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COVID in NYC: What We Could Do Better

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ABSTRACT
New York City hospitals expanded resources to an unprecedented extent in response to the COVID pandemic. Thousands of beds, ICU beds, staff members, and ventilators were rapidly incorporated into hospital systems. Nonetheless, this historic public health disaster still created scarcities and the need for formal crisis standards of care. These were not available to NY clinicians because of the state's failure to implement, with or without revision, longstanding guidance documents intended for just such a pandemic. The authors argue that public health plans for disasters should be well-funded and based on available research and expertise. Communities should insist that political representatives demonstrate responsible leadership by implementing and updating as needed, crisis standards of care. Finally, surge requirements should address the needs of both those expected to survive and those who will not, by expanding palliative care and other resources for the dying.

KEYWORDS
Health care delivery; rationing/resource allocation; health policy; public health

We can only begin to grasp the scale of this historic public health disaster and its specific impact on New York City. At the outset, let us note those things that went well. Governor Cuomo issued various executive orders easing licensing requirements to help integrate additional health professionals into the state workforce and also protected clinicians and institutions from civil liability when providing care in good faith during the COVID pandemic (NYS Executive Order 202.10 2020). The State Legislature included measures in the budget that expanded liability protections for criminal acts for health care providers during COVID (Stubbs 2020). The Governor also pushed New York's hospitals to expand capacity to an extent and in ways that seemed unbelievable just a few weeks ago. Our institution, Montefiore Health System, serves an ethnically and racially diverse, primarily low-income community in the Bronx. We opened 38 COVID general medicine wards and 11 new ICUs. Our critical care beds have quadrupled, going from 120 to 475. The number of ventilators in our hospital system has tripled. To accommodate all those beds and vents, we needed space. Conference rooms, administrative space, gyms used for physical therapy and an unimaginable variety of different locations in and around hospitals were converted into clinical spaces, virtually overnight. We needed staff to care for all the patients in all those beds and all those conference rooms. Our center is one of the largest training sites in the US for young physicians and all of them were drafted to serve where needed with most providing care for COVID patients on medicine wards. Attending physicians stepped up to serve, many working outside their standard realm of practice. This demonstrated our institution's commitment to valuing the lives of the community we serve.

This mobilization of medical resources, repeated at hospitals all across New York City, on such a scale and at such speed, is staggering and inspiring. Our resident physicians have confronted death on an unprecedented scale. We did not and could not have adequately trained them for this work. They will forever be different as doctors and as people because of the care they have provided and continue to provide during the pandemic. Thousands of our coworkers have become ill; some have died. Our providers are our heroes. Our community has honored medical workers who served during the crisis with countless gifts of meals, care packages, and words of thanks. Sidewalk graffiti full of gratitude decorates the entrances to our hospitals. Virtual cards with praise and thanks are showered on our housestaff from young doctors working in other cities who admire their

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courage and tenacity. This terrible disease has highlighted much to admire in the human spirit.

This synergy between the institution, the clinical staff, and the community has been critical. Our Bronx community has been one of the hardest-hit in the country. Structural racism has made our patients more vulnerable to the ravages of this terrible disease. Social distancing is hard to enact in high-density, low-income neighborhoods. Our community is also one that has suffered from lack of access to healthcare and poor treatment by the medical establishment in general. Therefore, we committed to the mission to "raise the bar" as well as "flatten the curve" to meet the needs of the community (Cortland 2020). This was a seemingly impossible feat, but our success went beyond what many of us hoped for.

From our vantage point, still in the heart of the pandemic, we also see things that might have been done better. We hope that as the pandemic spreads, these observations may help others. First and most importantly, NY State has failed to release crisis standards of care to guide clinical decisions during the pandemic. This is particularly striking since New York State was one of the earliest in the US to develop planning documents to prepare for just such a disaster. One of us was the lead author on the original NYS guidance document for allocating ventilators in a pandemic, outlining the ethical and clinical parameters for crisis standards and first published in 2007. A revised version in 2015 expanded comments on pediatric, neonatal, and legal issues (Powell et al. 2008; New York State Task Force on Life & Law and NYS Department of Health 2015). The other of us analyzed this work with an eye to implementation, developed a clear policy for our facility, and conducted a study of focus groups and staff attitudes about triage (Chuang et al. 2020). Planning documents like these have been drafted by numerous professional and expert groups and are necessary to guide the orderly transition from regular standards of care to crisis standards (Biddison et al. 2014, Care of the Critically Ill; Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations, Institute of Medicine 2012). They instruct providers under the duress of a disaster on the ethically and clinically appropriate methods to address shortages of "space, stuff, and staff" and other aspects of crisis care.

