care at alternative care sites, the challenges of asking personnel to perform duties outside their normal scope of practice when the system is overwhelmed, and the need to implement

interventions based on limited information as the crisis evolves.”<sup>23</sup> Thus it is critical that CSC plans include ethically appropriate liability protections for health professionals.

Furthermore, fairness requires society to protect those who take on risk on behalf of the public; this framework outlines strategies for meeting these duties of reciprocity. CSC plans should include provisions for promoting safety for health professionals, such as appropriate personal protective equipment and training. In addition, CSC plans should recognize that while the duty to care holds—even in the face of increased risk to the provider’s safety—limits do exist to the duty. Providers may take reasonable steps to protect themselves. In the face of life-threatening imminent harm such as an active shooter in their immediate work area (not just any part of the facility), providers may take reasonable steps to protect themselves (e.g., leaving patient to seek a safe environment). Generally, however, a duty to care means providers may not abandon patients under their direct care.

Health professionals have additional obligations that may conflict with their duty to care, including family obligations and—especially for volunteer professionals such as many EMS workers—other work duties. CSC plans should address these conflicting obligations.<sup>24</sup> While Minnesota law allows the governor or state director of emergency management (Minnesota Department of Public Safety, Division of Homeland Security and Emergency Management) to mandate that health professionals perform services for emergency management purposes,<sup>25</sup> implementing such mandates may be inadvisable. First, unless they are implemented in a context of additional support for health professionals’ conflicting obligations, such mandates may infringe upon the moral legitimacy of those conflicting obligations. Second, mandates may be enforced by withdrawal of the health professionals’ clinical privileges, but this enforcement mechanism may be counterproductive given strains on the health workforce in a crisis.<sup>26</sup>

When health professionals report for work in CSC, they encounter conditions characterized by a shift “in the balance of ethical concerns to emphasize the needs of the community rather than the needs of individuals.”<sup>27</sup> Some providers may perceive this shift to be a betrayal of their fundamental ethical obligations to their patients. To alleviate their moral distress, hospitals, health systems, or regions may establish triage teams, separating the bedside clinician from high-level allocation decision-making. This approach has the additional advantage of preserving the bedside clinician’s advocacy for their patients, thus protecting against abandonment concerns. However, the bedside clinician is expected to follow the directives of the triage team to fulfill duties to ethically steward scarce resources. Clinicians who believe they cannot practice in accordance with CSC may be transferred to support or non-clinical roles to ensure consistency of response. Local ethics advisory groups may provide invaluable guidance to facilitate communication and ethically appropriate decision making in resource allocation and patient care, and to alleviate providers’ moral distress. This ethics framework joins other guidance in recommending a time limited, simple process for real time reviews of decisions that

---

<sup>23</sup> [DeBruin et al 2010, 56](#)

<sup>24</sup> IOM 2012, p 1-73

<sup>25</sup> [Minnesota Statute §12.34 subdivision 1](#)

<sup>26</sup> [DeBruin et al 2010, 60](#)

<sup>27</sup> Dan Hanfling et al., *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* (National Academies Press, 2012)1-1



raise concerns for providers, performed by the Ethics Support Teams described in this attachment.<sup>28, 29</sup>

While CSC requires health care providers to provide the best care possible, this may be considerably different than achievable levels of care in non-crisis situations. For example, modifications to scope of practice, the use of triage protocols, and the potential for resource withdrawal for reallocation, all represent deviations from conventional practice. Ethics Support Teams should be established at the state and local level to facilitate application of the ethical frameworks for CSC in challenging circumstances and to help manage health professionals' moral distress. Such an Ethics Support process is critical for public health authorities and health professionals to respond to a broad range of evolving ethics issues that will inevitably arise in crises. MPEP offers detailed recommendations about how to implement Ethics Support processes.<sup>30</sup>

