Ethical considerations during the COVID-19 pandemic

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**ABSTRACT**

The care of patients during the COVID-19 pandemic has added many layers of complexity to ethical issues. Our response emphasizes the importance of having an ethically sound framework to inform our decisions, requiring caregivers to consider what is ethically optimal and feasible for the patient. It is increasingly important to understand the ethical principles and to appropriately apply them to both patient management decisions and guide scarce resource allocation. If we are to be prepared to face the many challenges of this pandemic, we must prioritize the ethical demands to our treatment and management concerns.

**CLINICAL ETHICS DURING A PANDEMIC**

Challenging ethical issues in healthcare are common because central to our role as caregivers is the relief of human suffering. Reviewed on a global scale, ethical issues surrounding pandemics are not unique to our healthcare systems, neither are the ethical issues surrounding scarce resource allocation. The concept of scarce resource allocation has value-incorporation, as shown during World War II when the US production of penicillin was not enough to meet all the need, with 90% being used for soldiers. This demonstrates the promotion of instrumental value (saves the most lives because soldiers were most valuable at that time) in allocation.1

As part of an anticipated response to the effects of the COVID-19 pandemic, the importance of having an ethically sound framework to inform our clinical decisions cannot be emphasized enough. During this time, healthcare leaders are asked to engage in proactive planning where addressing worst-case scenarios is the first step to reducing morbidity, mortality, and other undesirable effects of an emerging public health emergency.2

**POPULATION HEALTH VS INDIVIDUAL RIGHTS**

A public health emergency, such as a surplus of people seeking healthcare as well as critically ill patients with COVID-19 or another severe respiratory illness requiring admission to the intensive care unit (ICU), disrupts normal processes for supporting ethically sound patient care due to the steeply rising supply demand gap for treatment or supportive measures.3 The ethical framework in a public health crisis shifts to promoting the health of the population by using resources responsibly to maximize the total number of lives saved. Understanding the guiding principles surrounding public health ethics may help promote trust and alleviate moral distress and burn-out in bedside providers under austere circumstances.4 The focus of public health ethics, can require limitations on individual rights and preferences due to need for prudent use of resources and strategies.3 These limitations must be consistently and equitably applied, be proportional, necessary, and relevant.5

**PRIORITIES OF HEALTHCARE PROVIDERS**

During pandemics, the priorities of healthcare providers change. Shifts in these priorities create competing obligations for providers who are naturally geared towards focusing on their individual patients. Policy planners are asked to consider the two competing ethical obligations that must be held in balance (for the sake of brevity we only consider the two primary obligations listed here but concede that other ethical obligations exist):

- Duty to care—relief of suffering and respect for the rights and preferences of patients, which is a focus of ethics consultation services.
• Duty to promote equity and moral equality—fairness relative to need in the distribution of risks and benefits of care provision in society, which is the focus of public health ethics. Ethical reasoning thus requires caregivers to consider what should be ethically optimal and feasible for the patient. This is known as the crisis standard of care—a recognition of limitations during times of scarcity. In addition to duty to care and fairness, this ethical guidance is also based on duty to steward resources, transparency, consistency, proportionality, and accountability. As an ethical concept, it offers concrete guidance for a system-wide response to a disaster, addressing allocation.

**ETHICAL PRINCIPLES GUIDING PATIENT MANAGEMENT IN A PANDEMIC**

The severe acute respiratory syndrome (SARS) outbreak in 2003 exposed the healthcare systems’ vulnerabilities, revealing the need for coordinated and cooperative responses across national borders. As such, the Pandemic Influenza Working Group at the University of Toronto Joint Centre for Bioethics was formed. They created a document that provides a framework for values at risk during a pandemic. This is being used as a framework for ethical decision-making during the COVID-19 pandemic (Table 1).

**ETHICAL PRINCIPLES REGARDING SCARCE RESOURCE ALLOCATION**

A majorly anticipated ethical dilemma is the allocation of finite resources, defined as measures, rationale, or means by which resources or access to care is obtained by individuals to exclude others in a time of crisis. Estimates indicate that a moderate pandemic would infect 64 million Americans and necessitate hospitalization of 800,000 (1.25%) with 160,000 (0.25%) needing space in the intensive care unit (ICU). With dwindling resources as hospitals approach surge capacity, it is likely that an increased need will cause competition for resources such as testing, personal protective equipment (PPE), ventilators, vaccines, and ICU beds. Ethical principles that guide resource allocation are well-described in the literature (Table 2). Ultimately, we stress that no single value stands alone in determining which patients should receive scarce resources.

**APPLYING ETHICAL PRINCIPLES TO RESOURCE ALLOCATION**

It is important to remember that context will determine the crisis standard of care in order to apply ethical frameworks to our decisions. Thus, it is important to stress how pandemic-associated priority shifts will lead to the selection of ethical principles guiding institutional- and clinician-driven patient-level decisions. The current overarching goal is to “privilege the greater chance to successfully overcome critical illness with a greater probability of maintaining a good quality of life.”

Redefining our approach to individual patient care while adhering to the principles of clinical appropriateness and proportionality of care happens as we move between the three operational stages in a pandemic: Conventional, contingency, and crisis. Like Italy, we must contextualize and account for the current disease severity, comorbidity, and the presence and reversibility of organ failures when allocating crucial resources.

