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Ethical Dilemmas During and Beyond COVID-19

While ethical dilemmas existed in healthcare prior to the COVID-19 pandemic, this crisis presented healthcare workers with unprecedented challenges during patient surges related to adequate supply (e.g., of personal protective equipment, pharmaceuticals, and other hospital supplies) and ensuring equitable access to treatment and vaccines. ASPR TRACIE met with the following subject matter experts to learn more about how they managed ethical challenges during the COVID-19 pandemic and their thoughts on adjusting expectations for the future:

- **Laura Evans**, MD, MSc, University of Washington, Professor, Division of Pulmonary, Critical Care and Sleep Medicine; Medical Director, Critical Care UWMC
- **Vikramjit Mukherjee**, MD, NYU Langone, Assistant Professor, Department of Medicine at NYU Grossman School of Medicine; Medical Director, Special Pathogens Program and Medical Intensive Care Unit (MICU), Bellevue Hospital Center
- **Matt Wynia**, MD, MPH, FACP, Professor, Colorado University School of Medicine and Colorado School of Public Health, Director, Center for Bioethics and Humanities, University of Colorado

■ John Hick (JH)

Most of us in healthcare can now take some time to look back at our experience with the COVID-19 pandemic and survey the moral distress and ethical challenges we and our colleagues faced so we can understand and prepare for what is next. When did you realize that you didn't have an ethics "playbook" during the pandemic?

■ Vikramjit Mukherjee (VM)

The speed at which this hit our city took us all by surprise. We knew it was brewing in other parts of the world, but it went from 0 to 100 in New York City very quickly. We simply were not prepared for this kind of surge. As you said, there was no playbook, and we created solutions as problems came along. I don't think most people realized that we were also learning as we went.

■ Matt Wynia (MW)

Most systems and hospitals have crisis standards of care (CSC) guidance documents that include ethical guidance. The fact that they weren't used, and many didn't know they existed, could be attributed to poor communication and integration of the ethical guidance into incident command and overall emergency operations.

■ JH

What domains faced the most unexpected challenges?

■ VM

At first, we expected this to be a surge of demand for ventilators, but that was the least of our worries. The main issue was staffing. Regarding dialysis we were also caught off guard; the need was disproportionate to the supplies what we had.

■ Laura Evans (LE)

I worked in Seattle for the bulk of the pandemic but returned to New York in 2020; I had two very different experiences. Within the Seattle region, we never entered crisis standards of care (CSC) by any definition, but despite that, the stress and strain on the system was profound and there was a pervasive, profound sense amongst the team as whole that we couldn't deliver the care we wanted to or typically would deliver. Because part of my role is to reassure people that we are providing really good care, supporting staff—who were experiencing true, genuine heartache—was a challenge.

For example, the University of Washington Medical Center plays important role in the region as a tertiary referral center. It is a regional transplant center, provides advanced heart failure support, and provides some of the rarest and niche service in the region. We couldn't accept our usual transfers, a big part of the services we traditionally provide. Feeling like we couldn't perform our usual role or fulfill our sense of mission and obligations to our community was distressing. Our biggest capacity constraint was staffing, not necessarily medical supplies or physical rooms.

■ MW

Denying transfers you would normally take, to provide care you are uniquely suited to provide, means some of those patients will experience worse outcomes. It is therefore not “functionally equivalent” to usual care, which means it is CSC. We have either had a hard time accepting that contingency care isn't always, in fact, functionally equivalent, or we have had a hard time accepting that we were in CSC.

■ LE

To complicate the situation even more, there was never a “bright line” or signal indicating we had crossed into CSC. Everyone knew they were essentially in CSC but there was never a declaration. This region would have done so when the criteria were met, and the political side was prepared to do so, if necessary, but there was no bright on or off switch. It was important for us to note that CSC doesn't just happen all at once; it is a gradual process. For example, our normal standard of care is to perform patient assessments with a specific frequency. At some points during surges, we made slight modifications to the frequency of these assessments. This felt so different to staff at the bedside and modified things just enough that it didn't feel like business as usual. These changes caused apprehension and staff to question how much worse the situation was going to get, how long it might last, and whether and how they could support one another throughout the duration. A pandemic is different from other disasters or mass casualty incidents; COVID-19 unfolded and was protracted. The predictions about what was coming were often incredibly ominous (and sometimes true). When to pull that switch—how to recognize moving into next phase—I don't think it's possible for the entire system to do that uniformly.

