Reducing Moral Distress in the Setting of a Public Health Crisis

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CASE PRESENTATION

NE was an 11-month-old female who was diagnosed with a rectovestibular fistula at 9 months of age. After completing work up for her anorectal malformation, she underwent a posterior sagittal anorectoplasty along with a diverting colostomy, to facilitate healing of the perineal wound. Given her age, she was unable to easily tolerate routine office dilations, so intermittent dilations under sedation were performed to avoid inadvertent injury to her anoplasty and perineal wound. These were progressing well, and in mid-March 2020 plans were made to schedule her colostomy reversal at the beginning of April.

On March 16, as the scope and severity of the Covid-19 pandemic was coming into focus, surgeons in our institution were instructed to immediately start scaling back elective procedures in order to preserve suddenly critical resources. A phased approach was put into place by the Department of Surgery, but much of the decision making was left up to surgeon discretion. For many procedures, the decision to delay (eg, umbilical hernia repair) or continue (eg, a tumor resection that was time sensitive due to completion of neoadjuvant chemotherapy) was relatively straightforward.

The case of NE's stoma reversal was more difficult and led to a great deal of uncertainty about the right way to proceed. If the original plan was kept, she would be coming into the hospital potentially in the middle of a surge of cases, with limited resources available and a potentially significant risk of exposure to the virus for her and her family members. If the procedure was expedited, it could lead to loss of the intended benefits of the diversion in the first place, in particular healing of the perineal wound. However, delay of the reversal and also temporary halting of anal dilations would lead to stricture development and lost ground in her progress. It also left the family to continue to manage a stoma for an unknown period of time.

After discussion with colleagues and the patient's family, the decision was ultimately made to postpone the colostomy reversal until it was once again safe to proceed with elective surgical procedures. The family was graciously understanding.

DISCUSSION

Moral Distress and the Transition from Patient-Centered Care to Utilitarianism

Under normal circumstances, physicians make decisions based on what is agreed by relevant stakeholders to be in the patient's best interest. Foundational ethical principles of justice, autonomy, nonmaleficence, and beneficence work together to produce the best possible outcome for each individual from both medical and psychosocial frames of reference. The standard course of care for most patients results in this happening automatically with all parties involved in agreement over what is considered best. However, on occasion a situation arises where moral and ethical ambiguity allows for disparate perspectives to result in incongruous conclusions about what defines a patient's best interests. When physicians and other providers of care are compelled by external forces—a patient's family, hospital policy—that prevent them from being able to provide the care they feel is appropriate, moral distress sets in. It is not necessarily that one side is ''right'' and the other is ''wrong,'' but the physician feels conflicted when compelled to do what they consider to be the less morally appropriate course of action.

Moral distress is the experience one has when confronted with a situation that produces a moral conflict while acting within ''accepted professional values and standards.''[1,2] It is most commonly described in situations of prolonged, futile care, but it may occur in any case where an individual has made their own moral judgment about a situation and circumstances dictate that they must act in discordance with that judgment. This phenomenon is being increasingly recognized across all subsets of health care providers, particularly nurses and physicians. It is associated with decreased job satisfaction, increased consideration of leaving a position, and increased risk of burnout.[3,4]

The key behind the development of moral distress is the potential conflict between an individual's moral judgment and the ethical context within which the individual engages. For this reason, the imposed transition from patient-centered ethics to utilitarianism in a public health emergency increases the hazard for exposure to moral distress for health care providers. Instead of being singularly focused on what is best for the patient that one is currently caring for, this concern must now be weighed against how individual decisions impact the community as a whole.[5] The aforementioned principles of medical ethics are still applicable in our care for individuals, but now must be counterbalanced in an often vaguely defined way with the principles of utilitarian rationing: maximizing benefits, equal treatment, promotion of individual value, and prioritizing the worst off.[6,7] The act of triage is inherently harmful to some and is incompatible with the notion that all individuals hold inherent value.[8]

Given the difficulty transitioning from one ethical framework to another, impartial, objective guidance would help alleviate physicians of having to shoulder this difficult responsibility. Our allegiance is and should be with our own patients to maintain a strong therapeutic alliance, which in many cases will persist beyond the transient public health emergency. Leaving these decisions up to individual physicians creates a perfect moral distress scenario: one is left with either acting in a patient's interest at the possible expense of the community, or vice versa. Given that a physician is simultaneously committed to their patient's well-being but also a member of the community in question, this is almost certain to create internal moral conflict, impossible to be resolved without external influence to alleviate the pressure of the moral dilemma. It is for this reason that

