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The University of California Crisis Standard of Care – Public Reasoning for Socially Responsible Medicine. ***Alex Rajczi, Judith Daar, Aaron Kheriaty, and Cyrus Dastur. The Hastings Center Report, 2021***[1]

Short summary

In this article Rajczi et al. compare two processes for developing triage protocols. They contrast the University of California Crisis Standard of Care protocol's recommendations for triaging procedures during the Covid-19 pandemic with the Pittsburgh Framework, which has become the go-to model for people developing triage protocols. The authors describe how the UC protocol is founded in political reasoning around public preferences for triage protocols, and how the values that drive its recommendations derive solely from this reasoning. The paper illustrates how the UC protocol and the Pittsburgh Framework differ in their processes for selecting values. Next, they compare how the UC and Pittsburgh triage procedures demonstrate similarities and differences in the triage procedures and illustrate how political reasoning is reflected in all the UC protocol's recommendations.

Introduction

Both The UC protocol and the Pittsburgh Framework apply to all patients in need of critical care services, and both apply to patients currently receiving critical care. This means that both protocols include procedures for withdrawal of resources from patients currently receiving critical care. None of the protocols include exclusion criteria for certain categories of patients.

The rationale for the UC protocol's recommendations is that private medical institutions serve as delivery agents for public health care policies, and that medical institutions committed to political reasoning would accept that policies, such as triage procedures, would fall into the category of public governance. This includes commitment to basing triage procedures on the will of the majority, as long that this does not violate fundamental rights. In contrast to the UC protocol, the Pittsburgh Framework does not explicitly mention or commit to one specific line of reasoning - whether political or private reasoning or another type of reasoning - as a value foundation for its recommendations.

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[1] Rajczi, A., J. Daar, A. Kheriaty, and C. Dastur (2021). The University of California Crisis Standard of Care – Public Reasoning for Socially Responsible Medicine. *The Hastings Center Report;* Vol. 51 (5):30-41.

Similarities and differences in procedures:

- ***Usage of scoring***: The Pittsburgh Framework apply a combination of the patient's Sequential Organ Failure Assessment (SOFA) score, a severity of illness score, and an 'expected death within 5 years' score. The higher total score, the lower the patient's priority on the triage list. Rajczi et al. argue that the Pittsburgh Framework's 'expected-death-within-5-years' score, is not in and of itself a predictor of short-term survival in critical illness.

  In comparison, the UC protocol primarily applies the SOFA score but adjusts the score based on major comorbid conditions and /or severely life-limiting conditions. The reasoning behind the UC protocol's approach is that comorbidities and life-limiting conditions are predictors for short-term survival in critical illness. The number of co-morbidities and/or severely life-limiting conditions (if more than one) is not considered.
- ***Adjustments and exceptions***; Both protocols allow adjustment to the priority scores, but the criteria for adjustments differ. The Pittsburgh Framework allows for adjustment of scores to give priority to individuals who perform tasks that are vital to the public health response, including people who support the provision of acute care to others. The UC protocol allows for adjustment of scores or temporary exemptions from the triage procedures for a longer list of people, not limited to those who perform tasks that are vital to the public health response. Exceptions or score adjustments may be made for critical workers, pregnant persons, pre-transplant patients with an active organ offer, and to postoperative patients recovering from transplant surgery.
- ***Criteria used as tiebreakers***. Both protocols account for situations where two patients fall within the same triage priority category, but the protocols differ in their recommendations for a 'tiebreaker' to address this issue. The Pittsburgh Framework recommends using life-cycle considerations, prioritizing younger patients. The UC protocol uses random allocation.
- ***Appeals***: Both protocols recommend a procedure where the responsibility for triaging lies with a dedicated triage officer or triage team, and not with the treating physician. However, the protocols differ with regards to how and when someone can appeal the triage decision. The Pittsburgh Framework allows for direct appeals from patients, families or clinicians, and only in situations where there is suspected miscalculation of score or an inappropriate use (or non-use) of a tiebreaker. The UC protocol allows for appeals if made by an attending clinician or another licensed health care worker, who may appeal on request of patients or family members. The UC protocol recommends that all reallocation decisions be reviewed by a triage review committee.

Examples of political reasoning as value foundations in the UC protocol

- ***Triage priority and life-cycle considerations:***
  The authors argue that, while there may be some evidence of public support for tiebreakers based on age, there are concerns that the use of life-cycle considerations in triaging of critical care may not be publicly endorsed and/or may be illegal. Federal laws, such as the Age Discrimination Act of 1975, which prohibits age discrimination in programs or activities receiving financial assistance from the federal government, are mentioned to support this position. Additionally, it is argued that the use of age or disability considerations as a criterion or measure for triaging is unnecessary, because other measures, such as prognostic factors, can reasonably be assessed.
- ***Triage priority, length of survival and disability***
  The authors argue that criteria that focus on length of survival irrespective of the acute episode (such as the Pittsburgh Framework's 5-year survival rate), may discriminate against people with disabilities in cases where their disability limit their life span and that it may be inconsistent with publicly endorsed federal disability rights laws Moreover, an assessment of length of survival is associated with great uncertainty. This is the reason why the UC protocol uses a score for comorbidities only when these are predictors of the acute episode's outcome.
- ***Prioritization of critical workers***
  Prioritization of critical workers can be based on a) reciprocity, i.e., the public owes critical workers some level of priority in return for the risk they take to save other people's lives, and b) the multiplier effect, i.e., giving priority to those who contribute to save the lives of others, which will help save more lives overall. The Pittsburgh Framework offers priority to critical workers essential to the specific public health emergency. However, the framework does not offer a definition of 'critical worker'. The UC protocol allows for a reduction in points for critical workers, based solely on the multiplier effect, arguing that there is no public warrant for reciprocity-based prioritization of critical workers. The protocol recognizes that prioritization of critical workers has the potential to degrade public trust and offers a process for developing a definition of 'critical workers.' Transparency in the process of defining critical workers is therefore key: specific job categories must be named and the job categories' contribution to the multiplier effect must be justified; and the definition must be reasonable i.e., it must not lead to disproportionate prioritization of ICU beds for critical workers, leaving only few for the general public. A plausible argument must be made for prioritization demonstrating that a critical care worker would return to work quickly enough for it to contribute to the multiplier effect and that prioritization won't undermine public trust in the medical system.

- ***Triage and pregnancy***
  Prioritization of pregnant patients is not included in the Pittsburgh Framework, whereas the UC protocol includes it under specific circumstances. The UC protocol's inclusion of criteria for triage prioritization of pregnant people is based on the multiplier effect. The UC protocol allow for point adjustment to the triage scores for pregnant patients under specific circumstances: for pregnant patients who are more than twenty-four weeks pregnant. While the authors recognize that not including pregnancy in the triage protocol could be justified based on political reasoning, they argue that California's laws around fetuses might guide the assessment of public values, and that giving priority to pregnant patients who are more than twenty-four weeks pregnant would be in line with the multiplier effect (i.e., prioritizing pregnant patients save more lives).

Conclusion

The paper concludes that the UC protocol offers a robust political rationale for its recommendations that fit well with the values of the public in its jurisdiction. In comparison to the Pittsburgh Framework, it offers processes for defining 'critical workers,' and attempt to navigate the tension in public values around issues such as pregnancy.