One participant noted that they did apply less aggressive ICU treatment when they felt it would be futile but never faced the challenge of withdrawing care. They noted being concerned about legal protections, especially in the absence of a state declaration of CSC.

■ JH

Lawsuits were reported in some states from patients or families who felt they were denied treatment – particularly in cases of disability. Providers sometimes made implicit triage decisions based on what they thought was coming, without CSC being invoked. What do you think contributed to these situations?

■ VM

CSC prepares us well for one significant event, but this protracted event—even two years later—it remains unclear how to go from contingency to crisis standards. It is hard to draw the boundaries. In New York, we had triage guidelines in mind, and those were utilitarian and equitable in nature. The crisis care literature addresses acute issues, while the actual transition between CSC and contingency was back and forth during the pandemic.

■ JH

In Minnesota, we struggled with when to move from usual futility definitions to an inappropriate care definition when considering issues such as withdrawal of support. Sometimes it is very clear that is a matter of time before a patient is going to die in the hospital, and they are taking beds that other patients could benefit from. Ethically speaking, how do you determine who suffers the least? How do we transition from our usual futility decisions to making them under these conditions?

■ VM

In New York, we didn't formally have to withdraw care because of futility of care.

■ LE

We do not frequently face this specific situation in the ICU. What was more unusual was having increased visibility into the ripple and unintended effects on the patients who could not get into our facility because beds were occupied. The level of awareness of these consequences was a source of substantial distress for staff who felt like they weren't helping people they technically would be able to help because they were instead providing care to someone in that bed.

Every state has regulations around withdrawing life support. In Washington you can decide not to resuscitate by assent; in New York, the process is consent-based. That said, in Washington the legal, emotional, and ethical considerations related to withdrawing support over family objection are extremely complex. My colleagues and peers had different levels of comfort with this decision. We have systems in place, but even the willingness or appropriateness of initiating that process lacked uniform guidance, let alone consistency in practice. This process needs improvement; we need to better define the triggers and thresholds of defining and discontinuing nonbeneficial care.

■ MW

Moral distress is one consequence of operating under a first-come, first-served basis and not implementing CSC instead. The other possible consequence is having worse outcomes overall because the patient in the bed right now has a lower chance of survival than the person who is being denied a transfer.

We traditionally spend so much time in the ICU building relationships with families. The relationships go from introductions to very intense care decisions in a short period of time. These relationships can help us make difficult decisions as necessary.

Trying to do that over a video connection is near impossible; it was very hard to develop a sense of mutual trust. Families needed to trust the care team without being able to be with their loved one. That was even more prominent when we had family members from more traditionally vulnerable communities with understandable concerns about trusting the medical system. You can overcome some of that apprehension in person, but over video, this was challenging. This unmasked a lot of distrust of the medical system, making patient care even more challenging.

- Laura Evans

One participant noted that there was a level of oversight lacking at the height of the surge. There were limited visitation rights for family members or other visitors, and not a lot of "eyes" on providers making these decisions. A lot of boundaries were pushed.

■ JH

One of the key quandaries during COVID-19 was that these decisions would ideally be made in a standardized way, and yet, we don't have a standard way of making these hard decisions. Where do we go from here to develop a standardized approach?

■ LE

We had many discussions about this. The Northwest Healthcare Response Network (NWHRN; our local healthcare coalition) was very active in this space and convened a lot of very smart, thoughtful people to try to address some of these questions. Leaving staff to their own best judgment opens the door to potential inequity. As clinicians, we can't prognosticate unless it's very clear a patient is going to die or get better. Most patients, however, fall in the middle.

We considered incorporating other measures, such as a measure of frailty to address the inequities of the SOFA score. NWHRN stood up models of triage teams and carried out simulation modeling with them using a deidentified data set of COVID-19 patients. Teams were asked to review the data and triage patients to determine if there was inter-rater reliability across sites. Using patient level data to simulate and test systems before we need them is a good way forward to ensure equitable treatment.