## PROPORTIONALITY AND EQUITY IN LIBERTY-LIMITING INTERVENTIONS

- **Social distancing techniques**
  - May be justified when public health interests of society outweigh the burdens and harms brought to affected individuals or groups. Evaluation of burdens must consider the impact of these techniques on non-health aspects of well-being, including economic and financial, of those impacted.
  - Decisions to implement restrictive interventions must be evidence-based, and should be made using a fair, transparent process of consultation with public health leaders and an Ethics Support Team to avoid the influence of political agendas.
- **Proportionality**
  - Requires the use of the least restrictive interventions possible to achieve the outcome of interest.
  - Appropriate limits may become unfair as the context changes (e.g., further resources arrive or demand decreases).
  - Response plans should be flexible and able to adapt to the situation.
- **Equity**
  - Liberty-limiting interventions should not disproportionately impact populations with health disparities as well as those with access and functional needs.

Proportionality fundamentally concerns the balance of benefits and burdens. While benefits in the context of disaster response tend to be straightforward, typically related to health, safety, or continued societal functioning, burdens may be harder to fully identify. For example, isolation, quarantine, and other social distancing techniques are critical in many disaster responses; their use is legally protected in state and federal law. However, such techniques may adversely impact the population in significant ways. Closing schools affects families given

<sup>28</sup> James C Thomas et al., "A Code of Ethics for Public Health," *American Journal of Public Health* 92, no. 7 (2002).

<sup>29</sup> Hick, J.L., L. Rubinson, D.T. O'Laughlin, and J. C. Farmer. 2007. Clinical review: Allocating ventilators during large-scale disasters—problems, planning, and process. *Crit Care* 11(3):217.

<sup>30</sup> DeBruin et al., "Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic." (2010). p. 93-108

challenges arranging appropriate child care and may disproportionately impact families who rely on school meals programs for nutritional support for children. Closure of public spaces adversely affects business and may disproportionately impact low-wage workers. Isolation and quarantine may have serious personal and economic consequences for individuals, and may also have disproportionate impact on low-wage workers who may risk job loss and who have few if any resources to help cushion the economic blow they experience. Closure of public transport inconveniences some but disproportionately impacts those who have no other means of travel or getting to work. Beyond the risks to social or economic well-being, individual liberties—such as the freedoms of movement and association—are important goods in and of themselves. As such, they should be impinged upon only when necessary, and to the smallest extent possible that allows for effective and efficient disaster response.

A commitment to equity requires special attention to socially vulnerable groups to ensure liberty-limiting interventions do not disproportionately impact them. Moreover, decisions to implement restrictive interventions must be evidence-based, and should be made using a fair, transparent process of consultation with public health leaders, MDH’s Science Advisory Team for CSC (SAT/CSC) to avoid the influence of political agendas, and promote trustworthiness and accountability.

## HEALTH DISPARITIES, BARRIERS TO ACCESS AND FUNCTIONAL NEEDS

- **Health disparities, barriers to access and functional needs**
  - CSC plans at all levels should focus on alleviating health disparities, reducing access barriers, and meeting functional needs.
- **Partnerships to promote equity**
  - Planning regarding these issues should be conducted in partnerships across systems to best inform and implement relevant interventions.
- **Public engagement**
  - Activities should address challenges regarding health disparities, access barriers and functional needs.
- **Distribution of resources**
  - Efforts should be made to provide free or low cost services to those with greatest financial need.
  - Distribution of resources should ensure those at highest priority—including health disparities populations—have best access to resources.
- **Tribes**
  - MDH will engage tribes as equal partners in CSC planning and response.
  - If requested, MDH will aid tribes during emergencies and disasters.
- **Immigrants**
  - Immigration authorities should not be present or involved in the allocation of resources during a pervasive or catastrophic public health event, and CSC protocols should not be crafted to allow only legal residents of the state of Minnesota access to scarce resources in the state.
- **Consultation with the state and/or local CSC ethics support teams may be sought to support planning and response on issues of equity.**

Within the United States, Minnesota has one of the lowest percentage of people living below the poverty level<sup>31</sup> and ranks among the healthiest of states.<sup>32</sup> However, “Minnesota has some of the greatest health disparities in the country between whites and people of color and American Indians.”<sup>33</sup> Since people of color and lower income populations are often most vulnerable during disasters<sup>34</sup> Minnesota should aggressively plan to address health disparities and access barriers in a CSC situation.