One might question the need for such triage protocols in the developed world, where we are accustomed to having necessary resources. The experience with COVID 19 in nations with highly resourced medical systems, as in Italy and Spain, shows us otherwise. This pandemic taught us in New York that with extraordinary effort, we can accomplish much. However, even with an unprecedented augmentation of resources, tough choices and triage decisions have been made everyday during the pandemic. Future disasters may demand equally tough choices, particularly if there is even less opportunity to ramp up resources. NYS had developed guidelines that focus interventions on those most likely to survive the acute event. They explicitly reject limitations of access for those with disabilities or older age. They do not offer preference to people of any particular occupation. We believe these guidelines are ethically sound in prioritizing those likely to survive. They avoid the unfairness that stems from a first-come-first-serve approach, which privileges those with more access to healthcare. They avoid the excess mortality that results from a lottery, which assigns scarce resources to those with no hope of survival. NY's 2015 guidelines were imperfect; they certainly did not perfectly match the clinical circumstances of COVID. Yet, NY should have issued guidance, imperfect or otherwise, and it failed to do so.

Many guidelines cite the ethical obligation of political authorities to produce such documents, rather than force beleaguered frontline providers to invent solutions during disasters, while enduring great risk and exhaustion (Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster, Institute of Medicine 2012; Powell et al. 2008). Indeed, it is one of the principle lessons of Hurricane Katrina that it is unjust to force frontline providers to tackle problems that should have been addressed in advance. Leaving triage decisions up to front line clinicians is likely to result in decisions that adversely affect vulnerable populations. Studies have repeatedly shown that physicians have implicit biases (Maina et al. 2017; Sabin et al. 2009) and that these biases are more likely to affect care when clinicians are under stress (Stepanikova 2012; Dyrbye et al. 2019). Triage decisions are among the most consequential decisions that can be made about a patient's health.

Perhaps, NY's leaders thought that by greatly increasing capacity, they would avoid the need for triage and guidance. The speed at which new critically ill patients flowed into hospitals that were hit earliest and hardest may nonetheless have resulted in ad hoc rationing. However, for the most part, there were sufficient ventilators for those in respiratory failure (there were many instances of nearly running out, requiring much ingenuity, and some overrun hospitals may actually have lacked sufficient ventilators for brief periods). Nonetheless, COVID 19 has created a public health disaster of unprecedented proportions. As of this writing, weeks past the declaration of a public health emergency, NY has failed to implement guidance for crisis standards of care. It did not revise and/or release its own 2015 standards, still posted on the State Department of Health website (New York State Task Force on Life & Law and NYS Department of Health 2015), nor did it sanction the use of any of the many available similar guidance documents. NY incudes a wealth of expertise in public health and disaster management. Advice from these experts was heeded in many aspects of the management of this public health disaster, but not in the matter of releasing guidelines for the hard-working frontline staff. Massachusetts, hit less hard and later, has already released guidance for crisis standards and its healthcare workforce has received appropriate training in how to follow those standards. NY has let down its heroic clinicians, who provide care at significant risk to themselves and their loved ones.

By focusing on cure, and specifically on ventilators, we lacked appropriate planning for the predictable and large numbers of fatalities. Most crucially, providers did not receive guidance regarding cardiopulmonary resuscitation (CPR). To be sure, most people infected with COVID survive. A percentage become so ill they require hospitalization and a smaller percentage require ventilators. Of those who require and receive ventilators, many die. COVID 19 in its severest form causes not only a devastating respiratory disease, but the failure of multiple other organ systems as well (Liu et al. 2020, The Science Underlying COVID-19).

Cardiac arrest resulting from respiratory failure refractory to efforts at ventilation, often accompanied by the collapse of other organ systems, is not reversible. In this case, providing chest compressions or defibrillation is truly medically futile. A rational plan for crisis care acknowledges these realities. Most crisis plans explicitly include the right to withhold cardiopulmonary resuscitation efforts when they cannot benefit the patient. NY failed to support its doctors in making decisions not to resuscitate (DNR). In the unique setting of this pandemic, a decision not to initiate CPR is not an instance of withholding life-saving care from vulnerable individuals, but rather a response that is both empathic and rational in a futile situation.

