DEPARTMENT OF DEFENSE
UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES
4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4799

DMEC Bioethics Case File

Department of Defense Medical Ethics Center (DMEC)
COVID-19 Pandemic - Bioethics Guidance

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Working Group Members:

COL Frederick Lough, MC, USA, MD, FACS
CAPT Ryan C. Maves, MC, USN, MD, FCCP, FCCM, FIDSA
COL Jeremy V. Edwards, MC, USA, DO, HEC-C, FAAP
LTC Vincent F. Capaldi, II, MC, USA, ScM, MD, FAPA, FACP
Prof. James Giordano, PhD, MPhil
Mr. Joseph Procaccino, Jr., JD, MFS
Ms. Polyxeni Combs, MS
Mr. Joshua Girton, JD, LLM, MBA

Issue:

What ethical guidelines should be used by the health care professionals at Defense Health Agency (DHA) Military Treatment Facilities (MTFs) in the Triage and Treatment of patients with COVID-19?

Recommendations:

Situation:

The COVID-19 pandemic outbreak is a global phenomenon that has impacted all countries and citizens, while straining public health systems to an unprecedented level in recent times. In the next few weeks, it is possible that health care professionals at MTFs could face major ethical challenges in dealing with the COVID-19 pandemic. It is the DMEC's position, that the number and complexity of the ethical questions will be greatly reduced if the MTFs are adequately prepared for the forthcoming COVID-19 crisis. The following are suggested approaches to be adopted by the staff at MTFs to prepare for this eventuality. This document is not to be interpreted as mandatory Department of Defense (DoD)/Health Affairs (HA)/DHA Policy in any way, but rather a consolidation of pragmatic references and suggestions to assist front line MTF health care professionals navigate this challenging COVID-19 Pandemic in real time. The preparation includes the establishment of a COVID-19 Triage Planning Committee, wide ranging communication both within the MTF and also with assigned MTF Legal Advisors and local civilian medical facilities, and the creation of an ethical decision making apparatus. Adoption of these organizational recommendations will limit the number of ethical questions

and problems faced by the command, health care professionals, and staff, while simultaneously assisting in the effective resolution of the ethical issues that do inevitably occur.

Obviously the COVID-19 outbreak is an incredibly dynamic and evolving pandemic, which may quickly require modified guidance as the situation changes. Importantly, the following non-prescriptive ethical considerations must be operationalized in concert with the controlling DoD COVID-19 Practice Management Guide, other DHA guidance, and in coordination with the assigned MTF Legal Advisor/DHA Office of General Counsel (OGC). During these challenging times it is incumbent on all military health care professionals to remain flexible and conduct themselves according to the highest ethical standards. The DMEC stands ready to assist, at any time, as ethical challenges arise.

Underlying Ethical Principles and Corresponding Duties:

The DMEC has already provided, as part of the inaugural version of the DoD COVID-19 Practice Management Guide (Pages 36 and 37), initial guidance on the appropriate ethical frameworks to consider in specifically referencing *The Hastings Center Ethical Framework* (https://www.thehastingscenter.org/ethicalframeworkcovid19/), *The Society of Critical Care Medicine (SCCM) Emergency Resources* (https://www.sccm.org/disaster), and the *National Academy of Medicine (NAM) Discussion Paper* on crisis management of scarce medical resources (https://nam.edu/duty-to-plan-health-care-crisis-standards-of-care-and-novel-coronavirus-sars-cov-2/). Two other recently published and insightful commentaries, which bear consideration by MTF Directors and MTF health care professionals in the analysis of the prevailing ethical principles, appear in the *New England Journal of Medicine (NEJM)* (https://www.nejm.org/doi/full/10.1056/NEJMsb2005114) and *The Journal of the American Medical Association (JAMA)*(https://jamanetwork.com/journals/jama/fullarticle/2763953).

