Children's Bioethics Centre

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Briefing Paper from Children's Bioethics Centre

Balancing protection of staff with optimising patient care

Ethical questions:

1. How do we resolve the ethical dilemma of optimising patient care and protecting staff during the COVID-19 pandemic?
2. How do we balance the needs of the individual patient with the needs of the community
3. How does the hospital utilise its resources, including human capital, to best effect
4. How does the hospital respect the individual rights/autonomy of staff with the needs of the hospital to provide care to patients.

Response

In responding to these questions, it is first important to provide some general ethical context, before addressing the specific issue. Working in the context of COVID 19 means that it becomes *especially* important to make sure that decisions that are founded on accepted ethical principles, and can be clearly explained and justified in these terms (Appendix 1 lists key ethical principles and values which are particularly relevant in a public health emergency such as COVID 19).

1. General ethical context

The ethical principles for decision-making in health care have not changed because of the current COVID 19 situation. Basic ethical principles of beneficence and non-maleficence, respect for individual autonomy, and justice (fairness) should still guide all decisions. However, the current situation has changed the way in which these ethical principles are prioritised and balanced against each other, and has brought some aspects of those principles which usually receive little attention. This change represents a shift in the responsibilities of health staff from an almost exclusive focus on care for individual patients when the ethical basis of treatment decisions is generally aligned with the preferences and values of the individual patient (*autonomy*) and established standards of care (*individual beneficence*), to decisions about care which are guided by the public health values of minimising morbidity and mortality (*non-maleficence at a population level*) across the whole population through strategic use of resources (*justice)*.

The COVID-19 situation has brought into sharper focus the ethical obligations and rights of healthcare professionals. The fundamental principles are unchanged. Healthcare professionals have an ethical obligation to provide best possible care to all patients equally, without judgement or discrimination; and this obligation has standardly been taken include the obligation to accept some level of personal inconvenience, burden and risk in doing so. Healthcare professionals also have a right to a workplace that is made as safe as possible for them, and a right to professional and personal integrity. Protection of health professionals from physical (such as infection) and psychological risk (such as burnout) at work is always balanced against the needs of patients, but in usual times this balancing is less obvious. Usually, risk is lower and more easily managed without much impact on patient care. In a pandemic situation, risks are higher and less easily managed.

2. Ethics of protecting staff

In this situation, the aims of continuing optimal patient care and providing health care staff with optimal protection from risk of infection or psychological harm will be in some tension with each other. A balance will have to be struck.

There are two key ethical reasons to protect staff well-being in a pandemic: (1) staff are human beings whose well-being matters, just the same as everyone else's, and (2) staff are needed to provide patient care, so patients will suffer harm if staff are physically or mentally unable to do their jobs. This second reason for protecting staff points to the ethically special situation of healthcare professionals: that they have an obligation to accept some level of inconvenience, burden or risk in order to do their job of patient care (beyond that which applies to people who do other sorts of jobs). This is a standard view in clinical ethics /bioethics. It is based on the idea of internal values and virtues of the health professions, and that people who have chosen to do this work are knowingly and freely taking on this obligation to provide care to patients, even at some risk to themselves. Of course, hospitals and other workplaces have an obligation to take appropriate steps to reduce risks to health professionals but this additional level (beyond what others face in their jobs) cannot be completely eradicated. If it comes to a choice between continuing optimal patient care and allowing health care staff to optimally protect themselves from personal risk of infection or psychological harm, a balance will have to struck and some lines drawn.

In deciding how to strike the balance, some general guiding principles can be articulated.