Health equity means achieving conditions in which all people have the opportunity to attain their highest possible level of health, without limits imposed by structural inequities. No ethical framework for public health preparedness can, on its own, redress existing health disparities or inequities of access to health care for the people in Minnesota.<sup>35,36</sup> Rather, this ethics framework requires that CSC plans “reduce significant group differences in mortality and serious morbidity” and to “make reasonable efforts to remove barriers to fair access and address functional needs.” These objectives promote MDH’s mission to protect, maintain, and improve the health of all Minnesotans. They also honor the key commitments espoused by the IOM/NAM and the Bellagio Statement of Principles which emphasize health equity in public health emergency preparedness.<sup>37, 38</sup> This section of the CSC ethics framework offers strategies for achieving these objectives.

The objective relating to significant group differences in mortality and serious morbidity addresses health disparities. Substantial evidence documents these inequities in health status related to race, ethnicity, socioeconomic status and other characteristics associated with social disadvantage. A complex combination of factors—referred to as social determinants of health—influence health disparities, including experiences of discrimination or social exclusion, lack of convenient access to healthy foods, lack of safe options for exercise and recreation, unsafe housing conditions, and many others. Disparities cannot simply be attributed to barriers in access to care or functional needs. Consider the example of influenza pandemics. Members of socially disadvantaged groups tend to be less able to protect themselves from exposure to illness (e.g., they may lack resources that would allow them to avoid public transportation, or the employment flexibility to allow telecommuting to work, and thus be unable to adopt recommended social distancing strategies). Socially disadvantaged groups also tend to be more vulnerable to illness given their higher rates of co-morbid chronic conditions that increase influenza risks. In addition, those who are socially disadvantaged may have poorer access to

---

<sup>31</sup> World Atlas. [US Poverty Level By State.](#)

<sup>32</sup> Minnesota Department of Health Report to the Minnesota Legislature 2016. (January 15, 2016). Retrieved from [Eliminating Health Disparities Initiative.](#)

<sup>33</sup> Minnesota Department of Health Report to the Minnesota Legislature 2016. (January 15, 2016). Retrieved from [Eliminating Health Disparities Initiative.](#)

<sup>34</sup> IOM 2012, 1-72

<sup>35</sup> Vawter et al., “*For the Good of Us All: Ethically Rationing Health Resources in Minnesota in a Severe Influenza Pandemic*”, (2010).

<sup>36</sup> DeBruin et al., “*Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic.*” (2010).

<sup>37</sup> Dan Hanfling et al., *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* (National Academies Press, 2012)

<sup>38</sup> [Bellagio Group 2006, The Bellagio Meeting on social Justice and Influenza.](#)

care.<sup>39,40</sup> Disparities in morbidity and mortality during public health crises are thus more generally linked to other health disparities and social inequalities.<sup>41</sup>

Partnerships between MDH, the State Community Health Services Advisory Committee, regional coordinators, tribal health departments and local health departments (LHDs) throughout the state should attend specifically to health disparities, access barriers and functional needs. These partnerships will be critical to the promotion of equity given the special expertise of each of the partners. Equity will be further promoted through collaboration between LHDs and social service agencies, home care providers, community health centers, community organizations, faith-based communities that serve low income people and other populations with health disparities as well as those with access and functional needs. These organizations are vital as they are well-positioned to know what multiple casualty incident response strategies will be useful to their constituents and to bear witness to their needs. Regional health care disaster response plans (including homecare, outpatient, and inpatient care) should also attend specifically to efforts to alleviate health disparities, reduce access barriers and address functional needs. Working toward strong, collaborative relationships between these entities will facilitate patient care. All facilities and agencies should be open to accepting patients who typically confront access barriers that can block or delay care. Further, implementation of alternate strategies for care must consider access issues for those with disabilities, limited English language skills and other groups with functional needs. Public engagement efforts of the CSC Framework should also specifically address equity concerns. MPEP's public engagement process asked participants to identify barriers to access in their communities and suggest strategies to reduce these barriers. These discussions yielded significant input to recommendations regarding equity. Participants offered suggestions about culturally appropriate educational campaigns and how they might be structured to address functional needs, ways to address barriers in access to care, and strategies to improve trust in public health response initiatives, among others.<sup>42</sup>

