COVID-19 – Dealing with the Complexities of Ethical Decision Making & Moral Distress

March 2020

The COVID-19 pandemic is forcing nurses and other health care professionals to have to confront some of the most complicated and difficult ethical and moral issues they may ever face in terms of their decisions around patient care, their workplace and professional commitments, and their contributions to the wider society. Here we reflect on some of the resources that are currently available and will undoubtedly surface as this pandemic evolves.

Sadly, as the situation in Italy has made apparent, our society and our health care system may have to face painful choices around access to finite resources. This March 18, 2020 publication in the *New England Journal of Medicine* on Ethics, Logistics, and Therapeutics on the Epidemic's Front Line proposes some of the ethical principles that may have to come into play when the need exhausts the available resources. These authors talk about a "soft utilitarian" perspective that involves considering both the "greatest chance of short-term survival" and the "greatest chance of long-term survival."

Another key paper, published March 24, 2020 in the *British Medical Journal*, on New Guidelines on When to Admit Patients to Critical Care speaks of "taking into account the likelihood that a person will recover from their critical care admission to an outcome that is acceptable to them." An advantage of this approach is that it may free up the clinicians with critical care specialization to put their effort into the work they need to be doing, while clinicians from other specialties may be able to assist with conversations with patients at an earlier stage about risks, benefits, and possible outcomes of different treatment options.

We hope that these kinds of painful resource allocation decisions do not have to be made and we can accommodate the need both by flattening the curve and through excellence in care. We also hope that rapid information exchange allows us to fine tune practices toward optimizing treatment success. But we also know that we are in a dangerous situation, not only here in BC, but around the world.

For nursing the utilitarian approaches that focus on those patients for whom there is the most likely benefit are understandable but also worrisome from an ethical perspective. The values that may drive a utilitarian calculus (e.g. cost savings) can be implied rather than explicitly articulated, and may allow implicit judgements of "deservedness" to creep in (for example, would we allocate the ICU bed to the 82 year old judge or the 82 year old homemaker or the 82 year old homeless person?). All persons should be seen as morally equal, and the allocation ought to be based on clinical criteria as well as what we come to know about each person's wishes – which requires skillful supportive communication with individuals and those they identify as family. By virtue of our Canadian Code of Ethics, nurses are highly attuned to their obligation toward equity and protection of the rights and privileges of all, including those who are made most vulnerable by social determinants of health.

Advanced care planning is an approach that nurses have embraced that allows for the unique situatedness of individuals within their personal, family and community contexts to be deeply respected in decisions that have to do with matters like aggressive vs supportive care. Such decisions require skilled relational practice with respect to patient autonomy, and these principles ought to be universally deployed, including in a pandemic situation. From a clinical standpoint, we know that during this COVID-19 virus crisis, it is going to be even more important than it already is to proactively and consistently build trust and conversations with patients and their loved ones to see what patients would want if/when they face catastrophic illnesses, including this virus.

A key principle that all ethical guidelines around resource allocation would agree to is the expectation that there is separation between the clinicians providing care and those who make the triage decisions, along with a centralized (eg provincial or federal) monitoring system. This promotes fairness in decision making, and protects the clinicians most closely involved from the moral responsibility to choose. However, there is also a level of distress that clinicians may well feel when decisions are being made at a system level to which they feel they have no input.

From a moral distress standpoint, NNPBC believes that we ought to proceed with an expectation that *all* health care providers and managers are experiencing/will experience significant moral distress throughout this pandemic because of their inability to save all who need their care, and because of the very real worries they have for their colleagues' (and their own and their families') health. They are also likely to experience post-traumatic stress as a result of the nature of the experiences they are engaged with. As BC nurse ethicist Dr. Paddy Rodney wrote in What We Know About Moral Distress in the *American Journal of Nursing* in 2017, it will help nurses considerably to feel that they are working in organizations and within health care systems that intentional cultivate "our practice environments as moral communities where ethical values drive practice at all levels." When they have confidence that their systems are doing the best that they can, even under extreme circumstances, they are more able to manage the aftermath of their encounters with difficult ethical decisions.

From a precautionary perspective, we know it is wise for health authorities and workplaces to set up regular systems of de-briefing and counselling support throughout the pandemic. We expect that these will emerge across the system as this pandemic evolves. Professional associations such as the Nurses and Nurse Practitioners of BC (NNPBC) will also have an important role to play in making self-care resources widely accessible to nurses of all designations, when and where they need them.

Note: This Issues Statement has been prepared by the NNPBC RN Council President Dr. Sally Thorne with the expert advice of Dr. Paddy Rodney, RN (UBC School of Nursing – Vancouver) and Dr. Barb Pesut, RN (UBC School of Nursing – Okanagan), both of whom have extensive knowledge and publication records in matters of nursing ethics.

Resources:

- COVID-19: Emergency Prioritization in a Pandemic Personal Protective Equipment (PPE) Allocation Framework
- COVID-19 Ethics Analysis: What is the Ethical Duty of Health Care Workers to Provide Care During COVID-19 Pandemic?
- COVID-19 focus should be building intensive-care capacity, not 'who comes first' lists, ethicist says
- Journal of Pain and Symptom Management - Palliating a Pandemic: "All Patients Must Be Cared For"
- NEJM: Fair Allocation of Scarce Medical Resources in the Time of Covid-19
- New York Times - Opinion: The Psychological Trauma That Awaits Our Doctors and Nurses
- Ontario developing 'last resort' guidelines on which patients to prioritize if hospitals are overwhelmed by critical COVID-19 cases
- US National Palliative Care & Hospice Association - Shared Decision Making Tool
- **Blog:** What Happens When Hospitals Run out of Ventilators and Other Emergency Rescue Equipment? By Patricia Benner, R.N., Ph.D., FAAN

Revised April 7, 2020