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## Standard Racism: Trying to Use “Crisis Standards of Care” in the COVID-19 Pandemic

George J. Annas and Sondra S. Crosby

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Lowering the standard of care in a pandemic is a recipe for inferior care and discrimination. Wealthy white patients will continue to get “standard of care” medicine, while the poor and racial minorities (especially black and brown people) will get what is openly described as substandard care rationalized by the assertion that substandard care is all that we can deliver to them in a crisis. (IOM 2009) Paul Farmer’s experience in responding to the Ebola outbreak in West Africa is a shocking, if extreme, example of how dangerous to patients this practice is. White patients were treated with the US standard of care, including transfer to the US for treatment, black (local) patients were often given little no medical care at all (on the premise that it was too dangerous for caregivers to touch them or to place IVs to hydrate them). The standard of care for the local population, in Farmer’s words, “in many cases didn’t resemble care at all.” (Farmer 2020) As COVID-19 has taught us, structural racism in healthcare is not just a problem in West Africa, and does not just manifest itself in a pandemic.



Modifying the standard of care downward in a pandemic is unnecessary and dangerous to patients (Schultz and Annas 2012). Since shortages are much more likely to affect safety net hospitals that serve poor and minority communities, lowered standards of care are also most likely to be applied to these hospitals (e.g., as witnessed in Queens and Los Angeles) and primarily adversely affect minority patients (Fink 2021; Rosenthal et al 2020). In this way, lowering care standards in a pandemic can dramatically expose structural racism in the US. (Maxmen 2021; Manchanda et al. 2020a, 2020b) Because it is exceedingly unlikely that minority communities would voluntarily consent to second class treatment, even in a pandemic, a core element of the “crisis standard of

care” (CSC) mantra is eliminating or curtailing informed consent, including sidelining advance directives, health care agents, palliative care, and even visitor access to hospitalized patients, and replacing conversation with Sequential Organ Failure Assessment (SOFA) scores and triage teams (Annas 2020).

### INFORMED CONSENT DURING A PANDEMIC

Thankfully the National Academy of Medicine (NAM) has issued two news reports on “crisis standards of care” which seek to return informed consent to its central place in the doctor-patient relationship, and eliminate use of SOFA scores and “triage teams.” (NAM, 2020a, 2021) The most important overall point the NAM makes is that a crisis does not change constitutional or human rights law that protect all patients, and does not legally empower physicians and nurses to take harmful actions against the will of their patients (such as removing a ventilator), regardless of the patient’s race, religion, disabilities, sexual orientation, or any other categorical characteristic. Discrimination by lowering the standard of care or “waiving” informed consent is not ethically justified by equipment or staff shortages.

The December 2020 NAM news release stressed that resource allocation decisions be “based on *individualized assessment of each patient*” and that such assessment “should NOT use *categorical exclusions criteria*” (emphasis in original) (NAM 2020a). An earlier report from the Assistant Secretary for Preparedness and Response had stressed that while some states had relied SOFA scores to make treatment decisions, the published literature provides no support for this, and use of SOFA scores “is not ethically justified” (ASPR 2020). The NAM also called for engaging “families and palliative care departments in

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end of life discussions [and ensuring] that end-of-life wishes are documented” (NAM 2020a).

The May 2021 NAM news release clarified even further the rights of patients during a crisis. The NAM recommended, “Employing a standardized assessment of the goals of care with the patient and family at the time of hospitalization,” and reconsidering it “when the patient’s condition changes;” and “Encouraging best practices of palliative care ... to enhance the comfort of all patients and ensure that care is consistent with the patient’s wishes.” The NAM also called for the elimination of the “triage teams” that were to make resource rationing decisions involving individual patients (because they are arbitrary and not supported by data) and replacement of them with physician-family-patient discussions. Instead of a triage team, the NAM helpfully suggested providing physicians with access to an “expert” consultant instead (NAM 2021).

