Planning for COVID in Washington State

Dr. Doug Diekema has been working with a state planning task force and will talk about how they are thinking about the state's needs in dealing with COVID-19.

Featured Speaker:

Doug Diekema, MD

Douglas S. Diekema, MD, MPH, is attending physician and director of education for the Treuman Katz Center for Pediatric Bioethics at Seattle Childrens Hospital and professor in the Department of Pediatrics at the University of Washington School of Medicine. He received his MD from the University of North Carolina School of Medicine and his MPH from the University of Washington School of Public Health.

He completed his residency at the University of Wisconsin Hospital and Clinics in Madison. He is board certified in general pediatrics and pediatric emergency medicine by the American Board of Pediatrics. He is a member of several medical organizations. His teaching responsibilities include education in the emergency department, monthly pediatric ethics conferences and several education committees. He has been a visiting professor throughout the WAMI region (Washington, Alaska, Montana, Idaho). He is nationally sought after as a lecturer. He has numerous local and national committee responsibilities, as well as an extensive bibliography. He is past-chair of the Committee on Bioethics of the American Academy of Pediatrics and serves on the Ethics Committee of the American Board of Pediatrics. His research interests include pediatric bioethics and pediatric wilderness medicine.

Dr. Doug Diekema's bibliography includes Clinical Ethics in Pediatrics: A Case-Based Textbook,Cambridge University Press, 2011.

About this book: "I wrote this book to fill a gap in the literature. Many people asked me to recommend one book they should read to get an introduction to issues in pediatric clinical ethics. I was not happy with the options available, and decided to put together a volume that covered the issues

Transcription:

Welcome to the Peds Ethics podcast, where we talk to leaders in pediatric bioethics about a hot topic or a current controversy. Here’s your host, John Lantos from the Children’s Mercy Bioethics Center in Kansas City.

John Lantos, MD (Host): Hi, this is John Lantos. Welcome back to the Pediatric Ethics Podcast coming from the Children’s Mercy Hospital in Kansas City and the Children’s Mercy Bioethics Center. Today, we’re speaking with Dr. Doug Diekema, who is a Professor in the Department of Pediatrics at the University of Washington, School of Medicine, an Attending Physician and Director of Education for the Treuman Katz Center for Pediatric Bioethics at Seattle Children’s and has been living and working really at the center of the first big outbreak of Covid-19 in the United States. Thanks for taking time Doug, I

know you are busy.

Doug Diekema, MD (Guest): Yes, you're welcome.

Host: Tell us a little bit about what's been going on there and from your perspective where you've been working, what you've been seeing.

Dr. Diekema: Well we – I think most people know, had I think the first known case of Coronavirus in the United States not far from my house and then we had a very large outbreak occur at one of the retirement communities, assisted living communities that is run by Evergreen Hospital. And that was really sort of the beginnings of what has now become a fairly large epidemic that grows in size every day. And is involving more and more of the hospitals in the region and now the state and obviously, the adult hospitals have been impacted more than the Children's hospitals have. But we are part of the region and will be expected to assume some of the burden that comes our way.

Host: And have you been seeing patients in the ER? You, yourself?

Dr. Diekema: Well I personally have seen patients in the ER but quite honestly, COVID-19 is proving to be very rare in children so, the numbers I'm familiar with, the vast majority of testing we've done on kids who have influenza like illnesses are negative for COVID. I think I'm only aware of about a half a dozen kids in the region that have tested positive and most of them to my knowledge, have not required admission.

Host: Have you had enough tests? Are you able to get tests?

Dr. Diekema: Well tests have been a bit of an issue. We are still in a position regionwide where we are only testing people who are symptomatic with findings consistent with COVID and for whom there is a good reason to do so. So, we are actually asking people not to get tested if they have symptoms, but they are well enough to stay at home. And to some degree, I think the testing issues have been a little blown out of proportion. I mean we have not had enough test kits to accomplish the public health goal but in all honestly, the primary purpose of testing is epidemiology. There's little benefit to a patient at this stage in knowing whether they are COVID positive or not since we have no treatments. I think the main issue, it's probably most important when you are at a point in an epidemic where you can still contain it and then after that, it becomes important for tracking and cohorting and beyond that, I think everybody just –

Host: And if a treatment becomes available then it will –

Dr. Diekema: Then it ill change. Then it's much more important for the patient then.

Host: You've also been working with the state to try to figure out what's coming down the pike and how to respond. Can you tell a little bit about that?