To promote access to resources for those at highest priority, including health disparities populations, distribution of resources throughout the state should follow the geographic distribution of target groups. That is, more resources should be sent to communities with greater numbers of prioritized recipients, so that those at highest priority have best access to the resources. In contrast, if resources are shipped throughout the state in amounts proportional to area population as opposed to population in need, priority groups may not be reached efficiently. To further promote equitable distribution of resources, CSC plans should strive to make free or low cost resources available to those who face financial barriers to access. For example, resources from the Strategic National Stockpile could be provided at no or

---

<sup>39</sup> Blumenshine, Philip, Arthur Reingold, Susan Egerter, Robin Mockenhaupt, Paula Braveman, and James Marks. "Pandemic influenza planning in the United States from a health disparities perspective." *Emerg Infect Dis* 14, no. 5 (2008).

<sup>40</sup> Quinn, Sandra Crouse, Supriya Kumar, Vicki S. Freimuth, Donald Musa, Nestor Casteneda-Angarita, and Kelley Kidwell. "Racial disparities in exposure, susceptibility, and access to health care in the US H1N1 influenza pandemic." *American journal of public health* 101, no. 2 (2011): 285-293.

<sup>41</sup> DeBruin et al., "Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic." (2010).

<sup>42</sup> DeBruin et al., "Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic." (2010). p. 43-45

low cost to those with greatest financial need, while individuals with insurance coverage or other ability to pay could access resources through private providers.

It should also be noted that significant urban-rural disparities exist between the twin cities and greater Minnesota. While most of the state's population and hospital facilities reside in the Twin Cities metro area (as well as outlying areas in the seven-county metro area), over two million Minnesotans live and work outside the metro area. As such, facilities in these areas are critical to state-level disaster response and implementation of CSC. However, some facilities have relatively few health care providers, and some lack critical care resources. This significantly complicates disaster response under CSC, as transporting patients in need of critical care may become a limiting factor during response.

One important consequence of the ethical commitments outlined in this Attachment is that all Minnesotans, regardless of geography, have equal claim to resources if triage protocols prioritize them equally. This means someone in rural Minnesota would have as much claim to a ventilator as someone living in the twin cities if they are triaged to an equally priority. Allocation decisions would include resource considerations involved in the transport of the rural individual. Beyond infrastructure issues, some facilities in rural Minnesota may not have the necessary expertise to fully provide all needed services in a disaster response. MDH will work with private providers, through regional coalition partnerships, to maximize preparedness across urban-rural boundaries.

There are seven Anishinaabe reservations and four Dakota communities within the state of Minnesota. Tribal governments and lands are recognized as sovereign entities and thus warrant particular attention in CSC planning. Disasters do not recognize political boundaries. Moreover, Native American populations are affected by health disparities and so may be severely impacted by disasters. As part of disaster planning and response, the state should continue to engage tribes as equal partners to protect the health of all Minnesotans. The state must include tribal populations in risk analyses and resource allocation plans while recognizing and respecting the authority of tribal governments to decide how they will respond to disasters. Tribes control their own resources. When tribal members access care outside of tribal facilities – e.g., at MDH vaccine clinics or private providers following MDH's CSC plan – they should receive equal consideration for access to resources on this plan's triage protocols as non-tribal members do. If a tribal government chooses not to engage state or local government in disaster planning, the state should nevertheless plan to offer aid during a disaster.