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guidelines for resource allocation in a public health emergency routinely recommend the creation of a triage team or a protocol-driven triage strategy.[7,9]

An example of routine enforcement of utilitarian ethics is provided by organ allocation procedures for transplantation. By considering factors with respect to the transplant recipients and also the donor organs, the intention is that the greatest good will result for the greatest number of patients.[10] Importantly, such guidelines also are meant to minimize the ability of individual physicians to exert undue influence on the process, preventing any physician or patient to receive special treatment. Because the rules are based on objective criteria that are applied equally, and all participants in the organ allocation systems are in agreement, the system works well.

All those working in health care have been affected by the COVID-19 pandemic, however, as a field, surgery—and pediatric surgery in particular—has been and will be defined more by what we have not been able to do than by what we have done.[11] Despite the fact the virus seems to spare its worst effects on infants and children, our patient population has still been indirectly impacted. In the interest of utilitarian decision making, we were compelled to scale back substantially on all but emergent and some urgent procedures. This led to many difficult decisions and many difficult conversations, as presented in the case above. Now, as localities and states have been reopening, difficult decisions continue to be made about which patients should be prioritized. Postponement of so many procedures will have long term consequences that will take years to fully understand.

Various approaches to the cessation and restoration of surgical volume have been published in response to the Covid-19 pandemic.[12–16] Some provide generalized principles that can be used to guide individual and institutional approaches to scaling back caseloads.[12,13] Although these are critical at a fundamental level, they do not help in individual cases, especially those that are not clear cut in one direction or another. Most recommendations for instituting public health approaches to allocation of scarce resources in a pandemic or disaster situation recommend full transparency in the process and incorporating a separate triage group to make decisions.[6,7,9,17] Taking this decision-making process out of the hands of individual physicians providing care should help to alleviate moral distress as described above while also supporting the doctor–patient relationship since patients and families should be able to see that their doctors' role remains advocating fully for their own patients' interests without compromise. Although these guidelines are most commonly focused on scarce resources considered to be directly impacted by a public health emergency (eg, ventilators, ICU beds, and so on) this logic easily extends to other resources indirectly impacted by such events.

Similarly, utilization of scoring systems that incorporate objective information to stratify patients can help to separate subjective personal connections from such triage decision making. Of note, the Pediatric Medically-Necessary, Time-Sensitive (pMeNTS) scoring system, which is a modification of the adult MeNTS scoring system published previously, provides a multifaceted approach that considers patient and disease factors that get at the relative urgency needed for surgical intervention along with the procedure factors that underscore the associated resource utilization and exposure risks for health care workers.[15,16] The primary advantage of a system like this is that a score cutoff can be adjusted over time based on the current circumstances. For example, if resources are plentiful and the prevalence of Covid-19 is low in a community, a hospital could select a higher cutoff; this can in turn be lowered as resources diminish and case counts increase, as we have already seen occurring in many regions. Importantly, no patients or procedures are categorically excluded from care due to patient or disease factors, maintaining that all patients are eligible for care pending the availability of resources.[17] This also can provide a reasonable roadmap for which cases to prioritize as resumption of elective procedures takes place.

CONCLUSIONS

Based on the pMeNTS scoring system, the patient presented above would have scored a 52, at least based on one interpretation of some of the disease factors variables. Although an appropriate cutoff for cases with which to proceed is variable, at the beginning of the quarantine and shutdown efforts in March 2020 a procedure with this score would have easily been considered appropriate for delay. Using this method for decision making would have removed the burden of this decision from the surgeon and also provided an objective justification that could be presented to the patient and family. In the end, this patient would ultimately undergo a colostomy reversal following a minor anal strictureplasty shortly after the gradual reopening of the operating room took place.

The Covid-19 pandemic has revealed myriad areas for improvement in the public health infrastructure at every level. It has resulted in a once-in-a-generation cessation of routine medical care that exposed the difficulties in transitioning from a patient-centered ethics to that of a public health utilitarianism.[18] Given not only that future surges of Covid-19 are possible, but also that our risk for future disease outbreaks is increasing due to increased globalization, urbanization, and climate change, instituting clear protocols for rapid deployment in the setting of a new public health emergency should be considered standard practice for all institutions.[19] Creating a system for reduction or cessation in routine surgical care should be considered a priority, for the safety of our patients and communities and to help ourselves avoid moral distress.

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