

# Ethical Guidelines for Leaders in Health Care Institutions during the Covid-19 Pandemic

Task force Ethics Guidelines Covid-19 Philippines 2020<sup>a</sup>

## Introduction/Rationale

As the number of Health Care Workers (HCWs), Protective Personal Equipment (PPEs), life-saving devices and physical space is unable to meet the demand brought about by the COVID-19 pandemic, various centers for bioethics have raised the alarm that Health Care Workers (HCW) and leaders of institutions will experience moral distress. Moral distress is described as the discomfort arising from being unable to “do the right thing” or avoid harm (Berlinger et al, 2020). The distress needs to be understood and to be managed because it is crucial to the well-being of health care workers and decision-makers. If key principles are examined and discussed before actual dilemmas occur, this may allow for clarity of thought at the point of crisis.

Moral Distress<sup>1</sup> will arise mainly because of the tension that will occur between clinical ethics and public health practice (Berlinger, et al, 2020).<sup>2</sup> Clinical ethics is familiar ground for most physicians where clinical decisions are made primarily with the focus on the health, well-being and the desires of the individual patient. Public health practice, however, must necessarily make decisions on what will benefit the majority first, even at the expense of an individual’s good. It seeks to “minimize morbidity and mortality through the prudent use of resources and strategies” (Berlinger, et al, 2020). Individual autonomy often takes a backseat in serious and urgent Public Health considerations.

Tenets of clinical ethics must therefore be balanced with public health duties in times of pandemics. To this end, these guidelines are offered for two of the most morally distressing situations that are anticipated. It will also suggest guidelines for institutions wishing to have ethical advisers available during the crisis.

## Objectives

The objectives of these guidelines are: (1) To offer key principles in two specific ethical dilemmas that are expected to occur during the pandemic; (2) To offer suggestions on how leaders of health care institutions can set up a mechanism for ethical consult and deliberation during the pandemic.

## TWO ETHICAL DILEMMAS ADDRESSED

Two of the most likely ethical dilemmas that are anticipated to arise involve the allocation of scarce resources and the response of Health Care Workers to situations involving increased risk to their safety. A separate set of guiding principles are given for each dilemma.

In the allocation of scarce resources, it is suggested that the principles of Net Utility, Equity, Duty to Care and Respect for Persons provide guidance to decision-makers.

In dilemmas involving increased risk to the safety and well-being of HCW, it is proposed that the principles of Professional Duty, Prudence and Solidarity be applied.

**I. Allocation of Scarce Resources.** It is anticipated that a limited number of life-saving devices will not be able to meet the expected demand. This was true in China and is currently true in Italy. The United States, Spain, and the United Kingdom, as well as the Philippines are starting to face the same problem.

<sup>a</sup>Task force Ethics Guidelines Covid-19 Philippines 2020 was convened on March 26, 2020 to respond to morally distressing dilemmas brought about by the COVID-19 epidemic. A broad invitation was issued among those who routinely discuss ethical issues in the academe or as part of their membership in various ethics committees. Clinicians involved in intensive care and end of life issues were also consulted. Drs. Shelley Ann de la Vega, MD, MSc (Clin Epi) and Dr. Guia Crisotomo Tan, MD, MS Bioethics were responsible for this initiative. Dr. Tan also acted as main editor. The contributors listed at the end of this document represent multiple institutions and multiple stakeholders. Correspondence to [gtan@ateneo.edu](mailto:gtan@ateneo.edu) and [sfdelavega@up.edu.ph](mailto:sfdelavega@up.edu.ph)

<sup>1</sup> The outcry against the social media videos and posts alleging disqualification of those 65 years old and above from being given life-saving devices or of HCW choosing not to do life-saving procedures that increase risk of aerosolization of the virus, are prime examples of this moral distress. (<https://www.jpost.com/International/Israeli-doctor-in-Italy-We-no-longer-help-those-over-60-621856>; <https://www.washingtonpost.com/health/2020/03/25/coronavirus-patients-do-notresucitate/>)

<sup>2</sup> This tension is discussed well in the The Hastings Center, “Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19), Guidelines for Institutional Ethics Services Responding to COVID-19: Managing Uncertainty, Safeguarding Communities, Guiding Practice,” March 16, 2020.

The purpose of the principles is to help leaders of health care institutions implement a fair, consistent, and coordinated triage processes for the just allocation of scarce medical resources in the time COVID-19. The ethical principles discussed are to serve as a framework for decision making.

### 1. Net Utility

- a. Beneficial goods including HCWs, must be maximized and allocated accordingly. (Emanuel et al, 2020)

Once a patient with COVID-19 necessitates scarce life-saving resource such as a ventilator or ICU care, an evidence-based assessment of what will constitute either appropriate and life-saving measures or “disproportionate care” for that patient must be made. Disproportionate care is defined as a “scientifically funded estimate of the expected outcome, which implies knowledge of an advanced care plan, the medical condition of the patient, the antecedents, the acute evolution of his condition, and a funded estimate of his prognosis with and without intensive care” (Meyfroidt et al, 2020). The WMA emphasizes that the “physician should consider only the patient’s medical status and predicted response to the treatment, and should exclude any other consideration based on non-medical criteria” (WMA, 2017). To this end, some centers have applied various clinical assessment tools to determine risk and severity such as the SOFA criteria (Sequential Organ Failure Assessment) to predict ICU mortality (Truog et al, 2020) or the Clinical Frailty Score (Meyfroidt et al, 2020) to weigh the decision for ventilator assistance.

b. As a rule, resources should be allocated in such a manner that the greatest number of lives will be saved, and will favor those with the most number of life-years, i.e. maximize prognosis (Emanuel et al, 2020). Age alone cannot be the sole basis for triage decisions, but should be integrated with other clinical parameters (Emanuel et al, 2020; Meyfroidt et al, 2020). Criteria based on inappropriate characteristics such as, but not limited to, gender, race and ethnicity, religion, political affiliation, social or economic status should also not be a basis for priority setting.

c. To help clinicians navigate these challenges, institutions may employ triage experts who may be physicians in roles outside direct patient care (WHO Guidelines, 2016), or committees of experienced physicians (Meyfroidt et al, 2020) and ethicists. These triage experts will help apply guidelines, assist with rationing decisions, or make and implement choices outright — relieving the individual front-line clinicians of the allocation burden.

A triage expert should be a senior-level provider within the institution with the experience, respect, and authority to carry out the function. When possible, it is desirable to establish a triage team composed of at least three members rather than relying upon a single triage expert. The team approach allows for consultation, multiple professional perspectives, and a broader base of support from clinical/community stakeholders. The suggested professional makeup of a triage team would include, aside from a physician, a critical care nurse, and a respiratory care professional—the latter especially, if allocation of ventilators is involved. All team members must be fully licensed or certified and credentialed to engage in their profession. All triage experts, whether individuals or members of a team, should be chosen by the institution based on a past record of trustworthiness, integrity, compassion, competency in making consistent and difficult choices, and competency in clinical skills (CDC, 2011.)

d. In the same manner, net utility is applied when prioritization is given to health care workers for life-saving resources (Emanuel et al, 2020). To not prioritize health care workers may lead to a depletion in their number with severe consequences for society as a whole.

At the same time, if there is an algorithm that is based on likelihood of survival and recovery, this should be applied to HCWs in the same way as for others. So, while health care workers might be prioritized to access initial care, they may not be automatically prioritized for intensive care.

### 2. Equity

a. Those with similar prognosis must be treated equally (Emanuel et al, 2020). This is expressed in these individuals being given equal opportunity for access to scarce resources.

b. This can be done through a random selection process that is decided upon a priori. A “first come, first served” or “lottery”<sup>3</sup> method maybe employed (Emanuel et al, 2020). Each method has inherent advantages and disadvantages which decision-makers must weigh when they make their selection. The choice of the randomization process must be done before the allocation dilemma arises to guard against partiality or bias.

c. There should be no difference in allocating scarce resources between patients with COVID-19 and those with other medical conditions. Non-COVID-19 patients who need life-saving resources should not have less chances of being provided with the best care simply because they do not have COVID-19. They must be included in the random selection process when their condition carries a similar prognosis to a patient that has COVID-19. This guideline may be waived under 2 conditions: 1) the set-up of the ICU is such that it cannot guarantee that a non-COVID-19 patient will not contract the virus therefore increasing the risk for the non-COVID-19 patient; or 2) the institution has been designated primarily to be a COVID-19 center and therefore must prioritize patients with COVID-19.

3. Duty to Care - The foundation of the medical profession is built on the duty to care for others. The care is expressed in the total dedication to the well-being of those who seek their expertise, with special care always for the most vulnerable. To balance the principle of net utility, a conscious effort must be made to consider strongly those who are worst off or those

<sup>3</sup> NEJM article argues persuasively against “first come first serve” (Emanuel et al, 2020, p.3)

who have lived least number of years (the youngest). This is to be applied only insofar as it is consistent with the dictum to maximize benefits.

#### 4. Respect for persons – Persons include the patients as well as the health care workers

a. Decision not to initiate or to withdraw life-sustaining therapies should be openly discussed with patients, and/or their relatives, even if eventually, their wishes may not be followed. Discussions are to be culturally sensitive and documented. Informed consent shall be obtained for ethical consultation from the patient and/or next of kin prior to the start of discussions to protect the HCW, ethics committee members and the institutions in case complaints are later surfaced.

A register of triage decisions is to be kept for transparency and evaluation during and after the pandemic (Meyfroidt et al, 2020).

b. Palliative (comfort-focused) care must be given if life-sustaining treatment will not be initiated or is withdrawn. It should be made clear to the patient, however, that certain palliative measures which increase the risk for HCW will not be instituted; for example, BIPAP ventilation. BIPAP ventilation has been ascertained to increase aerosolization of the virus.

c. When Palliative Care is instituted, pastoral care is to be offered the patient if conditions allow and if the service is available.

d. Urge public health authorities to make a call for Advance Directives<sup>4</sup> to be discussed already among individuals at the level of the community even prior to any onset of symptoms of COVID 19 (Emanuel et al 2020; Meyfroidt et al 2020). This necessitates sensitivity in the messaging but if done correctly, this may minimize allocation dilemmas.

e. HCWs involved in triage should be offered psychological support.<sup>5</sup> This support should continue until after the crisis, and involve an ethical debriefing (Meyfroidt et al, 2020; Devrische et al, 2016).

## II. Safeguarding the Health and Well-being of Health Care Workers

Philippines of which 8 of these were physicians. The relative higher number of HCW affected is explained by the increased exposure to a patient with COVID-19 in the performance of their duties. Other reasons that have been cited include:

1. Lack of PPEs for HCWs when interacting with patients positive for Covid-19
2. Performance of high risk procedures such as tracheal intubation, tracheostomies, laryngoscopies or other airway procedures that aerosolize the virus.
3. Wearing of PPEs does not guarantee 100% protection from the virus during these procedures
4. Existing co-morbidities in the HCW that decrease immune response
5. Fatigue factor that decrease immune response

While it is recognized that keeping Health Care Workers alive and well is crucial to the care and recovery of COVID-19 patients, it is just as important to recognize that survival is not the end goal of HCW in the practice of their profession. To do so would be to remove an important ennobling feature of a professional; namely, service above self. Such acts of heroism, wherein patient care is rendered by health care workers in the front lines to the point of risking their own health and life, is to be lauded and celebrated, as they serve as shining examples of what makes the profession so noble and so worthy of high esteem, and as beacons for the following key values:

1. Professional duty–1. Professional duty– The Code of Ethics of each professional HCW (doctor, nurse, therapist, etc) states that the practice of the profession should always be centered upon the patient’s best interest.<sup>6</sup> For the physician health care worker, it is written in the 2019 Philippine Medical Association (PMA) Code of Ethics that the “*interest of the patient shall be placed above those of the physician. Societal pressures, financial gains and administrative exigencies shall not compromise this principle.*” Professional integrity requires non-abandonment of duty to individual patients in their need. This duty of non-abandonment is extended to the greater public when a massive threat to the public’s health is being faced. The duty is not only by virtue of their being physicians but also by virtue of being citizens from whom the government has requested assistance given their expertise.

The PMA 2019 Code of Ethics provides an exception to the performance of this duty in Article V. Section 5.2.2 . (Physicians shall cooperate with the duly constituted health authorities by) ...Attending to victims in times of epidemic and calamity, except when his/her personal safety is at stake.”

Generally, preservation of one’s own life is NOT an accepted justification to refuse to do life-saving services insofar as the risks are the same for other professions called into risky situations in service of the country; for example-- firemen called to battle a fire, the military in times of war, etc. However, if the situation is such that the safety of the HCW is sacrificed due

<sup>4</sup> Advance Directives should contain statements whether or not it is desirable to initiate: cardiopulmonary resuscitation, admission to the hospital, admission to an intensive care unit, endotracheal intubation, non-invasive mechanical ventilation, pharmacological hemodynamic support, the initiation of renal replacement therapy (Meyfroidt et al, 2020).

<sup>5</sup> Practical steps are given in the WHO Inter Agency Standing Committee (IASC) Interim Briefing Note—Addressing Mental Health and Psychosocial Aspect so of COVID-19 Outbreak (last updated February 2020). <https://interagencystandingcommittee.org/iasc->

<sup>6</sup> R.A. No. 2382 Medical Act of 1959, 2019 Philippine Medical Association Code of Ethics, RA 9173 An Act Providing for a More Responsive Nursing Profession, to name a few.

to neglect of controllable factors (e.g provision of adequate PPEs, proper skills training, correct environmental conditions, etc), the HCW may refuse to engage in life-saving services.

2. Prudence – Desire to serve the country should not result in reckless volunteerism.
  - a. Those with risk factors that may increase likelihood of morbidity or mortality have the right to avoid situations that promote increased risk. Some examples would include attending to patients with COVID-19 without the proper PPE, doing elective procedures that will increase exposure to the virus, extended periods of service that bring fatigue to the worker.
  - b. Ideally, those with co-morbidities that have been identified to increase risk of mortality should be given duties that do not increase exposure to the COVID-19 virus. Such co-morbidities include those with cancer, diabetes mellitus, using prescriptive steroids among others. Age is not necessarily a deterrent unless combined with other immune-suppressing factors.
3. Solidarity – This should be promoted as the main motivation for the HCW’s performance of duty in a time of national crisis. It enshrines not only the value of compassion and care that are inherent in the HCW’s profession but also the recognition by each HCW of their being an integral part of society at a time when the health profession is needed most.

Similarly, solidarity should also be manifested by the institution<sup>7</sup> towards the HCWs, in recognition of the latter’s acceptance of the risks involved. This solidarity should be expressed in the following manner (adapted from *Guidance for Managing Ethical Issues in Infectious Disease Outbreaks* by WHO, 2016):

- a. Minimizing the risk of infection through provision of PPEs, regular screening of front liners, regular information updates on the virus and the local situation;
- b. Priority access to health care not only for the HCW (discussed earlier) but also for family members of the HCW; which includes priority access to vaccines;
- c. Appropriate remuneration which includes financial support during the periods of illness and recuperation should they contract the virus and are unable to work
- d. Assistance to family members of HCW including provision of basic needs when the HCW is not allowed to be with family due to work or quarantine measures. Assistance includes death benefits to be given to the family if death is in the line of duty.

#### ESTABLISHMENT OF A MECHANISM FOR ETHICAL CONSULTATION DURING THE COVID-19 PANDEMIC

It is recommended that institutions should have in place an ethics committee whose members are available for consult when ethical dilemmas due to the pandemic arise (Emanuel et al, 2020). Depending on the institution, their function may include preparation of triage guidelines, actual triaging of critically ill patients, ethical de-briefing of health care workers (Truog, et al, 2020; Meyfroidt et al, 2020).

The following recommendations are adapted from the *Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19)*, *Guidelines for Institutional Ethics Services Responding to COVID-19: Managing Uncertainty, Safeguarding Communities, Guiding Practice*

- a. Clinical ethics consultation (CEC) services, clinical ethics consultants, and ethics committees should recognize duties to promote equality of persons and equity in distribution of risks and benefits in society and consider how best to support clinical practice during a public health emergency.
- b. A hospital’s institutional ethics services should prepare for service during a public health emergency. Leaders of institutional ethics services, such as ethics committee chairs or clinical ethics consultants, should determine the availability of committee members and consultation providers for service during a public health emergency, mindful that clinicians may have patient care roles and that many members will be limited to remote access.
- c. Preparation to provide ethics services during a public health emergency should focus on the consequences of contingency levels of care for patient-centered care, the consequences of crisis standards of care for patient preferences, and how ethics services will support clinicians in managing foreseeable ethical challenges in the care of patients with COVID-19. Training in or working knowledge of key principles of public health ethics and disaster response is integral to preparation.

Ethics leadership should support and contribute to discussion, review, and updating of relevant policies and processes taking into consideration local circumstances and contexts to ensure applicability and ease in implementation.

- d. Ethics services should collaborate with multi-disciplinary teams, including palliative care services when necessary concerning practice under contingency and crisis conditions, in view of their frequent collaboration under normal conditions and the likelihood that these services will be short-staffed. Whenever possible the multi-disciplinary approach should consider community representation.

- e. Ethics services should prepare to respond to staff moral distress under crisis conditions, with attention to different clinical areas, such as the emergency department, medical ward, and ICU, and to support across shifts. Training in or

<sup>7</sup> R.A. No. 2382 Medical Act of 1959, 2019 Philippine Medical Association Code of Ethics, RA 9173 An Act Providing for a More Responsive Nursing Profession, to name a few.

working knowledge of key principles of public health ethics and disaster response is integral to preparation.

f. Clinical ethics consultants should review and update consultation processes and practices to accommodate resource limitations, infection control restrictions, and visitor restrictions.

g. Ethical oversight for informed consent for any treatment, which may be expanded to include experimental interventions under a monitored emergency use of unregistered and experimental interventions (MEURI) agreement may be warranted (Kinlaw et al 2007).

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