

Bioethics: Essential to Meet the New Challenges of the Pandemic

RUCHIKA MISHRA, PH.D.

With 7.1 million confirmed infections and more than 205,000 deaths in the United States*, Covid-19 has created a pandemic like no other in our living memory. As epidemiologists and scientists have studied this virus and advised the public, this public health crisis has raised questions that are not merely scientific but also deeply ethical. The decisions that have been made across states, regarding quarantine, lockdown, or reopening, have centered on our values and how they should be applied. This novel coronavirus has not only brought about drastic changes in our lives, it has impacted hospitals and healthcare workers in an unprecedented manner. Doctors, nurses, pharmacists, pathologists, technicians, and cleaning staff have never been at such high risk of exposure to a deadly virus, and yet they are required to be on the frontline. The concepts of rights and duties have required careful examination and analysis as we struggle to contain the effects of this disease, experience the “new normal,” and prepare for future challenges.

As Sutter Health fought every day to rescue the stricken, the Bioethics Program grappled with the hard questions posed by the pandemic, both for individual patients and broader organizational issues.

Clinical Challenges

Clinically, there are numerous complex issues that needed to be addressed on a case-by-case basis. PMHV’s bioethicists helped clinicians and bedside teams respond appropriately to situations that ranged from an incapacitated symptomatic patient refusing to be tested for Covid-19, the family member of a dying patient asking for unapproved experimental drugs to be provided to their relative, requests to withhold information about a patient’s passing from their spouse when both were hospitalized at the same time but only one of them survived, to assisting with care decisions for the most vulnerable individuals who have no one to make decisions on their behalf.

Organizational Issues

In addition to the recommendations regarding the many challenging questions that have continued to arise in the care of individual patients, PMHV took on an essential leadership role in helping Sutter Health address some of the deeper ethical questions at a larger organizational level. These issues were multi-layered.

Allocation of Scarce Resources: One of the biggest fears during any public health emergency is the potential shortage of necessary medical treatments, supplies, and staffing. If hospitals become overwhelmed, they would not have the resources to treat all patients who are critically ill and save the lives that could have otherwise been saved. Who decides and on what basis? The answer to this ethical question is not easy. In such

▶ IN THIS ISSUE

The Ethicist Is In 2

Who Gets a Ventilator
When There Are
Not Enough? 4



▶ If you would like to receive this newsletter electronically, please email us at ethics@sutterhealth.org.



The Ethicist Is In: Age Is Just a Number

SHILPA SHASHIDHARA, PH.D.

Overview:

Healthcare workers are encountering increasingly complex ethical dilemmas as the coronavirus continues to rage. From mid-March onwards, hospitals have faced a surge of patients who are critically ill. Simultaneously, frontline providers must meet the challenges of allocating resources, dealing with shortages of personal protective equipment, and concern for their own safety and that of their families. There are currently no approved treatments or vaccines available. This adds emotional challenges when decisions must be made around the appropriateness of treatment, and also what to do when a possibly effective treatment is met by a patient's refusal. This complicated situation is illustrated in the case of Karen, who by the medical team's assessment is "young, fairly healthy, dependent on life-sustaining medical treatment right now but has a likelihood to survive."

The Case:

Karen, a 52-year-old woman, was admitted to the ICU with pneumonia due to Covid-19, after attending a party with friends without wearing a mask or social distancing. Despite treatment with BiPAP (Bilevel Positive Airway Pressure), a non-invasive therapy, she was not doing well. Furthermore, she had been agitated and attempted

to remove her BiPAP twice. Although Karen's medical history was notable for schizophrenia, depression, anxiety, chronic pain and opiate dependence, she did not have any significant respiratory issues.

Six months ago, Karen completed an advance care planning document indicating her wishes to not receive cardiopulmonary resuscitation (CPR) if her heart stopped. Should she stop breathing, she also documented her wish not to be put on a breathing machine in a Physician Orders for Life Sustaining Treatment (POLST) form. However, her attending physician felt there was a "likelihood that she may survive with ventilator support."

Because Karen's mental status was compromised and she was unable to make her own medical decisions at this time, the medical team contacted her only listed family member, her sister, who told healthcare providers, "Karen and I don't have the best relationship, I'm surprised that she chose me as an emergency contact." Although she was unaware of Karen's healthcare wishes, her sister stated that she wanted to respect Karen's decisions as documented on her POLST form. Multiple members of the medical team expressed significant moral distress around a decision not to provide ventilator support. They felt caught between respecting the patient's wishes and giving Karen every chance to live. An ethics consult was requested by the ICU team asking, "Are we doing the right thing? She is so young."

The Ethicist:

The role of the ethicist in a case like this is to guide the medical team by helping them determine the ethically appropriate plan of care as well as helping mitigate their moral distress. If the medical team followed a patient's POLST form, many felt they would not be fulfilling their perceived duty to their "young" patient who may survive with ventilator support. The ethicist needed to shift the medical team's focus from her "young age" to her prognosis and her healthcare wishes.

The medical team appreciated that patients have the right to refuse life-sustaining treatments such as ventilator support, nutrition, hydration, blood transfusions, and dialysis. However, when Karen refused life-sustaining treatment, the medical team considered these questions: Should the patient's refusal

be respected under these circumstances? Did she really understand the risks of refusing treatment at the time she completed the POLST? Would it be right to override her wishes?

No one should undergo interventions they do not want, and a significant number of patients indicate that they "do not want to live on machines." Thus, the medical team wanted to respect Karen's explicitly expressed healthcare wishes documented on her recently completed POLST form. But, they still wanted to proceed with intubation, at least short-term, to give her a "chance." Many voiced as their reasoning, "She is young; she could survive." Discussions led to these challenging questions: Is age a justified criteria for clinical decision making? Should Karen's age even be a factor in deciding whether she should receive aggressive interventions for coronavirus?

Continued on Page 5

Bioethics During a Pandemic

Continued from Page 1

a situation, triage must be implemented and patients with the highest likelihood of surviving the acute illness should be prioritized. Our team has been instrumental in developing guidelines for the system if such a situation arose and the state declared that crisis standards of care were effective. It is of utmost importance that this responsibility does not fall on the frontline clinicians who have a duty to care for their patients. To be prepared with a plan and to implement these guidelines in a fair and just manner so that our community's vulnerable populations are protected is the driving force behind this work.

A related allocation question that our team took on was developing guidance for Sutter Health around dispersing of an experimental therapy that is currently only provided for hospital use under the FDA's Emergency Use Authorization. Given the acute shortage of the drug, how should hospitals decide which patient should receive the therapy? From a bioethics perspective, it is crucial to devise a plan that thoroughly evaluates clinical evidence, ensures that methods of selection or prioritization are justifiable, and that patients, or their surrogate decision makers, understand that the treatment in question is not an approved treatment; and thus, consent on their part necessarily entails potential risks and benefits.

Protection of Providers: As providers make every effort to save each person under their care, the question of balance must also be addressed. To what extent should the doctor or nurse go in trying to attempt to save the life of a dying patient when the risk to the healthcare worker is exceedingly precarious? Should a severely ill patient with Covid-19 be resuscitated when the chances of survival are extremely unlikely and the risk of viral transmission very high?

Although an organization has a duty to its patients, it also has a duty to its physicians, frontline workers, and the many support staff who are crucial for keeping the hospital environment safe. Our professional bioethics team is working with Sutter Health's organizational leadership and critical care physicians to help them understand the boundaries of their responsibilities and devise policies that are in the best interest of patients, providers, and staff members. We also realize that understanding is one thing and enacting the decisions we know to be right is another. Communication is a key aspect of providing compassionate care. Under current circumstances when most encounters have been forced to become virtual, communicating with the families of sick patients and building trust is extremely challenging. Our PMHV team continues to provide education to residents and physicians about these sensitive topics.



Should a Covid-19 positive mother be separated from her baby? Do Covid-19 positive incarcerated patients have the right to make their own medical decisions?

Resolving the ethical dilemmas we have encountered during this pandemic are among the most challenging that we as professional bioethicists have had to face, among them: Should a Covid-19 positive mother be separated from her baby? Do Covid-19 positive incarcerated patients have the right to make their own medical decisions? Is having Covid-19 a qualified diagnosis to ask for physician aid in dying? Should hospital employees be tested for viral antibodies and be provided immunity passports on the basis of their results?

How to tackle these new dilemmas? The one specialty within Sutter Health that has the broad subject matter expertise to gather relevant information, carefully evaluate the findings, and thoroughly analyze the issues at hand is Bioethics, with its focus on applying ethical principles to actions. How these questions are answered has real life consequences for our communities. This pandemic has proven that for a health system, bioethicists and bioethics programs are needed not only to resolve ethical dilemmas that arise on a daily basis in patient care, but also to serve as an irreplaceable resource for dealing with the largest issues we face in this current climate of uncertainty, moral distress, and communal despair.

Who Gets a Ventilator When There Are Not Enough?

WILLIAM S. ANDERECK, M.D., FACP

On March 25th, the California Medical Association (CMA) asked me to lead a task force charged with producing a report on the ethical issues involved with rationing ventilators in the event of a shortage. The report, requested by Governor Gavin Newsom, had to be submitted in five days. Fortunately, the CMA provided me with excellent staff and resources. Eight physicians and ethicists, representing the major healthcare systems in California, were also recruited to spend their weekend adding valuable perspective and wisdom to the endeavor. What follows is not a recounting of the guidelines we developed. That is available from the CMA.

Here, I want to focus on the relevant moral issues we considered in a guideline document that would deny a potentially beneficial treatment to a patient under our care in favor of someone else. Letting a salvageable patient die is contrary to our acceptable moral standards. What kind of ethical framework would allow this to happen?

My colleague, Dr. Albert Jonsen, one of the founders of the field of Bioethics, described it as the “ethic of an epidemic.”

First, it is important to recognize the psychological context of the times. Like 9/11, we had fallen through a rabbit hole into Alice’s strange new world. Fear changes your perspective in lots of areas, especially on what is important. Priorities and values shift in ways that are sometimes not so subtle. We had to recognize the traditional ethical principles of medicine: avoiding harm, promote benefit, respecting the individual rights and dignity of the patient, and respecting our responsibilities to promote a just healthcare system (although this latter principle has always been a bit vague in the mind of those of us in the trenches).

What became immediately apparent was that in a crisis, those responsibilities to “steward resources” take on an increasingly prominent role while an individual’s rights to receive a particular resource diminish proportionately.

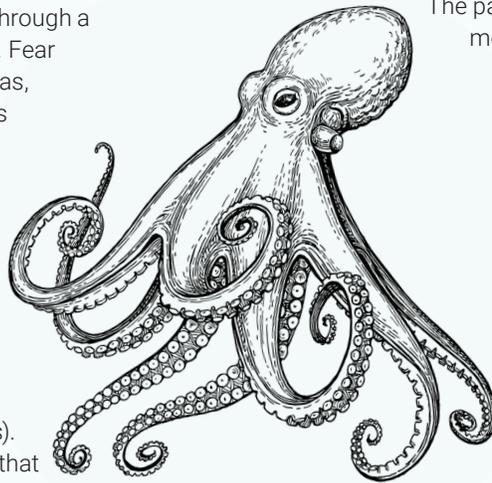
It is worth noting three essential freedoms that have been impacted by the shift into an “ethic of an epidemic:” freedom from disclosure of confidential information (privacy), freedom to choose medical treatments appropriate for one’s condition, and freedom of movement. Each of these freedoms is deeply engrained in the consciousness of our culture as something to which we are deeply entitled. What has shaken this entitlement? A more pressing concern.

