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COMMENTARY

Ethical and Legal Challenges During the COVID-19 Pandemic: Are We Thinking About Rural Hospitals?

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Emerging zoonotic infections are a major threat to public health. The current outbreak of coronavirus disease 2019 (COVID-19) is already overwhelming health care systems across the globe.[1,2] At the time of this writing it has already spread to 181 countries involving close to 1 million patients.[3] Health care resources including ventilators, dialysis machines, ECMO machines, and personal protective equipment (PPE) are finite. In the United States, intensive care units typically run at 90% of capacity and have little surge capacity.[4] In China and Italy, there have been reports of care rationing as the supply of key resources such as ventilators has been outstripped by the number of hospitalized COVID-19 patients.[5] Due to poor survival of patients requiring chest compression and resuscitation, some hospitals in the United States are also discussing universal do not resuscitation orders (DNR) for patients with COVID-19.[6] Health care institutions with the luxury of time must decide if they will proactively develop decision frameworks for these issues, or hope for the best and deal with crises as they arise.

Another ethical challenge is health care provider concerns regarding occupational hazard. Health care providers, like any other humans, are not immune to flight or fight responses during stressful situations. Health care providers' willingness to work against a potentially lethal infectious agent has also been investigated in several studies.[7,8] In these studies 80% of physicians reported willingness to work with patients with contagious and potentially lethal conditions, but only 55% agreed that "Physicians have an obligation to work during an epidemic even if doing so endangers their health."

Rural communities, whose population makes up 20% of the United States, frequently struggle with limited health care workforce and resources under ordinary conditions. When tertiary care hospitals reach capacity, rural hospitals and their communities may experience severely reduced access to critical care services and related resources as a result of timing and proximity, further exacerbating preexisting real and perceived health care disparities. These disparities have not been well studied,[9] but they are a source of concern during preparation for widespread disasters such as pandemic infection. Distribution of scarce medical resources including personnel, equipment, and services is a sensitive issue during a pandemic.[10]

Complicating the picture, older adults with multiple preexisting medical comorbidities are more vulnerable for worst outcomes of this pandemic and make up a higher share of the population in rural areas, which are already ailing with poor medical resources.

In addition to ethical dilemmas, another concern among health care providers and health systems are legal issues they may face during and after crisis situations. The history of medical malpractice dates back to the first

half of the 19th century.[11] Legal and ethical education is very limited in medical schools and training programs across the United States.[12] Law can help to establish a more flexible response by authorizing quick actions that otherwise would not have been permitted, for example waiving specific laws and providing liability protection for entities acting in good faith.[13] Conversely, law can be used to hold hospitals and health care workers accountable for patient injuries and harms, or for failing to plan for disasters.[14]

During the current situation, as in any other disaster, health providers are entering into unknown territory of ethical and legal complexity. Ethical guidance and legal and medical frameworks are an increasingly common component of disaster response plans, particularly mass casualty events. Because standards of care address not only what care is given, but to whom, when, by whom, under what circumstances, and in what places, planning must address all these factors to define appropriate standards of care in planning prior to mass casualty events.[15] Although the Health and Medicine Division of the National Academies of Science, Engineering and Medicine offers important guidance about frameworks of overall Crisis Standards of Care plans, different states embrace somewhat different basic ethical frameworks.[16] Legal and ethical challenges are inevitable in health care, and impossible to understand fully prior to, and during, an unprecedented event like the one we are currently facing.

History and Current State of Hospital Ethics Committees (HECs) in the United States

Review committees were formed in the 1960s for approval of abortion decisions. In the 1970s, dialysis priorities were reviewed by ethics committees.[17] While only 1% of hospitals had HECs in 1983, this rate increased to over 90% by 2001.[18] Limited data exist on effectiveness of ethical case intervention in adult patients.[19] Ethics committees are involved in different roles in different hospitals, but most are involved in patient care discussions following a request from the bedside care team facing an ethical dilemma. Active and organized ethics committees are needed to facilitate thoughtful and equitable planning and execution of care throughout the medical care delivery system during the current crisis.

Reorganizing Hospital Ethics Committees

The reorganization of ethics committees and development of institution- and system-level policies for allocation of health care resources requires input from multiple stakeholders. Physicians and nurses, legal professionals, ethicists, risk management staff, the general public, and patient advocates can all provide invaluable perspective and guidance during this process.