■ VM

We also know that COVID-19 hit underserved communities harder, because they couldn't work from home or access healthcare as easily as many others. A scoring system would have no effect on accounting for pre-hospital access or other variables that made someone seek treatment later than a patient from a more resourced community. This is not an "apples to apples" comparison.

■ JH

Our whole goal is to provide equitable access to care. If one hospital is overwhelmed, we have a major access and equity problem. Load balancing is so important in reducing these access issues. And incorporating social factors into these allocation decisions is controversial due to equal protection issues. From a frailty standpoint, those systems have drawn the attention of disability groups. What do we do?

■ LE

Yes, this aspect does provoke a vigorous reaction. Allocation frameworks don't address anything leading up to hospitalization. From a clinician's standpoint, it does make sense to try to predict survivability. But that does not address many of the other concerns (e.g., incorporating social vulnerability indices into the triage decision model). With each step you take prioritizing people with higher social vulnerability indices, many other issues arise.

■ JH

Laura, after Hurricane Sandy, you were faced with power failures at Bellevue and had to work with staff to think about discontinuing therapy for some patients. How did you make those decisions?

■ LE

Yes, that was several years ago now, and a very different model of disaster than the pandemic. The hurricane was a sudden catastrophic event. The question we were faced with did not focus on initiating life support. We were making decisions about providing critical care services to patients already in the ICU.

At that point, the best tool we had was the SOFA Score model. We put together an ad-hoc triage group, ensuring none of them were involved in direct provision of patient care. To prevent ties, this group had an odd number of participants. What was distressing for everybody was that we had far more patients who fell into the critical care access provision group than we had resources for, so we carried out a secondary level of triage to determine the group's best clinical judgement that this person would do well with critical care. The group of five came up with consensus order. We didn't end up needing to

Anecdotal evidence suggests that implicit triage was happening all the time across the country. Frontline workers were not always cognizant of how many ventilators were available while making decisions. There was also a lack of dialogue with the family about patient's wishes. Facetime and telemedicine does not replace face-to-face interactions.

use that, but this was incredibly stressful for us and the teams who were treating the patients. Not having them involved in the evaluation created a source of conflict between us. A clinician's role is to provide the best care, while our role as the triage team was to make the best decision.

■ JH

Was there agreement within the team?

■ LE

In real time in an untrained group, there was discordance. We resolved it with conversation and achieved consensus.

■ JH

To what degree did you engage your ethicists during the pandemic?

■ VM

Our plan was to have a triage team made of intensivists not caring for patients. As we made our triage resource allocation documents, we had their input. Beyond that there was not a role for ethicists to play during the surges. We didn't rely on them. We did plan to use them and rely on them if we ever did have to formally allocate resources.

■ LE

I'm always concerned that these decisions made by well-intentioned systems fail because they don't meet the needs of the people providing care, or that the model we are building is not going to be timely or nimble enough to help bedside clinicians. For example, the turnaround time must be fast for a critical patient. Having ethics being a driving force in these systems is essential, but not always efficient in triage at the bedside from a time-based perspective. The ethical consultant model in a mass casualty incident looks very different during a pandemic, where some patients are already on ventilators.

■ JH

As usual, translating ideals into practice gets sticky. You can't have an appeals process when you have six patients in the emergency department and have to decide who to intubate. Otherwise, you fall back on ad-hoc decision-making and that is not where we want to be—where providers feel like they are left to make own decisions. How do we balance structure with ad-hoc decisions?

■ LE

If we don't have a working structure, you default to first come, first served, then clean up later. The systems we are designing are well intentioned and probably unlikely to work. We might need to stop making "perfect" the goal, and instead make "iterative" and "better than what we're currently doing" the goal.

■ JH

Data from Vanderbilt has shown that if a COVID-19 patient that was a candidate for extracorporeal membrane oxygenation (ECMO) didn't get it, almost all of them died. How do we steward a very limited resource when we're tapped out under non-disaster circumstances? How can we set up a best-case use scenario?

