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

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As news of international response to COVID-19 gets reported, bioethicists are beginning to look at some critical responses and comment on the significant impacts they represent. These ethical dilemmas have a natural alignment with our strategic and operational duties as risk managers. Risk managers are being put on the front line of responding to ethical dilemmas, which may be challenges never faced before. With the news from Italy and other countries managing massive outbreaks, there are lessons risk managers should be aware of and prepare for in the U.S.

Rationing. As we see the rates of infections climb, we can extrapolate there will be an increased need for medical treatment in which space, qualified personnel, and equipment will become coveted resources and fought for by providers, patients, families, and the community. It has been projected that at its current trajectory, the U.S. may need as many as 100,000 more ICU beds to manage the pandemic in the near future.

In two weeks, Italy went from 322 confirmed cases of coronavirus to 10,149 (number as of 3/11/20) and is facing unprecedented pressure on their healthcare resources. They are running out of staff to manage the volume and ventilators to manage the suffering of those experiencing respiratory distress. As resources dwindle, physicians are being forced to implement battlefield triage techniques and ration medical treatment. As a result, the Italian College of Anesthesia, Analgesia, Resuscitation, and Intensive Care (SIAARTI) published rationing guidelines that encourage distributing dwindling resources to those who are more likely to benefit and have the highest opportunity for recovery. This rationing includes lifesaving equipment, space in ICUs, human resources, and clinical time focused on those fortunate patients.[1]

Though this micro-allocation approach may appear on its face to be a reasonable one, we need to be prepared for the reality that some level of rationing will occur in the U.S. and what that may look like. This is akin to the person saying, “I don’t want a DNR; give me everything,” and the inevitable response, “Do you know what everything looks like?” It could include removing people benefiting from devices or treatments to be rationed to another person, denying treatment or service to a patient in critical need, and the emotional turmoil that will impact the provider making that choice. These decisions involve a complex calculus to determine the patient’s risk factors and likelihood of recovery. This is all in light of the fact that we have patients in the ICU who do not have COVID-19 and the risks we are placing on these highly susceptible populations.

This is a real concern for us to face, as there are expected to be shortages nationwide in healthcare providers, space, and equipment. Since many hospitals routinely operate near capacity, they are unlikely to be able to manage major surges of patients without implementing their disaster plan, which could include setting up outside triage and treatment areas, repurposing space to manage overflow, reusing scarce materials, and diverting to outside facilities. A significant risk right now is the availability of ventilators and personal protective equipment. The risk of ventilator shortages is profound and significant. The Centers for Disease Control and Prevention (CDC) noted that the number of operational ventilators, both in facilities and in stockpile, are unlikely to meet the demand of emergency crisis.[2] Both ambulatory offices and hospitals need to have a contingency plan in place for such a likelihood.

When faced with these ethical concerns and limited time, there are a few approaches the institution can explore to see what is best for them:

1. **First come, first served.** This is often considered the natural lottery approach and manages cases as they come into the facility; whoever arrives first receives the benefits of facility resources. The advantages are its inherent ease, reasonability, and defensibility. The main concern is its blindness to important and relevant factors such as patient survivability and decreased access to diagnosis and treatment for those who arrive later.
2. **Maximizing total benefits.** This utilitarian approach, which Italy has taken, involves a calculus that works to save those with the most qualified adjusted life years. The obvious advantage is that this approach generally saves the most lives. However, a significant drawback is that it proportionally disadvantages those who are the highest risk: the elderly, the disabled, and those with comorbid diseases. This approach also requires a person to determine "who lives and who dies," which has a significant impact on the well-being of all those involved.
3. **Priority to the sickest.** This is traditional emergency department triaging process, also known as prioritarianism, priority to the worst off. It is predicated on the Rule of Rescue,[3] which highlights our sense of obligation and duty to care for those in need of rescue. This is often employed when there are limited or scarce resources. The CDC's Task Force for Mass Critical Care suggested that the following conditions be present to initiate the ventilator triage process:
    - Surge capacity fully employed within healthcare facility.
    - Attempts at conservation, reutilization, adaption, and substitution are performed maximally.
    - Identification of critically limited resources (e.g., ventilators, antibiotics).
    - Identification of limited infrastructure (e.g., isolation, staff, electrical power).
    - Request for resources and infrastructure made to local, regional, and state health officials.
    - Current attempt at regional, state, and federal level for resource or infrastructure allocation.[2]
4. **Social usefulness.** This approach prioritizes treatment based on the social worth or usefulness of an individual, almost like putting your mask on first before helping others. Though controversial in nature, there is value in prioritizing specific people in receiving treatment and vaccinations, like healthcare practitioners. An example was that penicillin was rationed during WWII and provided first to soldiers to keep them fighting for a bigger cause.[4] It is important that facilities have a plan in place that looks at providing care to our caregivers, else we may not have them in the future.

No single principle captures all the ethically relevant features a risk manager will face, and combining them is complicated at best. Some segments of healthcare have been doing this for a long time and have set processes in place (e.g., United Network for Organ Sharing and organ allocation) but most hospitals have not had to do this on a large scale before. Everyone should be on the same page as to the approach and how it should be enacted.

The next complexity is determining who makes the ethical decision, and how it is communicated? The CDC noted that the clinical care providers should not be the same as the triage provider.[2] This firewall allows patient care practitioners to act in the best interest of the patient and not be placed in a difficult ethical dilemma. It also promotes an impartial review based on the agreed upon process and expectations. However, open communication between the practitioners and the patient/surrogate is vital to maintaining clarity and trust in the process.

Important Takeaways

- The risk manager, ethics committee, and executive leadership must decide ahead of time the approach or approaches that best fit their unique culture, community, and needs.
- The approach to rationing care should be included in the disaster plan and openly discussed with leadership, physicians, and staff.
- Cases of rationing should be decided by a nontreating physician, reviewed by an ethics committee member and risk manager, and documented as an incident report.
- Take time to assess your staff's mental and physical needs, and provide care. They are your most precious partner and customer and need as much attention as your patients.

- Above all, transparency and maintaining public trust are critically important. Be clear and consistent in your approach, keep your promises to patients and staff, explain when and why variations occur, and respect the rights of all the stakeholders impacted.

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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References:

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