Immigrants must also be included in CSC planning and response. This CSC ethics framework echoes MPEP guidance that response protocols should not be crafted only to allow legal residents of the state of Minnesota access to scarce resources. First, in infectious disease outbreaks, withholding preventive or treatment resources from certain groups like immigrants can impede efforts to slow or reduce rates of infection. Second, all life has value and all rights must be respected, regardless of residency or citizenship. Third, any plan that recommends or requires verification of citizenship status to determine who is eligible to receive resources may result in denial of treatment for citizens who lack, or simply do not have handy, requisite forms of identification. Finally, those without proper identification may disproportionately be members of socially disadvantaged groups such as individuals with physical or psychological disabilities, thus compounding the unfairness of withholding resources on this basis. Further,

immigration officials ought not be present during crisis response.<sup>43</sup> Experience from response efforts to the Flint, MI water contamination crisis validates the concerns here:

*The sight of uniformed state troopers and National Guardsmen entering neighborhoods in convoys with flashing lights frightened many who did not open their doors to accept filter or water distributions. Initial requirements for identification scared many families away from distribution sites.<sup>44</sup>*

Requirements for identification or involvement of law enforcement personnel can impede the effectiveness of response interventions for groups that are particularly socially vulnerable.

## FAIRLY AND CONSISTENTLY STEWARDING RESOURCES

- **Coordination**
  - Equitably distributing of resources across jurisdictions is required to assure consistency of care and equity of access. Therefore, coordination of response activities and sharing of impact/demand data is critical to a successful response. Regional coordinators, health care coalitions (HCCs) and emergency management have critical obligations to ensure the ability to share information and manage resources to allow this balancing to occur.
- **General considerations for rationing/triage**
  - Extend supplies and conserve resources before implementing triage or rationing; use triage and ration as a last resort.
  - Expand providers' scope of practice to provide the best care possible in context of the need associated with the mass casualty event.
  - Scale rationing strategies to different levels of scarcity.
  - Generally, de-prioritize people who are unlikely to benefit from the resource.
- **Processes to promote accountability**
  - Triage/rationing decisions should be reviewed and revised as needed, consistent with this ethics framework.
- **Data**
  - Care must be taken in gathering data that reflects risk across populations in the state, since the State of Minnesota can implement recommendations regarding health disparities only to the extent that it works taking into account these risks.
- **Health records as a basis for decision-making**
  - Patients' self-reports about their health should be accepted as guiding triage/allocation decisions where possible.
- **Key workers**
  - When threats to societal functioning or disaster response are present, prioritize key workers who become ill or injured working in disaster response on either a separate track or in parallel with a track for the general public, recognizing that in some circumstances a two-track approach might not be justified.

<sup>43</sup> DeBruin et al., "Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic." (2010). P. 49-50

<sup>44</sup> Force, Flint Water Advisory Task. "Flint water advisory task force final report." *Lansing, Michigan* (2016). p. 56

- Two reasons to potentially justify prioritizing key workers:
  - Fairness requires that society protect those who take on risk to protect the public; this obligation is referred to as reciprocity.
  - If societal functioning is at risk in a crisis, it may be appropriate to create a separate priority track for key workers to maintain societal functioning. This priority is justified to support professionals' ability to provide services during the pervasive or catastrophic public health event, or that the key worker would be able to return to work and continue to provide key services during the event.
  - Ethics Support Teams should work with incident command to determine when and to what extent considerations regarding societal functioning and/or reciprocity justify prioritizing key workers for access to resources, especially given that prioritizing them may affect the general public's fair access to resources. Decisions should consider the professionals' level of risk, the importance of their services, and their ability to benefit from the resources in question.
  - The decision about which workers to identify as key is an event-dependent one, and should consider the role of volunteers.
  - The two-track approach must reflect a commitment to strive for balance between prioritizing key workers and prioritizing those groups in the general public who are at greatest risk for morbidity and mortality.
- **Rationing**
  - Do not ration based on:
    - Race, gender, religion or citizenship;
    - Age as a criterion in and of itself (this does not limit consideration of a patient's age in clinical prognostication);
    - Ability to pay;
    - First-come, first-served;
    - Judgments that some people have greater quality of life than others;
    - Predictions about baseline life expectancy (i.e. life expectancy if the patient were not facing the pervasive or catastrophic public health event related health crisis), unless the patient is imminently and irreversibly dying, because rationing based on such baseline predictions would exacerbate health disparities;
    - Judgments that some people have greater "social value" than others.
  - Ration resources based on the following:
    - Risk of mortality and serious morbidity;
    - Likelihood of good or acceptable response to resource;
    - Risk of transmitting infection;
    - Irreplaceability of key workers.
  - When the supply is inadequate to serve all similarly prioritized people then use a random process to allocate materials.