Dr. Diekema: Yeah, well I've – for years have sat in our regional disaster community advisory committee. And so, we've been planning for some kind of pandemic for years and on the one hand, we had the materials in hand that we were sort of ready to roll those out, we have actually already rolled

them out. But I think we have all been surprised by the sorts of issues that come up that maybe hadn't been foreseen and it made everybody very busy. But one of the advantages of the system we have in place is that we really do have a regional system and so there's a lot of planning going on at the state level right now which involves our disaster community advisory committee and health officials and hospital leaders around the state so that we have a coordinated effort that we are sharing scarce resources and probably the most important thing we decided which has been supported by the governor is that we will not have any hospital go into crisis mode where they are actually making triage decisions about patients until every hospital in the state goes into triage mode. And the reasoning there is that if not every hospital is there, then we need to be transferring patients rather than denying them at some hospitals and not others of care that might be of benefit to them.

Host: And is that happening yet or is that something –

Dr. Diekema: That has not happened yet.

Host: That's good.

Dr. Diekema: We have hospitals that are very close to crisis mode and not surprisingly, Evergreen is one of them. Because they have a significant chunk of the adults in the region who are very sick. But others are starting to get there. But no, we're still in the parlance of the disaster preparedness community, we are still in contingency mode where we are making changes but none of those actually jeopardize usual standards of care. But we're starting to talk about what it will look like in two weeks. I think most people realistically are assuming that we may need to declare statewide crisis mode in a couple of weeks where we would be making hard decisions.

Host: Particularly around ventilators?

Dr. Diekema: Ventilators will be an issue. ICU beds will be an issue. We already have regional efforts to increase our bed capacity for instance, just north of Seattle we are using a soccer field and putting up a huge tent that will house about 200 potential patients. I don't think we foresee taking care of six patients, I don't think we see those as mobile ICUs but one of the issues the adult hospitals are having right now which is one of those things that maybe we didn't foresee when we talked about this in theory is that they're having trouble freeing up beds because some of their older patients who are actually dischargeable, communities from which they came, the nursing homes for example won't take them back and our homeless population doesn't really have anywhere to go so, I think part of the of the idea with these additional beds is actually to have a place, maybe a step down unit for some of these patients to go to allow the hospitals to take care of the sickest of the sick.

Host: What about the healthcare workforce with the need for more ICU beds, you need more ICU doctors and nurses?

Dr. Diekema: Yes and just hospital staff. I mean ERs are busy and not every patient with COVID requires a hospital bed, 80% of them are probably – who are getting admitted are on the floor. And staffing I think is going to be the real barrier. We can probably create beds but then the question comes, who is going to staff those and I – right now, I think we are looking at two prongs, one is bringing physicians and nurses out of retirement; those who are willing to staff some of those areas. And the

other is to retrain and redeploy other healthcare workers who have less to do, dentists, occupational therapists, physical therapists and a number of healthcare professionals are actually – have less work to do right now because clinics have been closed and almost all elective procedures, surgeons actually are another group that right now because so many elective surgeries have been cancelled, they are sort of looking for ways to help.

So, that's probably – those are probably the two ways we'll do this. But the other piece of the healthcare shortages is it's not just that we are expanding beds and need people to staff them but our workforce is going to get sick and that's already started to happen and then you have professionals who are in high risk groups or at least believe they are and they have concerns about their own health and some of those are choosing not to work or and a small number may refuse to work because of the risks involved and all of that cuts into obviously the workforce we have available.

Host: How does the community disaster planning committee think about physicians or nurses who are in high risk groups? Are there any criteria by which you say no, you shouldn't work?

Dr. Diekema: Well I don't know that we have any established criteria and interestingly, the regional group has not looked at this in much detail. I've been spending a lot of time on this issue to help our local hospitals make those decisions. What we are trying to do is tailor it to the disease because COVID looks different than influenza or some other pandemic. And right now, the clearest high risk groups are probably those over 70. Now we have an advantage in that there aren't that many people over 70 in the workforce. We really don't know whether pregnant women are a high risk group or not. We don't really know whether immunocompromised people are. There's some evidence that those with heart disease and pulmonary disease may be. So, I think the strategy we've taken to date is to say look, you're professionals, you have a duty to work as long as we can protect you adequately. And as long as hospitals are able to provide adequate personal protective equipment, there is probably no reason not to have that expectation. I think the other piece that I found very compelling about outbreak is that it has gone on, it's become very clear to me and again, it's hard to find really hard data to demonstrate this but certainly, my experience and what I'm reading I think would justify this conclusion and that is that I really think right now that our workforce is more at risk working with patients who are not suspected to have COVID than they are working with patients who are. Because they are not wearing PPE when they see those patients. And at least in the World Health Organization –

Host: Some percentage is infectious.