- Make situation-specific rather than blanket decisions
- Identify probability and magnitude of harm that different types of patients will be exposed to if staffing or services are reduced. Some effects may be minimal. Prioritise methods of protecting staff that will be effective for staff and have minimal impact on long-term health and well-being of patients
- Only put staff at any increased risk if there is no other way to provide needed care to patients
- Make sure that any increased risk to staff will actually help patients in the way that is intended
- Make sure the increase in risk to staff is the minimum possible to produce the intended outcomes
- Minimise the number of staff exposed to the increased risk at any one time
- Share the burden of increased risk fairly across the relevant staff
- Take into account the situation of staff who are at increased personal risk of serious disease if infected, , or have dependents whose welfare would be significantly compromised is the staff member were infected
- Differential measure to protect staff might be warranted, depending on how replaceable each staff member's work is – eg how readily their work can be done, to the same standard, by others available to take over. Staff who perform very critical roles may have be restricted in choosing to expose themselves to risk, even when motivated by concern for patient and community health.

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Some of the decisions about balancing staff protection and patient care include:

1. Consider what forms of protection health staff should be provided with
    - what protective equipment should be provided (to which staff, in which settings), what spatial distancing from patients and families is appropriate?
    - How can work be rostered or managed to make sure that crucial clinical roles can always be filled? Should some clinical staff be required not to come to the hospital except when on ward duty, to help ensure workforce continuity?
    - Which staff, in which patient care settings, should be permitted to step back from front-line patient care, primarily in order to protect their own health?
    - Should staff who step back be required to take on other forms of work that do not involve patient contact, even if these forms of work are not part of their normal role?
    - How much might staff be required to disclose (to whom) about their personal health situation if they are asking to step back?
2. Consider how much free choice staff should have in volunteering for front-line work which exposes them to increased levels of risk?
    a. Should staff be permitted to volunteer for more front-line work, which will expose them to greater risk of infection? This may take time away from their usual work, and also increases the chance that they may be unable to do their usual role at all, if exposed or infected. What limits/conditions should be in place? Consider the comparative strength obligation to fulfil role RCH and obligation to the broader community.
    b. Should staff be required to restrict their movements and activities outside work, in order to minimise their risk of exposure and infection in the community?

3. Allocating resources

It is ethically appropriate to provide somewhat less than usual care to some patients, in order to provide care to others that is more crucial to their health and well-being, or to the well-being of the community overall. The principle should be to provide best possible care in the circumstances. This is based on the long-standing, well-recognised ethical principle of justice. The principle of justice requires that any prioritising of some patients over others for access to treatment is:

- based on one or more criteria of justice (allocation according to need, and/or capacity to benefit are the most commonly used in health care);
- done with the criteria being applied equally, in the same way, for all patients;
- can be transparently explained according to these criteria

Resources used to screen/test/treat for COVID 19 will inevitably mean less overall resources for the non-COVID19 patients - even with government funding for additional COVID-specific resources, this is very unlikely to reduce the impact to zero. In addition, numbers of hospital staff will inevitably be reduced as quite large numbers of staff become unable to provide clinical care, either because they are infected themselves, or have to go into isolation because of contact with an infected person.

4. Specific ways in which the RCH CBC can provide practical assistance

- Provide an ethical framework which sets out important ethical values to consider when weighing up competing values of patient care, staff protection and use of finite resources.
- Set out a process and assist clinicians to identify and weigh up relevant values to ensure treatment planning decisions in their clinical context are ethically reasonable and justifiable.
- Be available for (phone or ZOOM consultations) with clinical groups/clinicians encountering ethical conflicts and complexities and moral distress, which will inevitably arise in the day to day implementation of changing clinical responses and practices

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Appendix 1:

Ethical Values which underpin decisions in a pandemic situation[1]

