Christy Rentmeester, PhD, on standards of care and ethics during COVID

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Featured topic and speakers

In today's COVID-19 Update, Christy Rentmeester, PhD, the director and managing editor of the AMA Journal of Ethics, joins Helen Chapple, PhD, professor and ethics educator, College of Nursing, Creighton University; and Sarah Nelson, MD, assistant professor, neurosurgery and neurology, at Icahn SOM, Mount Sinai, in discussing moral distress among physicians and nurses during the pandemic, and how health care workers can respond equitably during the crisis.

Learn more at the AMA COVID-19 resource center.

Speakers

- Christy Rentmeester, PhD, director and managing editor, AMA Journal of Ethics
- Helen Chapple, PhD, professor and ethics educator, College of Nursing, Creighton University
- Sarah Nelson, MD, assistant professor, neurosurgery and neurology, Icahn SOM, Mount Sinai

Transcript

Unger: Hello, this is the American Medical Association's COVID-19 update. Today we're talking about the difficult clinical and ethical decision making during the pandemic. I'm joined today by Dr. Christy Rentmeester, a PhD and director and managing editor of the AMA Journal of Ethics in Chicago, Dr. Helen Chapple, a PhD and professor of ethics educator affiliated with the College of Nursing at Creighton University in Omaha, Nebraska, and Dr. Sarah Nelson, a physician and assistant professor of neurosurgery and neurology at the Icahn school of Medicine at Mount Sinai in New York. I'm Todd

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Unger, AMA’s chief experience officer in Chicago. Although thankfully, we’re starting to see some relief, the past couple of months have forced many hospitals to implement crisis standards of care. Dr. Rentmeester, can we talk about how crisis standards of care differ from normal standards of care and how they affect ethical decision making during the pandemic?

**Dr. Rentmeester:** Sure. So placing the word "crisis" and the word "standard" next to each other, deserves a little bit of unpacking. So in health care, crisis means triage and triage means that standards have to change to meet the conditions that are not normal. So under crisis conditions it's impossible to deliver clinically indicated care to every patient whose symptoms warrant that care. The cold hard fact is that not everyone gets what they deserve normally, and that's hard to accept, but it is just part of the ethical meaning of crisis and triage. So then which strategies do we have to responding equitably to these crisis? So since crisis conditions demand shifts in our decision making, perhaps the most responsible thing that we can do is to be transparent about which values we're using to guide our decisions about how we alter the standards of care under crisis conditions. So when the normal links between indications and interventions get disrupted, we have to make sure that we distribute the risks and benefits of that disruption equitably. So I'm not saying that equity is easy or comfortable, but it's what's required to manage a crisis justly.

**Unger:** Dr. Chapple, talk about those ethical issues that are at play in hospitals during the pandemic.

**Dr. Chapple:** Well, I'd be happy to do that, there's so many. It's hard to zero in on one. It's interesting that in the work that I've been doing, I've been finding out that the visitor policies are big problems. That nurses and physicians really want visitors, that patients do better when they have visitors. There aren't really numbers to show us that not having visitors is definitely better for people. So that's a problem that I'm hearing from people all over the country, basically that visitor policies are a problem and that patients do better and people do better if they can see one another.

**Unger:** It's funny that I never really thought of that as an ethical issue, but it is related to the outcome is what you are saying.
Dr. Chapple: Yes, it is. Yes it is. And then there are the sort of obvious things that you might guess. That if you've been able to stay healthy and your family's been able to stay healthy, which may be big assumptions under these conditions, that the nurse-patient ratios are stretched and that caring for patients you're not used to caring for because people are moving all over the hospital. Nurses are not having time off to sort of process what's going on. They go home, they sleep, they come back. So they're not able to reflect and process on the fact that they are having these kinds of problems. Maybe they're in a unit where they're seeing people die far more frequently than they're used to. So they're having trouble when they have to tell families that they don't have time to FaceTime with them, can be a problem. Yet, I am still hearing that nurses are really trying to be sure that patients are not dying alone, even as stretched as they are. That they are working hard to be in that room and holding that patient's hand as they die.

Unger: It's interesting you bring up the topic of shortages. I think during the, especially at the beginning of this, we talked a lot about shortages of equipment and shortages of PPE, but the staff shortages and the team shortages become a particular problem. Dr. Nelson, can you talk about personnel shortages and how that influences resource allocation both for patients with good and bad prognosis.

Dr. Nelson: Yeah, no, it's a great question and one that I know a lot of intensivists have had to deal with in the last year, I guess now there were up upon a year already. At the beginning as, you're right, PPE was a big deal, ventilators were a big deal. Are we going to have to triage some patients to getting these resources over others? Which is a huge ethical dilemma and one that I know caused a lot of psychological trauma globally. We kind of started hearing it first from Italy, but then other places as well.

But now as Dr. Chapple was mentioning as well, personnel getting burnout at this stage of the game, it's been a long, tough year for physicians. And I think more especially nurses and because they're so close to patients, caring for patients and also respiratory therapists as well, given their proximity to the patient as well. They're both, nurses and respiratory therapists, are in such high risk categories and both of them are extremely needed in a pandemic and one that is so focused on affecting the respiratory system in particular. And so I think we have seen over the past year, and even in the ICU in which I currently work in as well, some shortages, particularly in the nursing department.

