# Ethical Issues the Risk Manager Should Consider in a COVID-19 World Part 2

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In Part 1 of the series on rationing services, we looked at the types of healthcare testing and treatment rationing (first come, first served; maximizing total benefits; priority to the sickest; social usefulness; and combination approach), who should be the decision-maker, how those decisions are communicated, and important takeaways for the risk manager. In this section we will explore the ethical issues that arise in times of crisis as well as the framework for rationing decision-making.

The language surrounding this pandemic is "war-like" in its bravado. Aggressive and war-like language used to describe a situation can decrease feelings of empathy, compassion, and concern; this emotional disconnect gives opportunity to decrease the considerations of patient rights, patient and family emotional needs, and self-care.[1] It is first important to realize that this is a worst-case scenario for healthcare practitioners and the medical establishment as a whole.

There is no way to ration healthcare in a manner that will leave people feeling "good" about the outcome. Support, structure, and consistency are the keys to moving forward in these trying times. For the risk manager there are two primary issues anecdotally discussed: (1) the ethical issues and (2) operational issues. Ethically, there are a host of concerns which include rationing in light of the institution's mission/values, managing staff burnout and moral distress, maintaining the physical and mental health of our practitioners, and the concerns of rationing care. The last topic is explored in this publication but take care to remember the other concerns. Adherence to the ethical foundation and framework of your institution and caring for your staff are critical ethical considerations. From an operational perspective, risk managers should be working with executive and medical leadership to address accessing capacity (human, space, and equipment), instituting disaster plans, communication status and plans, and monitoring high-risk issues such as rationing, harm, and emergent or catastrophic systems failures. The Hastings Center noted that during public health emergencies, facilities are faced with competing moral authorities to provide care to those in need and to promote equity and fairness. These moral authorities may create tension as providers are faced with the allocation of limited resources. During a public health emergency, organizations still have three important duties: plan (managing uncertainty), safeguard (supporting workers and protecting vulnerable populations), and guide (instituting contingency levels of care and crisis standards of care).[2]

Whatever the situation, the ethical consensus on responding to these types of crises is summed up very well by Alex London, Director of the Center for Ethics and Policy at Carnegie Mellon University: "Such agents might agree that in a pandemic, when not everyone can be saved, healthcare systems should use their resources to save as many lives as possible because that is the strategy that allows each person a fair chance of being able to pursue their life plan."

**Frameworks for Rationing Decision-Making**. Making decisions in ethical and legal frameworks is critical to the defensibility of the patient outcomes. Since no comprehensive federal guidelines on rationing exist, states are either developing their own guidelines or are remaining silent on the topic. This results in some state recommendations that do not always align with ethical guidelines or that conflict with institutional or

community values. In an effort to assist with developing approaches to rationing, there are three principles to consider:

1. **Equal opportunity/access.** Categorically excluding large groups of patients from receiving ventilator services (e.g., age; intellectual disability; insurance status; wealth or poverty; long-term prognosis; co-morbid conditions like end-stage renal disease, class III or IV heart failure, or cognitive decline; etc.) should not be permitted and is fundamentally unethical. John Rawls referred to the act of equality as operating under a "veil of ignorance," meaning you treat people fairly and do not penalize particular groups regardless of their circumstances. These factors may be considerations in a consistent methodological approach for allocation, but a blanket exclusion is fraught with ethical and legal ramifications.

2. **Consistent methodology for utilizing resources.** German philosopher Immanuel Kant asserted the ethical adage "ought implies can," which means if you can do the right thing, you should. Obviously if you have scarce resources, you cannot do what you are unable to do. This is important in determining when to activate a rationing protocol. Rationing protocols should only be activated when a shortage actually occurs or is expected to occur in the near future.

   To activate this process/protocol, the institution should consider how and by whom the allocation assessments are to be conducted. It is widely recommended that an outside party collaborate with the attending and the clinical team to assist or direct decision-making. One recognized approach is establishing a triage team, with a triage officer, who applies the allocation process/protocol and removes the attending physician and treatment team from the decision. This primarily protects the therapeutic relationship and reduces the moral distress of the front-line practitioners.[3] The decision about when to activate the triage team, the authority that team has over direct clinical care, and communication to stakeholders is made on a facility-by-facility basis.

   Once the rationing process/protocol is initiated, a multi-factored, scored, decision-making allocation framework should be used in order to triage resources fairly and consistently.[4] Some states have recommended or endorsed some methodologies that meet ICU criteria in which patients are triaged and assigned priority scores based on (1) likelihood of surviving the hospital discharge and (2) likelihood of "achieving longer-term survival" given comorbid conditions.[5] One example of this type of framework is the Sequential Organ Failure Assessment (SOFA) scoring tool. However the rationing process is accomplished, it is essential to ensure the tool is widely accepted and consistently implemented.

   Determine how the team or outside decision-maker reviews the cases. One approach is a structured case presentation by the attending so that information is concise, consistent, and presented by someone capable of answering clinical questions. Having team members independently review the medical record could result in missing critical information, reviewers going down "rabbit holes," and the potential for increased liability related to inappropriate access to the medical record.

3. **Stopping treatment**. Even in a pandemic, there are basic ethical duties to beneficence (providing care beneficial to the patient) and non-maleficence (avoiding something that will cause harm to the patient) when either limiting or withdrawing life-sustaining equipment. A key approach to making this decision is to ensure a process for ongoing reassessment of patients on ventilation by the triage team.[6] This process should include a methodology of reviewing patients using a ventilator and those in immediate need. Be cautious of rapid weaning and give those started on a ventilator an opportunity to thrive.

Ensure there are appropriate weaning protocols in place and that they can be adapted to the complexities of the situation.[7] The two common approaches to withdrawal are either immediate removal (extubation) or terminal weaning, both of which are case-by-case. Those protocols should be clearly communicated to

practitioners and staff.[8] Once removed from a ventilator or denied ventilator use, ensure there is appropriate palliative care in place to ease suffering.[9] Having palliative care and social work available during this time could be advantageous to offer support and ongoing clinical planning.

Once treatment decisions are made, the difficult task of communicating those decisions to that patient and family begins. In part III of this series we will explore methods of communication as well as dispute resolution, quality or care and liability issues.

We hope you found this RisKey helpful. If you have questions or would like further resources on this topic, please contact your Coverys Risk Management Consultant.

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