Dr. Diekema: Correct. Yeah. And they are getting it in the community. And they are getting it from family members. So, I think there is kind of a false sense of reassurance if you are 65 year old for example and thinking well if I just avoid the COVID patients I'll be fine. I think that's probably unjustified. I think if you really want to be rational about this you either have to say groups, we are worried about have to stay home and not leave the house. Or they can come into work and wear personal protective equipment when it's appropriate and probably not be at all that much greater risk.

Host: Yeah. When do you send healthcare workers home? What sort of criteria for self-quarantine?

Dr. Diekema: I think that's also evolved. When the epidemic started most of our hospitals were sending anybody home with any sign of illness and anybody obviously anybody who was positive for COVID or

had had international travel was actually supposed to be in isolation for 14 days and stay away from the hospital. As the epidemic has evolved and it's sort of moved into the community in sort of a widespread way, I think we've sort of changed our assumption to assume that almost anybody has had a potential contact and it's not just the positive testers and obviously, we can't just tell everybody to stay home because then we can't staff a hospital. So, we have moved more in a direction of – and most of the hospitals are doing this now, screening everybody walking through the doors of the hospital, telling all nonessential, nonclinical staff to work from home and so when you go through the doors of the hospital, you have your temperature taken and you have to screen that you are not having a cough or myalgias or sort of symptoms consistent with COVID. And if you screen positive, or have a temperature over 100, you go home and self-monitor.

We do have testing available to employees who screen positive for symptoms, so they do have that option to get tested.

Host: That's up to them then.

Dr. Diekema: Yeah and even with a positive test, if they are still febrile, we are not going to let them come back because they are false – or with a negative test rather. There are false negatives. So, we have to kind of assume that they may still be carrying the virus.

Host: Yeah. What's your sense of the morale of the hospital staff?

Dr. Diekema: I think it's mixed. There are always individuals who kind of get energized by the crisis atmosphere. They feel like they are really making a difference and they rise to the occasion and the energy level is good. I have sensed over the last week increasing levels of anxiety from bigger numbers of people. And part of it is just the barrage of information not all of which is consistent. They hear different things from different sources and so they're like the general public, not entirely sure who to believe and not entirely sure just how safe they are working in a hospital environment. So, the anxiety levels are high.

Host: You said at the beginning that you'd been planning for a long time but there were some surprises in this particular disease or outbreak. What were some of those and what should other places be thinking about?

Dr. Diekema: Well I think one of the things that struck me was that despite the fact that we have been planning for this and talking about it for years; it still took a while to get things off the ground. It took a while for people to realize we actually had a situation that had the potential to get really bad, really fast. I think the rapidity with which this virus started to spread was striking to a lot of people. And so, it does take time particularly when you are dealing with a region with thousands of healthcare workers and hundreds of hospitals to get everybody on the same page taking things seriously. And of course, some of the regional sort of nonhealthcare interventions are pretty new to this country. I mean the shelter in place mandates that some places are putting in, social distancing, the cancellation of almost everything, and then the rush on grocery stores to buy toilet paper is all just –

Host: I never saw that in any planning documents that I read.

Dr. Diekema: Yeah, we didn't plan for that. And the other thing we didn't plan for quite honestly which some places, businesses have started to implement really well is there are these essential businesses like pharmacies and grocery stores that have to stay open and we really didn't talk about how can we keep them open safely. That person who is a cashier, a bagger at the grocery store, what sort of efforts should we be thinking about to protect them from getting infected or spreading infection to customers. And that was one of the things that we probably could have implemented weeks earlier if we had thought about those issues long before, but we hadn't. So, it took a while for people to say heh, this is an issue. And we should be thinking about –

Host: A lot of the surprises were outside the hospital system, outside the healthcare system.

Dr. Diekema: Yes.

Host: Anything else you'd like to add and then we can wrap this up. I know you're busy.

Dr. Diekema: Oh, not at this point. I do think it's going to be interesting to see what happens in the rest of the country. My assumption is places like Michigan and Iowa and Kansas City are probably a couple of weeks ahead of Seattle and San Francisco and New York in terms of social distancing efforts. So, if we're lucky, the impact will be less serious in places like that having taken advantage of the fact that you could see what was happening in some of the hot spots.

Host: That's what we're hoping. Well thank you very much for taking the time. We've been talking to Doug Diekema a Professor in the Department of Pediatrics at the University of Washington and a Physician at Seattle Children's Hospital. Thanks so much for joining us Doug. This is the Pediatric Ethics Podcast from Children's Mercy Hospital in Kansas City. I'm John Lantos.