Unger: How do you see that affecting the paradigm of team-based care? What changes have had to be made?

Dr. Nelson: Yeah, I mean, I wouldn't say that there's anything super specific. I would say that morale and certainly the psychological effects have been a big change that we have seen a lot of people just not with the "go and get them" type attitude that normally one went into medicine or nursing in the first place to kind of take care of patients and know that they're providing the best care they can. The fact that nursing ratio, nursing to patient ratios have had to change for the worse, I think has really made...
the dynamic worse in a sense. And having worked with, and continuing to work with nurses on a frequent basis here in an ICU type setting, the strain is unfortunately apparent. And typically I've seen nursing care in an ICU setting, it's usually best on a two to one ratio. Two patients to one nurse. And even in our ICU, sometimes it has to go to three to one and that's not ideal either.

**Unger:** Well, Dr. Chapple, we often talk about how the pandemic has really stressed a system that's already been flawed, so we've heard about a lot about physician wellness in this particular paradigm. But one thing that I want to ask you about is this idea of moral distress and how that has been plaguing hospital staff, and how that's different right now than in other times?

**Dr. Chapple:** So moral distresses is the idea that you see something that you want to change, that you think needs to be different, but there are powers beyond your influence that keep you from making those changes. And so in any normal times, nurses are caught with situations that they can't change and that they feel morally distressed about. It's part of the territory, but it's highly magnified in this situation. Because as I said, if you're working flat out for the entire shift and then you go home and sleep, if you can't reflect on what has gone on and what you are worried about in terms of not being able to meet the standards, speaking of standards, that you're used to meeting, or you haven't been able to meet with families in the way that you want to, then it is exactly true that you're going to be burning out. In fact, the New York times has an article today that says that clinicians are leaving the field because they can't take it anymore. There is just so much stress and moral distress going on for them.

**Unger:** I saw that article and it is shocking. There are so many underlying conditions that make physician burnout, already a huge problem before the pandemic. And now what you hear from physicians and the health care teams over and over again it's, "I've never seen this many people die." So can you talk about resource allocation and considerations that come with that kind of volume of dying patients during crisis like this, Dr. Nelson?

**Dr. Nelson:** Yeah. So resource allocation, as we were talking earlier, I mean, it was definitely a huge deal last or particularly when the pandemic was starting and people were not as aware of methods to try to decrease the risk like masking and social distancing, and so numbers were quite high and it was a, as we all know, it was a big surge on the medical system. And to try to alleviate that or to try to find a way to make sure that we were treating patients the best we could. There was several systems of allocation kind of put in progress. Various states, even each individual hospital in certain cases, convened scarce resource task forces essentially is what amounted to, and tried to put together documents and try to consider ways in which people would be triaged higher up on the list.

Prioritized in a sense to receiving some of these needed resources, such as ventilators and dialysis and things like that, which is really scary to think about and touches on the kind of the moral injury that Dr. Chapple kind of spoke a bit about as well. And you want to go in and treat your patients the best way that you can, but if you're not able to do that because you're forced to follow this algorithm,
then that's a really scary thing.

**Unger:** Well, Dr. Rentmeester, when physicians are making decisions based on things like prognoses. I think talked before about equity as a consideration here, because a lot of times you know that it's already stacked against patients who have been underserved traditionally. What is the ethical guidance about how medicine can respond to the health inequities that we've seen during the pandemic?

**Dr. Rentmeester:** The pandemic is widely documented as having exacerbated racial and ethnic inequity. And in public health ethics, it's common to hear folks talk about upstream and downstream roles of health care professionals. So downstream, that's where we are right now. Downstream medicine, downstream health care has to do with the clinical encounter, the point of care. A patient is ill or injured right now and needs health care right now. And upstream is where prevention based strategies should have been employed to prevent crises that are created downstream. So upstream medicine has to do with partnering with communities to mitigate the material conditions of poverty and discrimination and opportunity and equity.

So good upstream health care is really guided by two main ethical values, and those are organizational accountability and prioritization of the needs of the most vulnerable people in the communities. So you'll see an example, as a federal recommendations about how to distribute and administer the COVID-19 investigational vaccines, for example. These recommendations endorse these two values overall and how successful we as citizens will be at expressing those values in practice will certainly become evident over the next few months.

**Unger:** Okay. Dr. Rentmeester, the AMA continues to do a lot of work, obviously in ethics. Can you talk about some of the resources that we have for physicians and where they can find them?

**Dr. Rentmeester:** Certainly. In addition to the AMA Code of Medical Ethics, there are current articles, multimedia and continuing education content in the AMA Journal of Ethics. And that is all free to everyone in the world at journalofethics.org. So our current theme issue investigates racial and ethnic health inequity in the United States. So we encourage you to tap that resource and find some things that are helpful there.

**Unger:** Excellent. Well, you'll find that, of course, at the journalofethics.org, and you can also find more resources on COVID-19 at the AMA site. I want to thank Dr. Rentmeester, Dr. Chapple and Dr. Nelson for being here today and sharing their perspectives. We'll be back soon with another COVID-19 update. Thanks for joining us. Please take care.

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