Crisis Standards of Care Considerations: Reducing Provider Distress

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Provider psychological distress from the impacts of resource shortages on patient care throughout the COVID-19 pandemic has been profound and may contribute greatly to decisions to leave or change practice, burnout, and persisting mental health effects.[1] Reducing the triage decisions healthcare providers have to make under crisis conditions and providing robust support when these decisions are unavoidable may contribute to reducing the levels of distress. ASPR TRACIE identified several factors that contribute to provider distress during crisis situations along with potential mitigating actions to consider.

Inability to Maintain Equitable Access to Care through Patient Transfers

Providers were routinely distressed during the COVID-19 pandemic and other patient surges due to the inability to transfer patients to higher levels of care. At transferring facilities, providers felt they could not provide adequate care to patients who would conventionally be transferred. The number of phone calls and time consumed for providers trying to find a receiving facility increased that distress and distracted from patient care. At receiving facilities, providers expressed frustration they could not accept critically ill patients while providing what they felt was non-beneficial care to many patients already in their hospitals. In some cases, these patient transfer challenges exacerbated inequities between rural critical access hospitals and tertiary care centers. Stress was also generated by situations where selected hospitals (often serving disadvantaged populations) were overwhelmed compared to others in the area.

Some jurisdictions used Medical Operations Coordination Centers (MOCCs) to relieve the burden on individual providers by monitoring available beds and hospital conditions regionally and helping direct patients to a facility that could best provide care. MOCCs serve as a one-call point of contact for transfers when usual transfer partners are at capacity. They also can assist with load-balancing overwhelmed hospitals and help prioritize patients for transfer when limited resources exist. Systems like MOCCs reduce work and distress by taking responsibility for patient placement and prioritization off the provider as part of a regional approach.[2]

Lack of Administrative/Political Support

Providers are often frustrated by a "bedside to boardroom" discrepancy in perceived compromises in care. During the pandemic, both hospital and political leadership were often reluctant to acknowledge how strained hospitals were and the crucial triage decisions providers were forced to make. Formal acknowledgement of crisis conditions by states was rare.[3] Providers felt abandoned and unsupported, and bore the brunt of expectations of patients and loved ones that could not be met with current resources. Adding to this, some hospitals were inconsistent in how resources were allocated within facilities (e.g., boarding unstable critically

[1] Shanafelt, T., West, C., Dyrbye, L., et al. (2022). Changes in Burnout and Satisfaction with Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic. Mayo Clinic Proceedings. 97(12):2248-2258.
[2] ASPR TRACIE. (2024). MOCC Toolkit v3.
[3] ASPR TRACIE. (2022). Crisis Standards of Care Summary of State Actions During COVID-19.

ill patients in the emergency department while continuing to perform non-emergency surgeries requiring intensive care unit beds).

Distress during crises can be mitigated when providers feel supported by their hospital and political administrations. Hospital leadership can support staff by activating incident command and ensuring the command structure is aware of and backs the triage decisions providers make. Leaders can also ensure risk to patients is distributed equally across the hospital. At the jurisdictional level, whether or not a formal declaration of crisis standards of care is made, political leaders should acknowledge the strain on healthcare resources and the difficult choices being made by providers as well as the delays and limitations in patient care that can be expected.

Absence of Decision Support

Another source of distress for providers is the need to make decisions about care during crisis conditions with many unknowns and nowhere to turn for advice. In many cases, providers did not have the ability to consult with an expert provider on a triage decision. Guidelines are often lacking for what providers should do to mitigate a shortage of resources, such as medications, dialysis, or respiratory support devices.

To mitigate this distress, all providers making triage decisions outside their usual scope of practice should have the ability to consult with a physician with expertise in the area. Hospitals should ensure there is an expectation and mechanism for these consultations. MOCCs can play a significant role in facilitating these consultations for providers in community hospitals experiencing delays to transfer. When a resource shortage will affect multiple patients or be ongoing, clinical guidance must be developed with progressive strategies of restrictions providers can use as the resource situation changes over time. The hospital and region should align strategies and communicate the degree of restrictions necessary under the current conditions. Clinical guidelines for resource allocation may originate from national medical specialty societies, state agencies, or the hospital itself.

Limited Legal/Regulatory Support

Providers face legal and regulatory barriers to implementing strategies for the common good. For example, during the COVID-19 pandemic, courts issued restraining orders preventing hospitals from withdrawing non-beneficial care[4] and providers faced liability concerns related to their roles providing consultation to state MOCC and scarce resource allocation guidelines. Limited provider protections add concerns about legal liability, damage to professional reputation, and potential financial consequences to already difficult decisions about how to provide patient care in resource-constrained settings.

To reduce these stressors, providers and their hospitals need qualified immunity to make triage decisions when they are consistent with the situation and with clinical guidelines for resource shortages. Additionally, all states should consider adopting legal protections for providers who give consultation advice to the state or during care-in-place situations when patient transfers cannot be accomplished. (For further discussion, review the CSC Legal/Regulatory Considerations.)

[4] Harlow, T. (2022). Mercy Hospital Must Keep COVID Patient on Ventilator, Judge Rules. Star Tribune.

Lack of Psychological Support

Not being able to provide optimal (or even adequate) care to patients is extremely stressful for healthcare providers. Hospitals should acknowledge the stresses providers are experiencing and try to mitigate them to the degree possible. This could include consideration of "buddy systems" of peer support, adequate rest cycles, respite areas, peer and professional support mechanisms, and physical comforts that can be provided.[5] However, mitigation of stressors is always preferred to addressing the consequences.

Conclusion

Healthcare providers can be under enormous pressure when making decisions about patient care under contingency and crisis conditions. Facility/health system, regional, and state decision-makers can help relieve this stress by making tools such as MOCCs and clinical guidance for scarce resource allocation available to providers and providing administrative, legal, and psychological support for their actions.

Access the other documents in this collection:

- CSC Considerations: De-Escalation of Care
- CSC Considerations: Legal/Regulatory
- CSC Considerations: Non-Beneficial Care
- CSC Considerations: Pharmaceutical/Supply Shortages
- CSC Considerations: Recognizing and Mitigating Crisis Care

[5] Heath, C., Sommerfield, A., and von Ungern-Sternberg, B. (2020). Resilience Strategies to Manage Psychological Distress Among Healthcare Workers during the COVID-19 Pandemic: A Narrative Review. Anaesthesia.75(10):1364-1371.