Pandemic Specific Ethical Values	Standard ethical principle	Explanation
1. Duty to provide care	Beneficence, non-maleficence	As an inherent part of their professional role, health professionals have a duty to provide care to those in need.
2. Equity	Justice	In general, all patients have an equal right to obtain needed health care.
3. Individual liberty	Autonomy	Respect for patient's autonomy means, wherever possible, respecting a person's freedom to make choices about their health care based on their individual values and preferences.
4. Privacy	Autonomy	Staff and patients have a right to privacy when delivering and receiving health care. The value of privacy enhances trust and protects people from stigmatisation and blame.
5. Proportionality	Balancing between principles	Any restrictions to a person's liberty, privacy or opportunity to receive needed care should be proportionate to the risk of harm or burdens associated with the restriction
6. Protection of the Public from harm	Non-maleficence	Protecting people from harm is foundational to public health ethics. Public health measures which are designed to protect people must be transparently made and weighed against the value of personal liberty and be proportional to the harm.
7. Reciprocity	Justice	Recognising that health care workers have a disproportionate burden in protecting the public means that steps should be taken to reciprocate (to give back or ease the burden in other ways) by hospital administrators, other organisations for health staff.
8. Solidarity	Beneficence, non-maleficence	Governments, Health Institutions, individual departments, health teams should work to support each other in delivering healthcare in pandemic situations
9. Stewardship	Justice	Because healthcare staff, health leaders and their institutions are entrusted to allocate material and human resources, they should be effective stewards, guided by ethics and good decision-making
10. Trust	Autonomy	Trust is essential to clinician/patient relationships and requires that all decision-making processes are ethical and transparent to those staff and patients who are affected

[1] Thompson, Alison K., et al. "Pandemic influenza preparedness: an ethical framework to guide decision-making." *BMC Medical Ethics* 7.1 (2006): 12. These authors developed an ethical framework for pandemic influenza planning, with the expertise of clinical, organisational and public health ethics and validated through a stakeholder engagement process. Columns 1 and 3 of this table are from their framework

Further Reading:

COVID-19 – Ethical issues in the paediatric hospital environment

Ethical issues in pediatric emergency mass critical care (2011) Armand Antommaria et al. for the Task Force for Pediatric Emergency Mass Critical Care. *Ped Crit Care Med* 12(6):S163-S168

Focus on family-centered care (2011) – Task Force for Pediatric Emergency Mass Critical Care. Ped Crit Care Med 12(6): S157-162 (Authors: Mason, K.E. et al.)

Disaster preparedness in Neonatal Intensive Care Units. (2017). American Academy of Pediatrics. Pediatrics 139:e1-e11)

From Pediatric Critical Care Triage Algorithm – Crisis Standards of Care (Updated version March 2020) Northwest Healthcare Response Network/Washington State Department of Health.

COVID-19 – Ethical issues in the hospital environment (generally)

Pandemic influenza preparedness: an ethical framework to guide decision-making (2006). *BMC Medical Ethics*. Thomspon, A.K., Faith, K., Gibson, J.L. and Upshur, R. 7(12):1-11

Allocation issues

(** Excellent) Fair allocation of scarce medical resources in the time of Covid-19. (2020). Emanuel et al. NEJM. Pp.1-7

Maryland Framework for the allocation of scarce life-sustaining medical resources in a catastrophic public health emergency. (2017).

The moral importance of selecting people randomly. (2008). M. Peterson. *Bioethics*. 22(6):321-327
Valuing lives: Allocating scarce medical resources during a public health emergency and the Americans with Disabilities Act. (2011). Wolf L. & Helsel W. *Plos Currents Disasters*.

Duty to treat:

The physician's duty to treat during pandemics. (2018). D. Orentlicher. *American Journal of Public Health*. 108 (11) 1459-1461.
Ethics, pandemics, and the duty to treat. (2008). Malm et al. *AJOB* (target article). 8(8):4-19.
Not in my job description. (2008) J. Godley. *AJOB*. 8(8):25-26
Specifying the duty to treat. (2008). M. Selgelid & Y. Chen. *AJOB*. 8(8):26-27
Can self-preservation be virtuous in disaster situations? (2015) Justin Oakley. *JME*
On pandemics and the duty to care: whose duty? Who cares? (2006) Ruderman et al. *BMC Medical Ethics*. 7(5):1-6
The duty to care in an influenza pandemic: A qualitative study of Canadian public perspectives (2012). Bensimon et al. *Social Science & Medicine*. 75:2425-2430

(Prepared by Merle Spriggs)