**Allocation of ICU resources (beds and ventilator)**

The potential for recovery should be part of a patient’s criteria for ICU admission. This approach will be a conscious shift, taken deliberately so as not to pursue our usual framework of ICU admission and care on a “first-come, first-served” basis. This shift in the care model is indicative of the health emergency nature of the care provision, as illustrated by Italy, which, in March 2020, struggled with being the second most-affected country globally. Clinical decision support systems in triage decision-making with validated criteria for limits (eg, Sequential Organ Failure Assessment (SOFA) scores, Multi-Organ Dysfunction Prediction Score (MODS), age) are helpful. As such, ventilator allocation, should follow the same principle as allocation of ICU beds to patients with higher chance of survival. Consideration of time-limited trials with clear communication of this ahead of time will address proportionality of care and enhance transparency to families. It is also important to state that all patients, regardless of COVID-19 status, should be treated similarly during the pandemic (ie, viewed with the same lens of chances of survivability) when it comes to consideration for ventilator and ICU bed allocation.

**Withdrawal of life-sustaining treatment**

Early consideration of a patient’s history, current clinical course, expressed wishes, and expected goals are important when the patient is not responding to prolonged life-sustaining treatments. A consistent mechanism of streamlined de-escalation of care is important to have to guide clinician decisions. When a decision to withhold or withdraw life-sustaining
treatments is made as a matter of good clinical practice, appropriate palliative care should be made available to hypoxemic patients.

### RESPONSIBILITY TO FAMILIES

Communicating the definition of crisis standards of care to patients and families at admission is crucial to...
fulfill our commitment to transparency. Complimentary services (eg, ethics service, palliative care teams) should be involved early to potentially decrease distress for the patient and family. This applies to all patients being cared for during the COVID-19 pandemic, regardless of COVID-19 status.

**Use of extra corporeal membrane oxygenation**

Extreme measures with little evidence and greater resource utilization (blood products, personnel, exposure) that portend poorer prognosis challenge the principle of maximizing benefits, which aims at saving the most individual lives or number of life-years by giving priority to patients likely to survive longest after treatment.9

**Need for tracheostomy**

In the context of COVID-19, a tracheostomy...
increases the number of healthcare providers exposed and increases PPE use, which at various stages of the pandemic might itself be a scarce resource. So tracheostomy would be a case-by-case decision point.

■ ACCESS TO DIAGNOSTICS TESTING

COVID-19 testing is currently available in Ohio; however, nationally, testing may become scarce, requiring it to be allocated according to the same principles noted previously. We initially prioritize testing based on supply and demand and operating level of the institution (conventional, contingency, crisis). Therefore at the onset, we reserved testing for the patients with the greatest disease burden. As we enter a more conventional level in which normal operations in institutions resume, patients who are not suspected to be COVID-19 positive may require testing to be allocated in order to safely allocate healthcare resources and minimize exposure (eg, being tested for COVID-19 prior to accessing healthcare settings for services such as chemotherapy infusions, invasive procedures, or surgery).

■ RESPONSIBILITIES TO HEALTHCARE WORKERS: PPE, EXPOSURE RISK, PSYCHOLOGICAL AND MENTAL BURDEN

Pandemics challenge our duty to provide care to patients versus the moral obligation to ourselves and our families, among other tensions. The risk of occupation-related infectious exposures reveal vulnerabilities for both patient and caregiver populations during a public health emergency. Such populations include older individuals, those with underlying health conditions, and existence of pre-existing barriers to health care owing to insurance or immigration status. Thus, healthcare workers are prioritized when distributing PPE because their specialized training lends instrumental valve in pandemic response, which in turn increases their perceived duty to provide care.5,9 If providers are sick, their smaller numbers will impair the crisis response, further diminishing our ability to maximize benefits for patients. Furthermore, the risk of quarantine and loss of income, transmission of the disease, and, possibly, death prove that the risk to front-line medical providers is both physical and psychological—both aspects of which should be considered.

■ SUMMARY

The care of patients during the COVID-19 pandemic has multiple layers of complexity. A shift in the perspectives of both patients and caregivers is necessary.

If we are to be prepared to face the many challenges this pandemic will bring, we must prioritize the ethical demands of this disease as much as we do treatment and management concerns. Our Cleveland Clinic approach to resource allocation is summarized in Table 3. It aligns with guidelines from the Ohio Hospital association.16

| TABLE 3 |
| COVID-19 ethical resource allocation approach at Cleveland Clinic |

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<th>Resource allocation</th>
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<tr>
<td>• Recognize that pandemic crisis standards of care can interrupt access to care that is suspended temporarily in outpatient settings.</td>
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<td>• Use a clinical decision support system in triage decision-making with validated criteria for limits (eg, SOFA scores, Multi-Organ Dysfunction Prediction Score (MODS), age).11,15</td>
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<td>• Account for prognosis, comorbidities, and functional status in admission criteria to the ICU.</td>
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<td>• Form triage teams that are distinct from bedside care team and are specific to allocation decision-making, to reduce moral distress during pandemic settings for the treating team.</td>
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<td>• Palliative care for discussions on advanced care planning or decision to withhold or withdraw life-sustaining treatments are done on an individual basis.</td>
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<td>• Patients appropriately triaged to palliative care are notified of their right to discuss concerns or appeal decisions. In these situations, palliative care and ethics consultation services are readily accessible.</td>
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<td>• Conservation and reallocation of resources make utilization more efficient and allow appropriate PPE to be made available to healthcare workers across settings such as the hospital, outpatient, long-term acute care facilities, and hospice.</td>
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■ REFERENCES