The lack of ability to withhold CPR on the basis of futility markedly increased the problems of providing care during the pandemic. At some hospitals, workers endured the extra risk of COVID exposure during ineffective CPR multiple times daily. The risk to providers is quite significant during CPR, for aerosolized particles can spread widely with chest compression (Seto 2015). At the time of this writing, thousands of our associates have fallen ill from COVID19 and a number have died. It is one thing to take a risk to save a life. It is unconscionable to create risk to providers without benefit to the patient—and indeed to create the likelihood of a painful death if the patient retains any consciousness. The lack of guidance regarding CPR imposed other burdens on clinicians and families. Doctors spent significant time trying to persuade families to accept DNR status and were frequently unsuccessful. This was cruel. Families were frightened—appropriately so—and were prevented from being near loved ones because of necessary restrictions to hospital visitation. For most families, these were not discussions about death that followed a long illness, giving both patient and family a chance to say goodbye and accept the inevitable. The sudden, shocking nature of COVID forced families to address a fatal illness without warning and without the ability to provide the comfort of their presence. Under these conditions, placing the burden of a medical decision about CPR onto these traumatized families is also unacceptable. NY's failure to issue guidance is responsible for creating additional risk to staff and additional pain to dying patients and their families. This was a way to make a tragedy worse.

A further consequence of the lack of guidance was that care has been unequal in different facilities and likely even within the same facility, by report of our colleagues across the city. Some hospitals quickly adopted a standard of foregoing chest compressions for patients on ventilators and nearing cardiac arrest. Others thought they had no choice but to soldier on, providing futile attempts at resuscitation at family request, as if they were operating under normal conditions. Though these efforts to provide chest compressions did not benefit patients, we cannot yet begin to estimate the level of psychological and physical trauma to the clinicians forced to provide hopeless resuscitation efforts. The lack of consistency across institutions sowed uncertainty, fear and doubt, especially among our trainees, adding to their moral distress.

The lack of formal guidance meant that NY did not benefit from important prior planning efforts. The enormous surge of clinicians did not include a burst of additional resources for palliative care and hospice. Prior guidance documents have addressed the need to ramp up palliative care along with other crucial resources. (Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations, Institute of Medicine 2012). Outpatient hospice workers were not prioritized to receive protective equipment, so initially many hospice agencies could not and did not accept COVID + patients. There were insufficient stockpiles of sedatives and pain medications. A rational plan would have focused on best care, rather than on the unrealistic goal of saving all lives. Death was inevitable for many and without the benefit of guidance from a thoughtful plan, NY's clinicians were hampered in their efforts to facilitate comfortable deaths for many patients.

Multiple groups, institutions, and individuals objected to the lack of guidance, addressing their concerns with ascending levels of NY State government, in countless meetings, phone calls, and emails. Across the state, numerous individual institutions have wasted precious time in drafting their own protocols in the absence of state guidance. There is no officially sanctioned training for staff on how to provide care during the disaster. There has not been an orderly shift from normal to crisis standards of care. As of this writing (mid-April), we have seen more than 12,000 deaths in NY State alone; in contrast, the entire UK has had roughly 8,000 deaths. No public guidance for crisis standards of care has been released by NY State. This was an utter failure of leadership.

We hope there is no next time for a disaster of these proportions. However, we also argue, echoing NY State's own unused guidance document, that there is a duty to plan and prepare for such contingencies. Here are our recommendations:

1. States and other political entities should appropriately fund and continually reassess public health planning efforts, using the expertise of their own communities as well as those of the many professional groups who have provided excellent consensus documents for disaster guidance.
2. Communities should insist that political representatives demonstrate responsible leadership by implementing, and updating as needed, crisis standards of care in public health disasters.
3. Surge requirements should address the needs of those who may survive, but not to the exclusion of those who will not. When additional staff and resources are called up for critical care, they should also be increased for palliative care, hospice, home care, mortuaries, and other resources for the dying and deceased. The best available care is an appropriate goal for a disaster and must include appropriate care for the dying.

Disclosure statement

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

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