During the current pandemic, hospital-based physicians are already involved in clinical guideline synthesis, including developing COVID-19 care units, testing and treatment algorithms, discharge and follow-up advice, and resource management including distribution of medical and support staff, and appropriate use and conservation of personal protective equipment (PPE). Just weeks after the first US COVID-19 infection was reported, medical staff and hospital employees are facing increased workloads, strict infection control measures, uncertainty over the effectiveness of PPE, and anxiety regarding personal safety and the possibility of transmitting the infection to family members.[20]

Smaller hospitals, including community hospitals and rural institutions, frequently have less organized or nonexistent ethics teams.[21] When ethics teams do exist in these facilities they may meet infrequently, be consulted infrequently, and lack robust support from the health care and lay communities. Further, local relationships in rural areas are often overlapping, which further complicates ethical decision-making as objective parties with appropriate knowledge and perspective are sometimes not available.

Our health system includes both large urban hospitals, medium-sized suburban hospitals, and rural and critical access hospitals. This allows us to work in concert to prepare for the challenges, and to bring the strengths of each health campus to bear on our current crisis. At our large urban hospital, the Clinical Ethics and Value Program was organized recently, about a year ago. Previous work of this team was limited to its home hospital, and included challenging decisions about goals of care; assisting with management of patients with substance use disorder; and clarifying how to manage challenges in frontline health care. Currently, the program has expanded its reach to bring together professionals with wide-ranging perspectives throughout the health system to ensure that our process for ethical decision-making during the COVID-19 pandemic includes the concerns of small and large facilities, and shares resources in a way that all the communities we serve can understand and support. Hospitalists, intensivists, ED physicians, medical staff leaders, and nurses are working closely with ethics specialists, administration and legal counsel, and preparing as a team for the worst case scenario.

Some of the key action items taken to prepare for the expected pandemic-related ethical challenges are:

1. Creating and maintaining a dashboard of daily resource utilization
2. Defining clinical criteria for scarce resources and survival/recovery quantification
3. Identifying triage teams with a focus on clinical skills, community reputation, leadership, and communication skills
4. Keeping the bedside care team separate from the triage team
5. Identifying thresholds to trigger actions (eg, predetermined % ventilators already in use)
6. Public engagement
7. Patient and family education (especially discussions regarding the outcomes, and advance planning for worst outcomes) upon admission
8. Clear and well-defined appeal process

Challenges and Path Ahead

Creating an ethics team with all voices at the table to develop a scarce resource allocation protocol is challenging, especially in geographically diverse health care systems, where the needs and perspectives of large urban hospitals and small rural hospitals may be very different. During these times of great demands on health care, diverse leadership is required to provide coordination of care throughout the health care delivery system. Hospital-based clinicians working in large and small hospitals should take this opportunity to stand together for the good of all of our patients and communities, and begin immediately to work closely with ethics specialists and administration to provide this leadership. Shifting the mindset of frontline providers and the general population from a focus on the individual patient to a focus on the greater good for the larger community is the essence of this process.

If US health systems are required to grapple with rationing, as Italian hospitals and doctors have been forced to do, is societal backlash inevitable?[22] Only time will tell, but questions will certainly arise about appropriate allocation of limited lifesaving equipment, fluctuating evidence about disease-modifying medications, off-license medication use, postponement of semi-elective surgeries (eg, cancer surgery), patient movement limitations, restricted visitor policies, and lack of clarity about use, supply, and effectiveness of PPE. All of that complexity should not stop us from planning.

The AMA code of ethics advises, "Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians' own safety, health, or life."[23] The ability of health systems to support providers with practical tools such as clinical education, specialist consultation, and adequate PPE will be part of this story. Ethical support, with fair allocation of scarce resources and support for frontline staff experiencing moral distress as a result of the crisis, will also contribute. In the end, if history is any guide, most clinicians will choose to stay following the heroic example established through history and today.[24,25]

The point at which preparedness dissolves into panic will always be context dependent. But the tragedy in Italy reinforces the wisdom of many public health experts: the best outcome of this pandemic would be being accused of having over prepared.[22]

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