

Barrie J. Huberman and Debjani Mukherjee, Ezra Gabbay, Samantha F. Knowlton, Douglas S.T. Green, Nekee Pandya, Nicole Meredyth, Joan M. Walker, Zachary E. Shapiro, Jennifer E. Hersh, Mary F. Chisholm, Seth A. Waldman, C. Ronald MacKenzie, Inmaculada de Melo-Martín, and Joseph J. Fins, "Phases of a Pandemic Surge: The Experience of an Ethics Service in New York City during COVID-19," *The Journal of Clinical Ethics* 31, no. 3 (Fall 2020): 219-27.

Phases of a Pandemic Surge: The Experience of an Ethics Service in New York City during COVID-19

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ABSTRACT

When the COVID-19 surge hit New York City hospitals, the Division of Medical Ethics at Weill Cornell Medical College, and our affiliated ethics consultation services, faced waves of ethical issues sweeping forward with intensity and urgency. In this article, we describe our experience over an eight-week period (16 March through 10 May 2020), and de-

scribe three types of services: clinical ethics consultation (CEC); service practice communications/interventions (SPCI); and organizational ethics advisement (OEA). We tell this narrative through the prism of time, describing the evolution of ethical issues and trends as the pandemic unfolded. We delineate three phases: anticipation and preparation, crisis management, and reflection and adjustment. The first phase focused predominantly on ways to address impending resource

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shortages and to plan for remote ethics consultation, and CECs focused on code status discussions with surrogates. The second phase was characterized by the dramatic convergence of a rapid increase in the number of critically ill patients, a growing scarcity of resources, and the reassignment/redeployment of staff outside their specialty areas. The third phase was characterized by the recognition that while the worst of the crisis was waning, its medium- and long-term consequences continued to pose immense challenges. We note that there were times during the crisis that serving in the role of clinical ethics consultant created a sense of dis-ease as novel as the coronavirus itself. In retrospect we learned that our activities far exceeded the familiar terrain of clinical ethics consultation and extended into other spheres of organizational life in novel ways that were unanticipated before this pandemic. To that end, we defined and categorized a middle level of ethics consultation, which we have termed service practice communication intervention (SPCI). This is an underappreciated dimension of the work that ethics consult services are capable of in times of crisis. We believe that the pandemic has revealed the many enduring ways that ethics consultation services can more robustly contribute to the ethical life of their institutions moving forward.

INTRODUCTION

When the COVID-19 surge hit New York City hospitals, the Division of Medical Ethics at Weill

Cornell Medical College, and our affiliated ethics consultation services, faced waves of ethical issues sweeping forward with intensity and urgency. We were well versed in the theoretical need to shift to crisis standards of care,¹ and how the needs of individual patients might become secondary to the utilitarian exigencies of a pandemic. But in practice, the ethical terrain was fraught with unknowns. The implementation of crisis standards of care was complex and imperfect.

In this article, we describe our experience providing clinical ethics consultations and ethics advisements over an eight-week period (16 March through 10 May 2020). We tell this narrative through the lens of time, describing the evolution of ethical issues and trends as the pandemic unfolded. We set this story against relevant externalities such as supply shortages, institutional policies and guidance, legal considerations, and ongoing governmental declarations about the public health emergency that gripped our state. Through this temporal framing we describe the dynamic nature of our work and the arc of this evolving story. