

Ethical dilemmas in clinical care during COVID-19 pandemic

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Abstract

In a short span of a few weeks, the COVID-19 pandemic has affected the entire world like no other event in modern history. Healthcare institutions and providers have been at the forefront of containing the ravages of this disease, and are experiencing unprecedented challenges. Medical decision making has become all the more complex because of the moral weight of difficult decisions that need to be made. This paper discusses three areas where ethical decision making is extremely important: dealing with those patients with COVID-19 who no longer have access to their doctors; following ethical criteria for assigning risky duties to healthcare professionals; and in making life and death decisions while allocating scarce resources. This paper describes a national level guidance document for the COVID-19 pandemic that is designed to facilitate ethical decision-making.

Keywords: Allocation, Scarce resources, Ethical decision-making, Pandemics, Ethical dilemmas.

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Introduction

The past few weeks have witnessed robust health systems fall like a house of cards before the ravages of COVID-19. Our health sector in Pakistan already treated as the undernourished mule that is expected to pull ten times its weight, is reeling under the added strains of the pandemic which has not as yet unleashed its full fury upon us. With the increasing burden on medical services, the spectrum of ethical challenges on healthcare professionals will also mount.

This paper focuses on three areas of ethical concern that are already being faced by healthcare professionals: These include 1) ethical challenges in putting an indefinite hold on the ongoing care of patients without COVID-19 who still require care; 2) fairly assigning hazardous frontline COVID duties; and 3) ethically making life and death decisions for gravely ill patients, with very

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little resources.

Responsibilities to Patients without COVID-19

A physician's relationship with his patient is a longitudinal one, lasting until the need lasts. These connections, especially involving patients suffering from serious diseases or chronic ailments, are of critical importance not only for the patients, but also for the concerned physician.¹

As we await the much dreaded upsurge, regular clinical work has been slowed down to a full stop. A myeloma patient can no longer come and see her doctor for advice, a 62-year-old with atherosclerotic heart disease with new symptoms cannot see his cardiologist for the next phase in management, since practically all non-COVID related elective work is at a standstill. Routine immunizations are suffering and will only increase our infant mortality rates, already among the highest in the world.² That is a huge moral burden to bear.

This extraordinary situation at our hospitals will certainly drag on for a while. The difficult choices that need to be made by health professionals will include choosing which of the old patients to try and continue to manage, and which ones to put on hold. Would it be safe to call the immune suppressed transplant patient for a follow up to adjust dosages, or that overly anxious patient who needs anxiety alleviating visits every few weeks? A doctor has a relationship of trust with his patient, one often built over years. An inability to continue care may potentially lead to a sense of abandonment, devastating for both patient and doctor. With no guidelines to follow, these are judgment calls each physician has to make, balancing the risks and benefits.

COVID-19-Related Duties

Another ethical dilemma is around the management of personnel on the front lines. Provision of appropriate personal protective equipment (PPE) is an absolute and non-negotiable requirement before personnel may be deputed for COVID duties. However, as data from Wuhan reveals, even with the provision protective gear, healthcare workers have contracted the virus.^{3,4} These are

hazardous duties even with adequate PPE protection, and one assumes the health workers in Wuhan were properly protected. As widely reported in the press, Pakistan has already lost three doctors to COVID-19 while numerous are reported to have been infected.

While doctors all over the world, including Pakistan, take an oath to serve humanity without prejudice, no oath requires them to do so at the risk of personal peril.⁵ If they choose to serve, they do so as a choice, not as an obligation. Providing care is not an absolute duty.^{6,7}

In light of these inherent personal dangers, a major challenge lies in finding an ethical way of determining how to allocate COVID duties. Three ethical parameters have been proposed for the allocation of duties.⁸

One of these parameters is that of volunteerism. Those who volunteer their services, without coercion or undue influence, must be applauded. But it must also be remembered that one person's inherent sense of duty can be exploited by another who may conveniently relinquish his own duty to share the burden.

Another ethical means of allocation of dangerous duties is through a transparent lottery, with everyone standing an equal chance of posting in the front lines for a period of time. In order to be fair, this lottery must be seen to be fair, with all relevant categories of providers having an equal chance of hazardous duty posting.

A third ethical model is a system that ensures equal sharing of burden. An appropriate rota that is put in place can ensure that all relevant staff is moved through the red zones. However, it is essential that healthcare force must be allocated responsibilities fairly, according to their capacity and capability.

Enhancing capability of the workforce in dealing with the pandemic is an essential ethical duty of healthcare facilities and the government. In addition to provision of PPE, front line workers also need to be trained appropriately in managing these patients, whether these are stable patients in isolation, or the sick ones in ICU. Sending an ill-trained doctor to do something entirely out of his depth is not only unfair, it is dangerous for both patient and caregiver. The objective should not be merely placing human workers in patient care areas; but workers who are well equipped to achieve the intended objectives.

Another ethical imperative while planning COVID placements is taking into account their own risk factors

like older age factors such as diabetes, heart disease and pre-existing lung diseases like COPD. Physicians must not become fodder for COVID-19.

Individual compulsions of the healthcare workers must also be taken into consideration. Physicians and nurses not only have responsibilities to their work, but have obligations towards their families. A doctor may be the only caregiver for an elderly parent at home, a nurse may be a mother of two small children with no other support system. There is a very real danger of transmission to loved ones at home, and this fear may be far more paralyzing than the fear of becoming a victim oneself. Instead of losing capable workforce because of unfair decisions, the health system needs take into cognizance realities of real life, and use resources wisely.

Resource Allocation

The greatest emerging ethical challenges are around decisions of allocation scarce life-saving resources. These choices translate into who is given a chance to live by providing a ventilator, and who will be left to die a very difficult death. While our physicians are used to resource scarcity issues while making medical decisions routinely, the projected magnitude of this problem in the wake of the COVID-19 pandemic adds an altogether different dimension.

Learning from experiences from other countries of the past few weeks, clinical parameters for admissions to ICUs will need to be adjusted for optimal utilization of resources, so that the largest numbers of patients can benefit.⁹ Such decision making "will have to be based on intuitive, but reasoned, clinical discretion".¹⁰ Additionally, they will also need a profound ethical basis to satisfy the conscience of those making them, and also for patients, families and society to accept them.

Several ethical guidelines have emerged in the past few weeks to help navigate these murky waters.¹¹⁻¹³ They are all primarily looking at situations when demands outstrip resources.

These guidelines utilize the utilitarian ethical framework, looking towards maximising benefit for greatest number of people. They recommend allocation of available resources to patients with the best survival chances, and excluding sicker, older patients with significant comorbidities who may not survive despite provision of precious resources. This approach also takes into account "most life years" saved which benefits society in the long term.^{12,13} This philosophical approach is generally applied in public

health policy development.

The decision of withholding potentially life-saving care from one patient because another would probably do better on it is in itself an ethical minefield. However, for clinicians, the thought of having to withdraw ventilatory support from a patient because of poor prospects of survival, and give it to another patient with better survival chance is in itself a paralyzing proposition. These are the kinds of decisions physicians in several countries hit hard by the virus have been making these past few weeks.

In normal times, such acts of withdrawing ventilator support are done when either the patient has left such instructions, or when physicians consider further treatment futile. In patients with COVID-19, neither of these two criteria may be fulfilled, and patients may need to be unhooked so that someone else with a better chance may live. While physicians may find such choices repulsive, ethicists consider them justifiable in the circumstances.¹⁴

These decisions are not being done in a bioethics classroom. These are very real decisions with an immense psychological baggage for those making them. While the entire world may be facing similar challenges, how they deal with them will vary.

Realizing this need for Pakistan, the Centre of Biomedical Ethics and Culture (CBEC) at the Sindh Institute of Urology and Transplantation, Karachi has, through a process of consultation with different stakeholders, developed Guidelines for Ethical Healthcare Decision-Making in Pakistan addressing the COVID-19 pandemic.¹⁵ CBEC is a WHO Collaborating Centre for Bioethics and is the only bioethics centre in Pakistan. These guidelines have also been approved by the National Bioethics Committee.

The guidelines will assist institutions for developing their own COVID-19 Standard Operating Procedures (SOP) which define criteria for medical decision-making involving scarce resources, both for COVID and non-COVID patients during the pandemic.

These guidelines outline criteria including age, probability of survival and expected outcome of each patient before being considered for ICU admission. The document stresses the need for an honest dialogue with patient and family regarding the possibility of having to make difficult withdrawal choices based on progress. This is extremely important to maintain a relationship of trust.

Following guidelines and SOPs can point the front line

physicians in the correct direction, but cannot lessen the personal moral weight of responsibility. It is therefore recommended that decisions are undertaken collectively with involvement of peers, and if available, ethics committees.

These guidelines also attach great importance to indemnification of medical decisions made by physicians in the times of the pandemic. This is important to facilitate work without fear of reprisal.

Conclusion

Physicians in Pakistan facing the impact of COVID-19 pandemic will have to deal with healthcare imperatives in extreme adversity, scarcity and personal dangers. Being aware of these ethical challenges can help them be better prepared, and utilizing appropriate guidelines may ease the moral burden of difficult decisions.

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