## PLANNING FOR THE NEXT PANDEMIC

While we applaud the NAM for putting the patient back at the center of pandemic caregiving by eliminating reliance on SOFA scores and “triage teams,” other major problems with the CSC framework remain. The first is, as noted by Paul Farmer, its implicit support of systemic racism at the community level. This is because only racial minorities are likely to be the victims of a lower standard of care. Of course, this problem is exacerbated by the label “crisis standards of care” itself, which is the second problem. CSC is based on the false premise that the medical standard of care actually changes in a crisis (Annas 2010). It does not, as the American Bar Association has previously and authoritatively concluded (ABA 2011). The medical duty of care (aka standard of care) is always “what would a reasonably prudent qualified physician [nurse, technician, etc.] do in the same or similar situation (taking into account the resources available to treat the patient).” For example when a flight attendant asks, “is there a physician on board?” and a physician responds to care for a sick passenger, the “standard of care” for the physician is (and remains in the emergency) what would a reasonably prudent [fill in the specialty of the physician] do in the same or similar circumstances, given the medical equipment available on the plane? There is not a separate standard of care for physicians flying on planes.

Given its incoherence it is somewhat surprising that the term “crisis standards of care” survives. Fink has argued that we could be better off without problematic triage protocols (Fink 2020). That’s primarily

because of the needless confusion they foster, and the lack of evidence of their value to patients. In the proceedings of a 2020 NAM workshop, “the question of terminology was brought up multiple times” with one participant arguing that “people are fundamentally uncomfortable with the term ‘crisis standards of care.’” The moderator responded that “stakeholders” had discussed changing the term, but decided that they would “instead focus more on concepts and elements instead of the term itself” (NAM 2020b). This explanation is not persuasive, and the entire preparedness field would likely be better able to communicate with each other if CSC was simply relabeled as “treatment guidelines in a crisis.”

A third major problem is jurisdictional: who is in charge of fairly distributing medical resources when there is a shortage? We think the answer must be the federal government, and that the federal government’s failure to properly plan for the pandemic, including its failure to stock the national stockpile, was a disgrace that should never be repeated. The pandemic has taught us that while some decisions can be made on the state level, virtually all important planning decisions (including, of course, vaccine development and distribution) are federal. Instead of adopting a uniform national standard, as originally recommended by the IOM (IOM 2009) or even having individual hospitals or individual states make the determination, the NAM, adding to the confusion, adopts an “all of the above” approach in its December 2020 news release, calling on “governors, health departments, hospitals, and other health care sector partners” to make the decision of when to lower the standard of care. Of course, when everyone is in charge, no one is. There was no plan, only a plan to make a plan (Lewis 2021).

Even in a crisis, basic legal and ethical rules apply (the way human rights law continues to apply in wartime): patients cannot be legally or ethically treated without their consent (if they are capable of giving it), or the consent of their next of kin or health care agent (if the patient is incapable of giving it). There are some rare emergencies where the patient is unconscious and no surrogate is available when the rule changes to: in an emergency, treat first and ask legal questions later. That is accepted as good medicine and good law. It also means that we should do whatever we can to encourage all potential patients (that includes all of us) to designate a trusted friend or relative to be our “health care agent,” with the authority to make healthcare decisions for us when we are not able to make them ourselves. This could even be seen as an ethical responsibility in the time of pandemic.

The pandemic is also an opportunity. First, it is an opportunity to take the health and welfare of black and brown people much more seriously. Of course, all patients should be treated equally. The lesson exposed by the pandemic is broader. It is that health equity requires a recognition that a person's health will be determined as much (if not more) by their race, income level, address, and education than by anything physicians and hospitals can do for them, even (or especially) during a pandemic. Attempts to lower the standard of care for treatment and eliminate informed consent in triage proposals did not create the racial inequities in our healthcare "system," but these proposals did seek to exploit them.

## DISCLOSURE STATEMENT

No potential conflict of interest was reported by the author(s).

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