Open Letter to Crisis Standards of Care Advisory Committee

We are writing today because of our grave concern regarding the Crisis Standards of Care issued on 4/7/20 and the impact that these crisis standards will have on equity of access to life-sustaining care for communities most impacted by COVID-19.

We are doctors, nurses, health workers, residents, medical students, social workers, patient navigators, and other members of multidisciplinary teams who are on the front lines of care for patients and families at Boston Medical Center and other hospitals and community health centers throughout Massachusetts.

On 4/7/20, Crisis Standards of Care were issued by the Crisis Standards of Care Advisory Committee convened by the Commissioner of Public Health. This committee had little to no representation from the communities most impacted by COVID-19 and had no community oversight. Only two of the sixteen authors were people of color.

The Crisis Standards of Care state that "tragically difficult decisions must be based on criteria that ensure that every patient has equitable access to any care from which they might benefit."

Subsequent to this stated commitment to health equity, the Advisory Committee proposed a "scoring system" for patients to determine how available resources (ventilators, etc.) in crisis situations should be allocated when there aren't sufficient quantities to care for all who need them to survive. Under this scoring system, the lower a patient's score, the higher they are prioritized for access to life-saving resources. Points are added to a patient's score for "major comorbid conditions with substantial impact on long-term survival" -- that is to say -- comorbid conditions that might affect a patient's survival will count against them during such allocation decisions.

The scoring system does not reference or account for structural racism, economic injustice or poverty, ableism, ageism, or the resultant major health disparities that harm Black communities, Latinx communities, indigenous communities and other communities of color, low income communities, disabled communities, incarcerated individuals, and elders. These factors will make it statistically less likely that people from these communities will be allocated life-saving resources in a crisis.

Certain health conditions that directly or indirectly factor into the SOFA scoring system are disproportionately high among Boston's communities of color. For instance, diabetes rates are highest in Mattapan (17.3%), Roxbury (14.1%), and Dorchester (02121/02125: 12.8%). Dorchester, Mattapan, Roxbury, and Hyde Park have the highest percentage of both diabetes-related and heart disease-related hospitalizations among Boston neighborhoods.

Due to a well-documented presence of housing and environmental triggers (e.g. mold hazards/violations, poor indoor air quality), asthma-related illnesses are disproportionately high in Dorchester, Mattapan, and Roxbury, placing residents in those neighborhoods at increased risk of more severe cases of infection.

The Massachusetts Department of Health has released limited racial and ethnic data on COVID-19 cases. As of April 8th, 67% of the confirmed cases and 69% of deaths are listed as "unknown" or "missing"

racial or ethnic information.[1] The Massachusetts Public Health Association has stated that this data is "inconclusive and unactionable" and called on the governor to ensure timely and complete data collection. Despite this lack of critical information, there is every indication that Massachusetts, and specifically Boston have the same patterns of COVID-19 infection noted in other urban settings in the US.[2] Chicago is 30% Black, but Black people account for 70% of all COVID-19 cases in the city and more than half of the deaths. Michigan's population is 14% Black, but Black people account for at least 33% of COVID-19 infections and 41% of deaths. In Detroit, specifically, Black people are 7% of Michigan's population but 26% of Michigan's infections and 25% of its deaths. Similar patterns have been noted in New York City, Philadelphia and North Carolina.

In Boston, significant health disparities for Black and Latinx people are emerging given the racial and ethnic make-up of neighborhoods most impacted by COVID-19, with disproportionate illness amongst residents of Hyde Park, Mattapan, and East Boston.[3]

Black, Latinx, and Asian populations are at heightened risk of contracting COVID-19 and exposing their families given overrepresentation as essential, frontline workers. A report from the New York City comptroller published two weeks ago shows that 75% of frontline workers are people of color, and 50% are foreign-born. Grocery and store clerks, package delivery and postal carriers, food and childcare service providers, caregivers, and cleaning staff may not be able to practice strict social distancing or respiratory hygiene, work remotely from home, nor receive paid time off, thus increasing their risk of infection, hospitalization, and the inequitable harm inherent to the current Crisis Standards.

Another group of people at higher risk of acquiring COVID-19 are correctionally-involved/incarcerated individuals who must live in crowded conditions and bear a higher burden of comorbid conditions as compared to the general population. Since mass incarceration is driven by racial and economic injustice, Crisis Standards of Care need to take into consideration that those individuals who are put at risk for COVID-19 because of their identities and socioeconomic status will also be the ones who will be further penalized by the scoring system due to comorbid conditions acquired during incarceration.

Moreover, the scoring system proposed in these guidelines discriminates against those living with disabilities or chronic conditions that are considered penalizable comorbidities. In their open letter to care providers, disability activists stress that "denying or withdrawing care based on protected characteristics violates many laws including the Americans with Disabilities Act, Section 504, the Affordable Care Act, state and local civil rights laws, and/or the U.S. Constitution." Triage guidelines that evaluate patients by age or "comorbid conditions [that] impact survival" or "underlying medical diseases that may hinder recovery" implicitly rely on value judgements about these patients' quality of life and deny these patients justice in our healthcare system.

These Crisis Standards of Care will result in the withdrawal of life-saving care-- including mechanical ventilation-- from a disproportionate number of indigenous people, Black people, Latinx people, other

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[1] https://www.mass.gov/doc/covid-19-cases-in-massachusetts-as-of-april-8-2020/download

[2] https://www.wgbh.org/news/local-news/2020/04/09/early-boston-data-shows-disturbing-racial-disparities-in-covid-19-infections

[3] https://www.dotnews.com/2020/city-report-parts-dot-mattapan-are-above-citywide-average-covid-19

communities of color, elders, immigrants, asylees, refugees, and those who are undocumented, uninsured, incarcerated, homeless, experiencing poverty, or living with disability. These communities already experience oppression and marginalization through structural racism, economic injustice, ageism, and ableism, which altogether perpetuate healthcare disparities when compared to those who are granted privilege in our society.

We thus demand the following:

1) Just and ethical crisis standards that take into account political and social determinants of health to assure truly equitable allocation of resources;

2) Involvement of community stakeholders in developing and approving the crisis standards, keeping in mind the populations most affected by complications of COVID-19;

3) Transparency regarding the nature of mutual aid agreements between health care institutions to ensure that hospitals with higher demands for resources such as staffing support and ventilators can receive resources from hospitals that are serving fewer COVID-19 patients with maximal lead time to avoid acute crises when possible; and

4) If, after the above demands have been met, and a need for a scoring system remains, we demand, at minimum, the elimination of criteria designed to "save the most life years," which involves points added for comorbid conditions and would negatively impact communities historically experiencing health disparities from racial injustice and other political and social determinants of health.

To remain true to our professional and ethical obligations as health care providers and members of the health care team, we must implement standards that are responsible, ethical, and equitable. If we do not fight for and rapidly adopt standards that address structural racism and other forms of oppression, we will be complicit in that oppression, rather than fulfilling our moral obligation to do no harm.

Sincerely,

Please sign your name in form link below:

https://docs.google.com/forms/d/e/1FAIpQLSeHZR-knvT3I4aHCLHOlyICx_ITKnWvSaCBbE9t-y4iv70lIw/viewform?usp=sf_link

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