■ VM

In my view, the ECMO question is technically one of resource allocation during peacetime. Those principles are hedged on resources, staffing numbers, and equipment

■ LE

There is lots of precedent here. In normal or peacetime circumstances, we are able to tell patients that the risk of certain therapy exceeds the potential benefit. This is in line with the Hippocratic oath. ECMO is interesting because when you have "appropriate" candidates and not enough resources, there is concern about ripple effect on other patients and being able to provide more routine care. I was struck by the Vanderbilt data—they did a really good job selecting who would be able to benefit from ECMO. We do need to get better with context-specific prognostication; how can we ensure that a patient is likely to die without ECMO and likely to survive with it? We might also use this as an opportunity to better develop systems that work outside of the ECMO context.

■ MW

This is a futility determination, which unfortunately doesn't help when there is an absolute shortage and more people for whom ECMO would be appropriate than there are ECMO resources. That said, there's something to be said for learning about rationing within disasters for application of "routine" rationing during peacetime. This applies to ECMO almost everywhere, but it also applies to drug shortages.

■ JH

Regarding triage during these types of events versus mass casualty events, do you feel that there isn't the level of scrutiny—ethically, procedurally, and morally—for some of these decisions made in the spur of the moment? For example, do you think that decisions emergency physicians or surgeons make in the moment are not scrutinized as much as the decisions of physicians in the ICU?

■ VM

This brings up the difference between actively causing harm versus passively not causing harm. Not doing something is somewhat easier than actively taking support away. It is a more comfortable decision to make to not intubate someone than it is to pull life sustaining resources, even though it leads to the same outcome. That is where having ethics at the bedside is impractical; there needs to be some sort of model to help make those decisions.

■ MW

This point might be a distraction, but in one sense it should be morally and clinically easier to withdraw a resource that someone has had a chance to use than to choose not to start it in the first place. After all, at least that person had a chance, and now you have more data on whether they are doing well or continuing to do poorly despite getting the resource. But I admit, it doesn't feel easier or more comfortable.

■ LE

When a surgeon decides that a patient is not a candidate for a surgery, we traditionally defer to their expert judgment. We need to determine how to account for the fact that our clinicians are trained in this and can determine how best to allocate resources. Maybe we should consider their expertise and training in making these decisions as a core competency.

■ JH

How can we shift people's expectations around end-of-life care?

■ LE

Cultural and societal expectations are hard to change. Practicing in different regions of the country has allowed me to understand the variations in how people approach this. The palliative care team traditionally does a lot of work up front to help people define their wishes. They explain options, including options that help control symptoms and maximize their quality of life. Most people prefer quality over quantity, so we need to put infrastructure in place that maximizes this; this is a huge undertaking.

For a long time, I've been saying that we should be using routine shortages to learn and practice how to do triage in disasters better. But the opposite is also true: what we've learned in the pandemic should be applied to these more common triage dilemmas.

- Matt Wynia

We also found that community members who historically have an intrinsic distrust of the healthcare system were more likely to choose more aggressive treatment (e.g., more dialysis, more chest compressions, more care). It is key for us to address this type of distrust when discussing options with patients and their loved ones.

- Vikramjit Mukherjee

■ VM

It is the responsibility of the medical community to engage people in the consequences of critical care; we especially need to do a better job explaining this to those not as involved in critical care. Asking a patient's loved ones whether they want chest compressions is a non-starter and an unfair question. It is our job to explain what the tradeoffs are. It was and is difficult to have these discussions over video chat. Those of us in the field are familiar with the data that shows how long-term acute care comes at huge expense to family; it also affects the patient's quality of life and the healthcare system overall. It behooves us to explain to the family that yes, we can do this, but at this expense.

■ JH

What closing thoughts do you want to share?

■ VM

From a system perspective, it is still disturbing that many areas do not have patient load balancing in place. Interhospital transfers can be done safely, and it is unacceptable that we don't have agreement between systems to share resources. I would like to work on this more. Ethics really starts with access, and we need access to be consistent across a geographic region.

■ LE

I read a quote from someone in NYC at the beginning of the pandemic who said, "My biggest fear is that people will look back and not remember that this happened." My biggest fear is that we won't learn from this or use both the good things and the failings of the system to improve our plans and processes. If we fail to learn from this, that is an ethical failing on us. We have an ethical obligation to do so as a system and individuals.