CSC becomes necessary in crisis situations involving scarcity of resources; thus, guidance about stewardship of scarce resources is central to an ethical framework for CSC. While rationing and triage are inevitable features of CSC, efforts should be made to extend supplies and conserve resources before implementing triage or rationing. While Minnesota law permits the state to commandeer resources from private organizations to support public health emergency

response,<sup>45</sup> previous guidance notes this possibility creates perverse incentives for private organizations to refuse to stockpile resources, given the risk that they will be commandeered. Thus, it may best promote preparedness for the state to reassure private partners that it prefers to avoid commandeering of resources.<sup>46</sup> There are, of course, other ways to extend supplies or capacity to respond in a crisis. In a disaster of relatively local impact, supplies or personnel may be transported from unaffected jurisdictions. Some medications may be safe and effective beyond their recommended shelf life, or it may be possible to reuse N95 respirators. Expanding scope of practice for personnel may ease staffing pressures.

Once plans for rationing or triage are implemented, resources must be balanced across jurisdictions to ensure consistency of care and equity of access. Public health authorities should pay explicit attention to the types of data that will be required to reflect risk across populations in the state and thus guide rationing decisions. Certain sources of data may fail to adequately reflect the burden of disease in populations with health disparities as well as those with access and functional needs. For example, data gathered from hospitalizations or on personal health care records may not capture rates of morbidity and mortality in populations lacking good access to care. When treating individual patients, providers should accept patient self-reports about health status and co-morbid conditions. In crisis circumstances, health records may not be readily available, and delays in seeking information will only hamper response capacities.

Perhaps most importantly, processes should be implemented to routinely review and revise triage/rationing decisions and processes. This is true at the level of individual patients and the systems level. For individual patients, there may be changes in their status that would alter initial triage/rationing decisions. Individuals who initially were deprioritized for access to resources may become prioritized. Individuals who were granted access to resources—for example, a trial on a mechanical ventilator—may not be responding well to that resource, and if it is needed by others, it may be withdrawn and reallocated to someone at higher priority. At a systems level—e.g., a health care organization—decisions about allocation of resources should be monitored to ensure that they are made in as principled and effective way as possible, and changes made as needed. Ethics Support Teams may provide helpful guidance for institutional or systems-level reviews of triage/rationing decision-making.

The framework's strategies also endorse specific decision-making criteria for triage/rationing. These include a number of considerations that ought not to be taken into account—ability to pay, first-come first served, judgments about quality of life, predictions about extending life, race, gender, religion, citizenship, judgments about social value, amount of resources to be allocated to patient, or the duration of resource use per patient. These considerations introduce systematic unfairness into triage/rationing decisions.<sup>47</sup>

The framework also advises against using age as a criterion for triage/rationing. This recommendation does not prohibit using age as a factor in clinical assessment of risk or prognosis for particular individuals or groups of individuals. For example, evidence may indicate certain antibiotics are not safe and effective in infants, or that morbidity and mortality risks for

---

<sup>45</sup> [Minnesota Statute §12.34 subdivision 1](#)

<sup>46</sup> DeBruin et al 2010, 62-63

<sup>47</sup> [Vawter et al 2010, 19](#)



influenza are especially high for the elderly. It is morally appropriate for allocation decisions to take into account information about health risks and prognoses faced by members of certain age groups. These are clinically based decisions, not age based decisions. The guidance in this framework relates specifically to age as a criterion for rationing distinct from its correlation to health considerations such as risk and prognosis.