The following supplemental guidance is offered by the DMEC as a means to provide a transparent, equitable, and consistent approach to the allocation of scarce medical resources during the COVID-19 pandemic. The development and implementation of these processes requires an intentional commitment to our shared ethical responsibility to hold in primary regard the health, safety and dignity of patients. The allocation of scarce medical resources should be developed in a manner that is: accountable, transparent, and trustworthy; promotes solidarity and mutual responsibility; affords equitable response to needs; and remains sensitive to the values of the community and respects their perspectives and input.

During periods of limited medical resources, there exists a fundamental tension between a patient-centered approach to medical treatment under normal conditions, and the public-centered/force-protection approach of medical treatment under crisis conditions. An ethically-sound framework for MTFs during a scarce medical resource crisis acknowledges two competing sources of moral authority that must be navigated and balanced: (1) the duty to care for individual patients that is based upon and sustains the ethical foundation of the medical profession; and (2) the duty to equitably distribute the benefits of limited goods, services and resources to society.

From these primary duties, obligations to plan, safeguard, and guide the institutions of medical care can be formulated. The obligation to plan and manage uncertainty, and to anticipate and respond to foreseeable ethical challenges that may be present, requires a proactive approach to develop comprehensive and equitable triage processes and decision-matrices. The obligation to safeguard our patients and health care professionals requires identification of vulnerable patient and staff populations, a recognition of the potential for occupational risks, threats and harms, and mandates institutional development of comprehensive risk assessment and mitigation strategies and tactics. The obligation to guide the institution and the larger military medical enterprise requires that MTFs develop proactive contingency planning to meet increasing demands for care under circumstances of medical resource scarcity. Triage plans need to be focused on all elements of patient care, from the Emergency Room to ward to Intensive Care and to discharge. Particular attention must be focused on discharge planning. Failure in this area will lead to overcrowding in the facility and complicate every challenge facing the MTF leadership and staff. Complex ethical challenges will be amplified should fear and distrust become rooted in an MTF.

As noted in *The Hastings Center Ethical Framework*, planning committees should incorporate representation from local Medical Ethics Committees to provide insight to, and planning for, the moral distress that health care professionals are likely to experience during crisis conditions. Moral distress may be exacerbated by feelings of social isolation and disruptions in normal routines, social distancing, and concern for personal/family safety and well-being during times of crisis. Resources should be expanded so as to enable ethically sound allocation in support of health care professionals prior to, during, and following times of crisis. This includes opportunities for structured debriefing after critical events, and ongoing engagement to promote community connectedness based, in part, upon reflection and fostering of professional and personal meaning engendered by individuals' experience. Additionally, existing support/morale programs should be fortified to develop and maintain resilience among health care professionals and their patients. The United States Military Medical Corps has faced these same challenges during the wars in both Iraq and Afghanistan. Recognizing the stresses placed on the health care professionals, and using all means available to address these issues, will protect and maintain the health care force.

Finally, within the MTFs, in both CONUS and OCONUS alike, it is critical to note that there are occasions when unique military circumstances define the ethical responsibilities and actions of military health care professionals, when necessary and appropriate. These exigencies are explained in the recently published "A Code of Ethics for Military Medicine" article in the *American Military Surgeons of the United States (AMSUS) Journal* (https://academic.oup.com/milmed/advance-article/doi/10.1093/milmed/usaa007/5803039?searchresult=1). Distinctions in certain ethical obligations of military and civilian medicine derive from the oath taken by military health care professionals to their function within military units, and in consideration of the military mission.

