

MORAL Balance

An Ethical Framework to aid Medical Decision-Making

COVID 19 – Hypothetical Case 2 – Mrs Jones

Possible infection, severe respiratory impairment, isolation capacity in critical care is extremely limited – “escalation” bed in theatre complex.

What is the medical decision you are trying to make?

To admit a possible COVID 19 patient in the ED, with significant comorbidities and who is not for intubation to ICU.

For NIV & vasopressors versus admission to medical ward for NIV only?

Make sure of the Facts

Outline the facts of the case and decision in question (e.g. diagnosis, prognosis, comorbidities, frailty, all treatment options, verbal or written statements, resources). Include degree of uncertainty if present.

- 77-year-old female.
- Presenting meeting ‘possible COVID 19’ definition.
- Pneumonic changes on CXR. Some respiratory distress; RR 32, FiO2 60% for SaO2 88%.
- Fever, relative hypotension & new oliguria – likely to require vasopressors for distributive shock (uncertainty, may represent cardiogenic component).
- Background of severe COPD, exercise tolerance 10yrs. Right ventricular dilatation on echo. Under consideration for long term oxygen therapy (not yet prescribed).
- Usual treatment would include NIV, vasopressors and *probable* limitation to exclude invasive ventilation on the basis of burden > benefit after discussion with patient & family.
- Very likely to need intubation if this is COVID 19 (uncertainty depends on current population prevalence / risk factors)
- Predicted mortality in the event of COVID 19 + COPD + multi organ involvement is very high.
- If COVID negative short term mortality significant, medium term mortality based on COPD severity high.
- Wouldn’t normally intubate at this early point (- increased mortality & morbidity of IPPV if not required, “trial of NIV” looking for response to treatment)

- Very limited capacity. Isolation bed on ICU available
- ICU staff are off work in self isolation. None +ve yet.
- Medical ward has COVID 19 x 8 patients in isolation. Five in isolation awaiting test results. Can deliver NIV in an isolation bed but not vasopressor therapy – which would require ICU bed.

Outcomes of Relevance to the Agents Involved

Agents are anyone who has a moral stake in the outcome (e.g. patient, family, other patients both in the hospital and outside the hospital, hospital staff, and society). Try and outline what outcomes matter most to these agents, especially taking account of any conversations you have had.

Patient

- To live (mortality risk)
- To not infect her family.
- Avoid pain & distress (physical & psychological morbidity)
- Long term functional outcome & duration (may not initially realise this is at risk)

Patient's Family

- All the outcomes the patient values but in addition...
- They are frightened for patient and themselves. How will they be able to visit if they are in self isolation for 14/7?

Other Agents

- ICU staff are concerned about getting infection or needing to self-isolate and similarly reducing staffing levels.
- Other patients in hospital are worried about cross infection.
- Public - need to protect availability of health care
- Dr - concerned that deviation from "usual" care is not justified; professional risk (complaint, legal) & ethical / emotional risk - moral distress if fails to deliver 'best' care.

Level out the Arguments in a Balancing Box

Populate facts and outcomes into a Balancing Box which uses Beauchamp and Childress’s four principles of medical ethics.

<p style="text-align: center;">Autonomy (what outcomes matter to the patient)</p> <ul style="list-style-type: none"> - Mortality risk - To not infect his family. - To get the right treatment needed - Functional outcome - To not suffer. 	<p style="text-align: center;">Burden (what are the burdens and to whom)</p> <ul style="list-style-type: none"> - ? Mortality risk of denying inotropes - Deviating from usual care - moral distress in staff - Safety risk - staff to carry out unfamiliar procedures (inotropes on the ward) - Offering false hope in patient and family
<p style="text-align: center;">Benefit (what are the benefits and to whom)</p> <ul style="list-style-type: none"> - If COVID 19, mortality expected, ward care with NIV and no inotropes minimises any length of suffering. - Offering inotropes and NIV in ICU usual practice. 	<p style="text-align: center;">Justice (fairness in the distribution of benefits and risks)</p> <ul style="list-style-type: none"> - Uses ICU isolation bed - fixed resource (isolation bed on medical ward available) - Need to protect from infection other patients and staff - protects health system

Level out the arguments by seeing if you can balance the calls of each principle and judging if each fact or outcome is truly commensurate?

Consider asking three questions of the Balancing Box:

(i) Anything of particular note?

The ethical tension of deviating from normal practice and the moral burden this places on staff.

(ii) Where is the greatest conflict?

Reserving ICU isolation bed for another patient who may have a greater chance of benefit. Offering a reduced level of treatment to the patient.

(iii) Where is the greatest congruence (agreement)?

The need to minimise mortality risk.

Document Decision (it can be helpful to use the framework to help guide documentation or place this sheet in the medical notes)

Mrs Jones presents to ED with moderate respiratory failure, significant comorbidities and possible COVID 19 infection. She requires NIV and possibly inotropes. ICU isolation bed capacity is very limited. Her mortality risk is extremely high, and almost certain if she has COVID 19.

I have discussed the case with my colleague Dr Gardiner (ICM Consultant). On balance we do not consider that trial of centrally administered inotropes is likely to offer Mrs Jones any material benefit to her outcome, over low dose peripheral inotropes. We have negotiated that the medical ward would be willing to provide peripheral inotropes to her if this would be required, with support from CCOT. We recognise this is outside our usual practise and is a result of pandemic situation (according to latest GMC guidance).

I have explained our plan to Mrs Jones and her family. They are aware that if this intervention is not enough, then, sadly, we would seek to adopt a comfort care approach. With patient and family agreement we have completed a DNAR.