Besides challenging our traditional moral principles, the immediacy of the situation also clarified our purpose. Our multicultural society usually enjoys a multiplicity of goals. For some it is to accumulate wealth, for others to enjoy friends and family, while many work to improve our community. But in the time of a pandemic, everyone’s goal becomes crystalized – *staying alive*.

This goal may seem obvious, but there are a number of ways to allocate resources aimed at achieving that goal. Goods can be

distributed by need, want, social status, ability to pay, potential contribution to society, randomly, and even equally. We chose to treat according to need. If it came to the point that we did not have adequate medical resources to treat everyone in need, we chose a distribution based on expectation of survival with treatment. The stated point was to avoid any implication of implying the “worth” of any individual patient. Thus age, as a specific variable, was rejected as a means for prioritization.

Once the CMA task force had determined that its primary goal was to save as many lives as possible, regardless of age, race, disability, or other criteria beyond medical prognosis, our decision making became clearer. In a setting where there were not enough ventilators available to manage patients who needed them, the duty to promote survival trumped an individual’s right to request and receive a beneficial but limited resource. The autonomy to choose, a medical principle which has evolved over the past 50 years, is curtailed. Patients with the least chance of benefit would not be offered that chance.



The pandemic’s effect on the freedoms of privacy and movement can be just as significant as its effect on rationing medical treatments. Contact tracing, one of the core strategies to control the spread of the virus, depends on identification of those infected as well as those with whom they have been in contact. Privacy must take a back seat. Many of us have spent months sheltering in place and lack the freedom to seek employment. Forced quarantine has been effective in many parts of the world as a public health containment measure.

Four months have passed since we submitted our report. At the time, we expected the situation to last a few months at most. The continuing surges were seen as a possibility, but no one wanted to expect that reality. Efforts to loosen the restrictions on our freedom result in an uptick of cases, and failure to abide by the restrictions results in catastrophe.

From Alice’s world, looking up, I see a prior world like an octopus in a calm sea. Its many arms, our values and freedoms, spread far and wide, drifting in a warm bath of different perspectives and priorities. But in response to threat, survival takes precedence, the arms telescope into the body, and the octopus can contort itself into the smallest of spaces.

Fear, as a response to a recognized threat, is the most effective driver. Looking to the greater good may not be enough. Our experience in the past few months suggests that individuals who do not fear for themselves are less willing to sacrifice their freedoms if the benefit is to someone else. Beneficence, as a motivator in our current culture, doesn’t seem to extend beyond our grandparents. It is laudatory but not compelling.

Where does this lead the ethicist’s advice to those tasked with

Continued on Page 6

The Ethicist Is In

Continued from Page 2

Physicians are facing the dual challenge of managing this disease to extend life but also wanting to ensure that their patients have an acceptable quality of life.

The ethicist posed several questions to the medical team: What is her prognosis? What are the relevant factors to take into account when developing a treatment plan? Are there other interventions besides intubation that could help Karen? The ethicist considered Karen's potential outcomes with and without intubation. In Karen's case, even with maximal medical support, she would die without intubation as BiPAP had proven insufficient. Although her POLST form indicated that she did not want to be on a ventilator, the medical team was uncertain if she would require a ventilator long-term. Before Karen's illness, she had been fairly healthy with no significant respiratory problems. Her medical team felt that she could potentially have a promising future, even though rehabilitation could take months, or possibly years, in a long-term acute care facility (LTAC).

Physicians are facing the dual challenge of managing this disease to extend life but also wanting to ensure that their patients have an acceptable quality of life. The patient's sister explained that Karen has had a difficult 52 years. She had struggled with mental illness and substance use disorder for a long time. A few years ago, Karen was in a car accident and was intubated for a week. She described it as "very uncomfortable." Although her sister had not had direct discussions with Karen around her healthcare wishes, she understood the reasoning behind her decision to not receive CPR or be placed on a ventilator. From her perspective, ventilator support (even short-term) would not be an acceptable quality of life for Karen.