Ethical Frameworks and Triage Models:

With regard to the specific medical care to be provided to MTF patients, the details of various medical areas are already discussed in the overarching DoD COVID-19 Practice Management Guide. Therefore, specific recommendations regarding initial evaluation, hospital admission, initial treatment, general medical ward care, transfer to the Intensive Care Unit (ICU), consideration for ventilator care, pregnancy, pediatric care, surgery, resuscitation, and other specified medical areas can/should be addressed by reference to the DoD COVID-19 Practice Management Guide. In addition, MTF health care professionals should consult currently existing military medicine publications when seeking to tailor appropriate triage procedures in accordance with principles contained in war-time response protocols during this COVID-19 pandemic. Specifically, the following document can provide an exemplary foundation upon which to craft such triage procedures: Chapter 3, Mass Casualty and Triage, *Emergency War Surgery*, 5th Edition, 2018, (https://www.cs.amedd.army.mil/borden/FileDownloadpublic.aspx?docid=744757d4-660d-432b-9286-9565c70f7e2b).

Ethical questions and triage decisions are influenced by, and should be sensitive and responsive to local and situational factors, as well as state laws and regulations. Each MTF should evaluate its individual capability and the local COVID-19 situation. An MTF's response will be modified by the level of need(s) incurred during periods of *Conventional Capacity*, *Contingency Capacity*, and *Crisis Capacity*. It is also suggested that each MTF should hold simulation drills to practice the facility response to relevant COVID-19 contingencies and exigencies. Smaller MTFs, with more limited intensive care medical resources, should be regarded as (short-term) Treat and Evacuate Centers. This is similar to the status and function(s) of Forward Surgical Teams (FSTs) that have been employed with great success in both Iraq and Afghanistan. Conversely, larger MTFs will typically have significantly greater flexibility to adjust care, the use of space, health care professionals, and medical resources as the situations demand. The MTF Director, Triage Planning Committee, and Medical Ethics Committee, and other relevant parties, can/should assist in the ongoing decisions of triaging care in accordance with triage protocols employed on the battlefield. Similar techniques are applicable in the current COVID-19 pandemic. To reiterate, great attention needs to be focused on the ultimate placement of patients, whether to the next more capable referral center, skilled nursing facilities, home care, or hospice. Failure to address these difficult challenges risks the MTF being overwhelmed.

Roles and Responsibilities:

MTF Director:

- Establish a Triage Planning Committee to coordinate all aspects of the MTF response.
- Assess all available resources, space, personnel and materials.
- Adopt and follow the DoD COVID-19 Practice Management Guide.
- Coordinate with major local military units, Base Commander, military police/fire department, and Base EMS.
- Meet regularly with all senior staff to provide updates on the real-time status of the MTF.

- Establish a Communications Center, with rapid connections to regional military referral centers, local civilian referral centers, Base Commander, local large unit commands, and military clinics that refer patients.

MTF Chief of Staff:
- Coordinates with all major service directors, to include but not limited to the following:
- Medicine;
- Surgery;
- Nursing;
- Pulmonary;
- Emergency Service;
- Infectious Disease;
- Intensive Care Unit;
- Pediatrics/OB;
- Psychology;
- Medical Service Corps; and
- Chaplain/Religious Services.

MTF Medical Ethics Committee:
- Monitor local response protocols and DHA recommendations as the situation evolves.
- Provide guidance to MTF Director, Triage Planning Committee, and MTF health care professionals.
- Smaller MTFs should identify a senior health care professional to be the lead Medical Ethics Officer. This individual will provide a resource for health care professionals, as well as the MTF leadership as the situation evolves.
- Coordinate with DMEC for case specific assistance.

MTF Senior Medical Service Corps Officer:
- Coordinates admission/discharge, record keeping, and pharmacy services.
- Monitors status of supplies, re-supply, and medical evacuation (paramount in smaller facilities).
- Establishes a Discharge Team to coordinate this critical function.

MTF Legal Advisor:
- Advises MTF Director, Triage Planning Committee, and Medical Ethics Committee on relevant jurisdictional laws and regulations.
- Maintains awareness of newly issued legal guidance to ensure no patients are unfairly discriminated against based on categorical exclusions (i.e. age, comorbidities, etc.), to specifically include the recent HHS Bulletin on the treatment of patients with underlying disabilities in the COVID-19 context (https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf).
- Coordinate with DHA OGC to ensure consistency with the prevailing federal/state laws and DoD/HA/DHA/Service regulations.

