

# Louisiana Doctors Drafting Guidelines on Access to Critical Care During a Disaster

by [Sheri Fink](#), ProPublica - December 27, 2009 11:00 am EDT



Developing plans on how to allocate depleted health care resources was prompted in part by Hurricane Katrina. (Nicholas Kamm/AFP/Getty Images file photo/Sept. 5, 2005, New Orleans)

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Louisiana health professionals are developing guidelines that specify which patients would get access to lifesaving treatments – and which wouldn't – during a severe pandemic, bioterrorist attack or natural disaster that overwhelms the medical system.

Around two dozen hospital leaders, health professionals and ethicists in Baton Rouge began crafting the guidelines last summer after the emergence of the H1N1 flu, also known as the swine flu. In November, the state's Department of Health and Hospitals sent an early draft to representatives in Louisiana's nine public health regions asking them to reach out to hospitals and the medical community for feedback.

The draft identifies several categories of patients – including those with incurable metastatic cancer with less than six months life expectancy and those with a very low predicted survival from extensive burns – who would not be admitted to hospitals when beds and ventilators are no longer available. Instead, the draft guidelines call for patients in these categories to be offered care for pain and discomfort at home or in other facilities.

The draft also calls for doctors to take off life support patients thought to have a higher risk of dying to make way for others with a better prognosis if there are not enough intensive care resources to go around. Those patients would also receive care for their pain.

“It’s an exceedingly ugly topic altogether,” said Dr. Stephen Brierre, an intensive care unit physician with Louisiana State University Health Sciences Center who was chairman of the group developing the guidelines.

Normally, Brierre works to save the lives of each of his critically ill patients. However, he believes a different standard, a “crisis standard,” would apply to dire situations in which there are shortages of doctors, nurses, medicines, supplies and life support machines. That has not occurred in the United States during the first two waves of H1N1 flu, but federal officials have said it could occur during a future pandemic or other crisis.

Brierre said the goal of the current draft guidelines is to direct scarce resources to patients who doctors believe have a higher probability of short-to-medium term survival. But he said experts are struggling with how to predict survival and how depleted resources would have to be before the measures would become “morally acceptable.” Similar conversations are unfolding across the country at the urging of the U.S. Department of Health and Human Services.

Utah’s triage guidelines for pandemic influenza would bar the elderly from hospital admission during a severe pandemic. Minnesota has recommended conservation and substitution strategies to stretch supplies of oxygen, medicines, intravenous fluids, ventilators and staffing and provide them to more patients. Maryland planners are developing a system to score patients on several criteria and set flexible cut-off points for hospital admission depending on the resources at hand.

Such planning was prompted in part by Hurricane Katrina. Then, medical evacuation helicopters were in short supply, and doctors struggled with how to prioritize patients. Some died, and lawsuits followed.

Louisiana later passed three laws aimed at protecting health workers from prosecution for acting “in accordance with disaster medicine protocol.” However, the state, like many others, has not defined what that protocol should be.



Alan Levine, secretary of Louisiana Department of Health and Hospitals (Eliot Kamenitz/The Times-Picayune)

### **Planning ahead**

The secretary of the Louisiana Department of Health and Hospitals, Alan Levine, says such planning is necessary. “The time to have the discussion is not when the wheels are coming off,” he said. “The goal is to try to figure out a methodical way that kind of helps physicians with how do we prioritize, so you don’t have every provider doing it differently.”

Levine said the health department’s role is to act as a “conduit,” coordinating efforts to develop a plan. After feedback is received in the coming weeks, the current draft will be revised. Ultimately, once a version is deemed acceptable by the state, it will be offered as a community standard and a resource to health-care providers. “We’ll want to have hospitals and medical staffs review it and decide for themselves if they want to adopt it,” Levine said.

He added that responding effectively to a crisis requires improvisation, and doctors will do what they think is right for their patients. “I don’t know that there is any one group of standards that can be imposed successfully,” he said.

While health departments have a wide latitude to enforce public health measures during a crisis, Levine does not envision making crisis standards of care mandatory on doctors and hospitals. “We would have to be in the absolute worst case scenario, total chaos, total meltdown before the state would step in and say here’s what you have to do. I say never, I don’t anticipate us doing that, but who can predict what will happen?” he said.

Levine said it will be important to give the wider community in Louisiana a chance to weigh in on a later version of the plan. “They need to know if we have a worst case scenario, there’s a chance we might not have enough resources,” he said. “I do anticipate we will have a public comment on it.”

### **Public perception**

The general public and health professionals might have different opinions about whose care should be prioritized when resources are scarce. That was true in a rare public engagement exercise on rationing care in a flu pandemic held in Seattle and King County in Washington. Many participants rejected a major feature of the guidelines – disconnecting life support – finding it “unacceptable if the individual’s life was at stake,” according to a report of the exercise, which was paid for by the Centers for Disease Control and Prevention.

Members of the public were also concerned that using survival statistics to determine access to resources might be “inherently discriminatory,” the project report said, “because of institutional racism in the health care system; if some groups (e.g., African-Americans and immigrants) do not receive the same quality of care, then their rates of recovery and other survivability measures would be biased.”

Roger Bernier, a senior advisor at the CDC, said it is both possible and necessary to engage the wider community of nonexperts in these discussions. “They are the holders of our public values and are in the best position and in the most nonpartisan position to weigh competing values and make tradeoffs.”

But the conversation won't be easy, said Knox Andress, an emergency preparedness director at Louisiana State University in Shreveport who worked nationally on the development of crisis standards. Most such plans call for a committee to decide, using guidelines and medical expertise, which patients get lifesaving care and which do not. "Gee that sounds like a 'death squad' to me, maybe," Andress said. "There's a big potential public perception issue."

Some have questioned whether it is even possible to engage Americans on the subject.

"The level of public discussion is so poor in the U.S.," said Norman Daniels, an ethics professor at the Harvard School of Public Health. "The partisan attacks of the health reform debate have set back the public discussion of resource allocation in a very serious way by putting things in terms of 'death panels' or 'it's un-American to limit resources,' as if American insurers don't do that all the time."