The ethicist made the recommendations that it was ethically appropriate to follow the patient's wishes on her POLST form. The medical team had an ethical obligation to respect her wishes in this circumstance. It was also consistent with information provided by her sister regarding the context for her decisions. Since Karen's condition continued to worsen despite maximal medical care, her care goals were transitioned to focus on her comfort at the end of her life.

When speaking with members of the medical team, it came to light that several members of the team had recently dealt with



the loss of a patient due to coronavirus. The distress around that death was still lingering. With the goal to "save lives" during the pandemic, it was especially difficult in this situation because they did not want to "give up" on Karen who was "still young."

Karen's age and her comparative youth was a recurring question and central feature in this case as to whether or not to respect her wishes. This focuses attention on the issue of age more widely. *Is age a justified criteria on which to either administer or deny treatment? Or, is it a bias that needs to be recognized, like other biases, as an irrelevant factor? Is age anything more than just a number?*

Rather than focusing on age, it would seem that a stronger argument would be that a patient's *ability to benefit* should be the determining factor in decision-making. In times of limited resources, if it is medically indicated that an older patient would benefit from a treatment more than a younger patient, to deny that person treatment on the basis of age would be discrimination. If older and more vulnerable patients are more likely to benefit from a treatment, they should receive it (not based on a chronological number) based on what medicine deems to offer the greatest patient welfare. According to this perspective, the youthful age or the more advanced years of a patient, are numbers that form part of the patient's story, but they do not determine treatment decision-making.

Ethical Times Readers: Is age a justified criteria on which to either administer or deny treatment? Or, is it a bias that needs to be recognized, like other biases, as an irrelevant factor? Is age anything more than just a number? Let me know your thoughts at: shashis@sutterhealth.org.

PROGRAM IN MEDICINE & HUMAN VALUES

2324 Sacramento St.
San Francisco, CA 94115

Tel 415-600-1647
Fax 415-600-1355
Hotline 415-600-3991

sutterhealth.org/bioethics

Email ethics@sutterhealth.org

Ruchika Mishra, Ph.D.
Program Director

William Andereck, M.D., FACP
Medical Director

Robert Fulbright, J.D., M.A.
Bioethicist

Kelsey Gipe, Ph.D.
Clinical Ethics Fellow

Steve Heilig, MPH
Public Affairs Specialist

Linda Hummel, Ph.D.
Program Supervisor

Albert Jonsen, Ph.D.
Bioethics Scholar Emeritus

Antonio Kruger
Administrator

Thomasine Kushner, Ph.D.
Neuroethicist

Shilpa Shashidhara, Ph.D.
Bioethicist

Who Gets a Ventilator?

Continued from Page 4

limiting freedom to save lives? First, the nature of the threat needs to be stated clearly, and in a way that most of us can understand. It should be neither “sugar coated” nor “crepe laden.” Fear of eternal damnation doesn’t work anymore either. It should also be clearly recognized that data can change based on new experience. This is the nature of science, the field that most of us are relying on to get over the pandemic.

Those who perceive a direct threat can be expected to comply with freedom restrictions commensurable to the threat. Many of those not directly affected may comply as well. For those who continue to refuse to comply, the ethic of an epidemic allows for action to enforce compliance if that action can be directly related to a threat to lives. Thus, fines for individuals and license restrictions for businesses can be justified in favor of disease prevention as long as the data suggests its need.

One final note: No leader wants to provoke public displeasure by enforcing limitations. It is much easier to govern if the citizens voluntarily limit their freedoms. One way to promote this is to exaggerate the threat and let fear do the rest. But then the octopus must stay retracted in shelter. It takes a courageous leader to resist the temptation to stoke fear and instead, stand for the right thing. That is a commodity that is scarcer than ventilators.