Establishment of Triage Planning Committees:

Each MTF should develop either a local, or regional (for smaller or jointly located facilities), Triage Planning Committee as the institutional oversight body that will be charged with creating the specific MTF triage SOPs, establishing the pertinent inclusion and exclusion criteria, and ultimately serving as the final arbitrator for difficult scarce medical resource allocation decisions (situation and time permitting). Whether or not those triage SOPs should, or should not, include a reliance on quantitative metrics, such as a Sequential Organ Failure Assessment (SOFA) score, or similar physiologically-based scoring, is unresolved at this point in time amongst the prevailing experts. Many leading civilian medical facilities are utilizing SOFA scores as part of their treatment decisions in an attempt to anchor on an objective physiologically-based scoring system in evaluating similarly situated patients. However, other highly regarded professional medical societies have opined that such scoring systems are unlikely to predict critical care outcomes with sufficient accuracy, in particular patients suffering from COVID-19, or be a useful basis for triage decisions based upon the current protocol cut points. In reference, a recent elucidating article was published by *The Hastings Center* to tease out these competing tensions more specifically, with particular emphasis dedicated to patients with underlying medical conditions or comorbidities (https://www.thehastingscenter.org/disabusing-the-disability-critique-of-the-new-york-state-task-force-report-on-ventilator-allocation/).

Consequently, additional medical/science evidence-based factors may also be utilized in creating triage SOPs that achieve the maximum benefit outcome, while not unfairly discriminating against specific patients (i.e., patient's age, patient's comprehensive health status, state of patient's illness, prognosis for patient's recuperation, patient's likely response benefit from a medical intervention, medical facility's availability of space, current or anticipated status of medical facility's personnel and resources, current or anticipated care trajectory of aggregated patients, the effect of Do Not Resuscitate (DNR) orders, Advanced Directives, and/or Health Care Power of Attorney documents, etc.).

As noted in the recent *New England Journal of Medicine (NEJM*) commentary, there are four general ethical values that may assist in guiding allocation decisions of scarce medical resources during the COVID-19 pandemic: 1) *Maximize benefits*; 2) *Equitable treatment*; 3) *Promotion of instrumental values*; and 4) *Priority to the vulnerable*. *Maximization of benefits* can be understood in various ways, to include saving the most lives or saving the most life-years by giving priority to those likely to survive the longest. *Equitable treatment* dictates that similar patients (e.g., patients with identical triage scores) should be treated equally via a transparent and consistent method. Possible approaches to allocation include random selection (e.g., lottery) or first-come, first-served. Equitability would also mandate that in most scenarios all COVID-19 patients and non-COVID-19 patients are subject to the same triage procedures. *Promotion of instrumental values* recognizes a potential preference given to those who can save others and those that contribute to public/national safety and security. *Priority to the vulnerable* recognizes that priority might be given to younger, or pregnant patients who will have lived the shortest lives if they were to die untreated.

Triage Planning Committees within individual MTFs or within pre-specified regions should be established immediately. The position of this recommendation is aligned with the *Society for Critical Care Medicine (SCCM)* with regard to the purpose of the Triage Planning Committee: 1) It facilitates a patient's medical team to advocate on behalf of their patient without a conflict of interest; 2) The designation of a Triage Planning Committee provides consistency, transparency, and fairness in the decision-making process; and 3) The presence of a Triage Planning Committee may assist in the mitigation of burnout and stress that inevitably is experienced by frontline health care professionals during a crisis.

1. Triage Planning Committees should be established to have ultimate oversight of scarce medical resource allocation decisions (situation and time permitting). Triage Planning Committees should be charged with establishing pre-defined triage SOPs for *Conventional Capacity*, *Contingency Capacity*, and *Crisis Capacity*.