Is there a special obligation to provide first for children when not all can be given resources? Should younger adults be prioritized over older adults, on the grounds the latter have already had more of an opportunity to live a fuller life? This framework recommends against the use of age based rationing for two reasons. First, the IOM/NAM recommends that age be used to guide triage/rationing decisions only if its use clearly reflects community values.<sup>48</sup> MPEP's community engagement activities demonstrated lack of consensus about how age should factor into decision-making.<sup>49</sup> Second, age based rationing raises implementation issues concerning the possible violation of age discrimination law.<sup>50</sup> For example, the Federal Age Discrimination Act of 1975 prohibits age discrimination in programs or activities that receive financial assistance from the federal government. Given the federal support involved in the Strategic National Stockpile program, the Age Discrimination Act may apply to state guidelines for rationing resources during a pandemic or other pervasive or catastrophic public health event when federal resources are used. Medicare and Medicaid providers must also comply with the Age Discrimination Act.<sup>51</sup>

Moreover, it does not appear that the governor can set aside the protections of the Age Discrimination Act under state emergency powers. The IOM/NAM also notes that: "Some liability protections will not apply – even during emergencies – to acts of discrimination. Specific limitations on liability or indemnity protections focused on willful or wanton misconduct should be interpreted to include unlawful acts of discrimination."<sup>52</sup> Thus, given difficulties in crafting triage/rationing protocols using age in a way that genuinely reflects community values, and concerns about the violation of age discrimination laws if such protocols were implemented, this CSC ethics framework recommends against age based triage/rationing.

The framework recommends prioritizing key workers for access to certain resources in at least some circumstances. Doing so does not depend upon a judgment—prohibited by this framework—that such individuals have more social value than other individuals. Rather, the permissibility of prioritizing them flows from their role in preserving vital infrastructures that serve to benefit and protect the public's health and safety, and from fairness considerations given these personnel are placed at risk because of their work to protect the public. When it is justifiable to prioritize key workers for access to resources, they should be assessed for triage/rationing on a separate track from the general public. Ethics Support Teams should work

---

<sup>48</sup> [IOM 2012, 1-77](#)

<sup>49</sup> Dorothy E. Vawter, J. Eline Garrett, Karen G. Gervais, Angela Witt Prehn, Debra A. DeBruin, Carol A. Tauer, Elizabeth Parilla, Joan Liaschenko and Mary Faith Marshall. For the Good of Us All: Ethically Rationing Health Resources in Minnesota in a Severe Influenza Pandemic 2010. Available at [Minnesota Pandemic Ethics Project Report](#).

<sup>50</sup> DeBruin 2010, 72-76

<sup>51</sup> 29 U.S.C. §§ 621-634

<sup>52</sup> [IOM 2012, p. 51](#)

with incident command to determine when key workers should receive prioritized access in this way, given the realities of a particular crisis. Which workers should be seen as “key” should also be an event dependent decision.

## Conclusion

This Attachment presents a foundational ethical framework for CSC planning and response. Should a significant disaster occur that overwhelms public health and health care systems, the analysis herein would help guide an ethically appropriate response. However, as clinicians and scholars have noted, there are circumstances every day across the US where rationing occurs, where there is not enough of a particular resource to attend to all the patients needing it. In these circumstances, contingency standards of care will be attempted first, but sometimes crisis principles must be the de facto means of operation due to the levels of scarcity. The reality may be that even supply shortages or small disasters could necessitate application of these principles. For example, if there are insufficient ambulances to transport patients after a large traffic incident, triage must occur. It is our hope that the framework and supporting analysis in this attachment may ground lessons for all applications of resource triage and not just in mid- or large-scale disasters.