2. The Triage Planning Committee should have, at a minimum, two senior clinicians with experience in tertiary triage (such as Critical Care, Trauma Surgery, Emergency Medicine, etc.), a member of the Medical Ethics Committee, and a member of the community, if available, feasible, and legally permissible. Where available, a Palliative Care provider and a Pastoral Care provider should also be included.

3. Clinical Treatment Teams should not be responsible for making triage decisions (situation and time permitting). Instead, each MTF should develop Triage Teams prior to the onset of medical resource scarcity.

4. Triage Teams, at a minimum, should be comprised of a Triage Officer, a nurse with acute care experience, and an administrative staff member. If available, feasible, and legally permissible, Triage Teams should also include a member of the Medical Ethics Committee, a representative from Pastoral Care, and a representative member of the community.

5. Responsibilities of the Triage Team should include initial assessment of a priority score, matching priority score to available resources, and communicating this information back to the Clinical Treatment Teams. The Triage Team and Clinical Treatment Team should work collaboratively in determining the best approach to informing patients and families regarding allocation decisions.

6. The Triage Team should receive the patient's age but no other patient demographics or identifiers. The Triage Team should be apprised of the patient's clinical condition and other medical information relevant to prognostication. All Triage Team consults should be documented and a record of all patients reviewed and decisions made should be maintained according to MTF SOPs. A process for regular review and appeal of Triage Team decisions should also be established at the MTF level to ensure fairness and accountability.

7. It is also critical to ensure that these incredibly difficult allocation decisions regarding the anticipated scarcity of medical resources are made in conjunction with the counsel

and guidance of the assigned MTF Legal Advisor in order to ensure consistency with the prevailing federal and state laws and regulations.

In general, effective planning should consider three broad categories: *Conventional Capacity*, *Contingency Capacity*, and *Crisis Capacity*. *Conventional Capacity* refers to the period during which space, staff, and supplies are consistent with daily practices within the institution. Resources should be allocated normally when readily available. Careful stewardship of resources by institutional leadership is prudent to preserve supply if contingency or crisis scenarios are anticipated. *Contingency Capacity* refers to the period during which extreme resource scarcity is present and a shift from "first come/first served" to a triage model occurs. Access to resources remains fluid and is subject to reallocation among patients as circumstances require. Triage Planning Committees are utilized to systematically review and allocate resources based upon application of exclusion criteria, assessment of mortality risk and likelihood of benefit, and utilization of time-limited trials. *Crisis Capacity* refers to an extreme scenario in which all critical resources (ICU beds, ventilators, etc.) are in use and new patients are triaged. Under these circumstances, it is ethically permissible to divert life-sustaining treatment from a patient who is deemed less likely to benefit from the ongoing application of limited resources toward a patient more likely to survive. *This is a consideration to be taken with the greatest respect for human life and dignity. This recommendation also requires consistency with individual state law.*

Special Considerations in the COVID-19 Pandemic:

Cardiopulmonary Resuscitation (CPR):

Health care professionals have an a priori duty to provide potentially life-saving treatments, to include cardiopulmonary resuscitation (CPR) even in the context of some degree of personal risk. According to the United States Centers for Disease Control and Prevention (CDC), CPR in COVID-19 patients is currently considered a medium-risk exposure event. In such a context, it is reasonable to assess the potential risks to health care professionals against the potential benefit to the patient. Additionally, it is necessary to allow clinicians to don appropriate personal protective equipment (PPE) prior to entering the room of a decompensating patient, with the understanding that this may delay their response. Code teams should consist of the minimum necessary number of personnel in the room and must all be in proper PPE prior to entry. Virtual health assets should be considered to augment resuscitation teams which allows for minimization of exposure of personnel and use of PPE.

Palliative Care:

Patients who do not receive critical care resources must not be neglected and all reasonably available supportive and comfort-oriented care should continue to be provided for all patients, as clinically appropriate. Families should be compassionately informed of the rationale for medical decision-making. The shift in roles that patients and their surrogates typically play in the decision-making process represents a significant deviation from normal clinical practice. This shift carries with it an obligation to both to clearly communicate clinical rationale and to provide the best possible care for all patients within the constraints of the crisis. The role of

palliative medicine should be considered at all stages of contingency/crisis planning and resources/processes for effective palliation of patients should be established prior to resource scarcity. Rationing decisions may come into conflict with patient Advance Directives, and the assigned MTF Legal Advisor should be consulted for resolution.

Investment in teleconsultation capabilities for real-time long-distance consultation is advised due to scarcity of formally trained palliative medicine specialists available to the Department of Defense (DoD). Additionally, due to the unique isolation conditions placed upon families of critically ill and end-of-life patients, facilities should investigate and develop means for remote communication between loved ones and patients in isolation. This can be achieved using off-the-shelf programs on tablets, phones, or laptop computers.

Moral Distress and Spiritual Care:

With evolving changes to standards of care and pervasive uncertainty, health care professionals may be frequently faced with moral distress related to decisions and actions that feel counter to their training and values. In anticipation of this approaching crisis, and to preserve a ready medical force, support resources including chaplaincy, behavioral health resources, and peer support networks should be maximized. Ongoing education and communication with staff on the status of their facility, the status of medical resources, and the overall planning process allows transparency and alignment of focus on the COVID-19 pandemic.

Special Consideration for Health Care Professionals and First Responders:

In the current COVID-19 pandemic, relief efforts and clinical care have been hampered by shortages of critically-needed PPE for health care professionals. In addition to the baseline risk of living in affected communities, health care professionals are at risk for frequent, often intense exposure to grievously-ill patients with COVID-19 on a regular basis. This increased risk may serve to demoralize frontline health care professionals, especially in light of PPE shortages. As such, increased consideration in triage situations for health care professionals involved in the COVID-19 response is considered appropriate. This preference should apply to all health care professionals involved in the care of infected patients, including not just bedside nurses and physicians, but also medical technicians (including Medics and Corpsmen), clerical staff in emergency departments and inpatient units; respiratory therapists; first responders including emergency medical technicians; and housekeeping staff involved in the cleaning of hospital spaces occupied by patients with COVID-19. This is done both with the hope that these personnel may recover and return to care for others, and also as a compact with those who place their own health and life at risk, a concept that should resonate with the military community. Each MTF should determine a plan for how to operationalize these considerations.

Special consideration for Active Duty Military:

Whether or not the patient's status as an active duty service member should give them triage priority in responsive care over other MHS beneficiaries, from a health force protection perspective, is a legitimate variable for consideration by the MTF leadership. However, if an MTF has lost responsive care capacity to the point that non-active duty patients will be

relegated to a lower treatment category versus active duty service members, then that triage procedure should be widely communicated to that impacted patient population in order to allow those beneficiaries to potentially consider alternate care options from the outset at local civilian medical facilities. Again, that possibility underscores and reinforces the importance of MTFs immediately establishing good lines of communication with their civilian medical facilities counterparts in their local geographic areas. Each MTF should determine a plan for how to operationalize these considerations.

Conclusion:

The COVID-19 pandemic continues to be an incredibly dynamic and evolving global health emergency. Issues and procedures will evolve and require refinement as more information becomes available about the nature and breadth of the disease. However, being familiar with the most recent counsel and guidance from the experts in the field will assist all medical leaders in implementing the best possible policies and treatment decisions for both individual patients and the society at large. MTFs are encouraged to utilize enterprise-level resources (e.g., DMEC and service-specific Office of the Surgeons General Consultants (OTSG) for Medical Ethics) to augment their ability to proactively address and respond to these ethically challenging times.

Closing Remarks:

Please feel free to re-engage with the DMEC for additional assistance and guidance if these issues require further discussion towards resolution. DMEC POCs are Mr. Joshua Girton, DMEC Deputy Director (joshua.girton@usuhs.edu), and Ms. Poly Combs, DMEC Program and Management Analyst (polyxeni.combs@usuhs.edu).

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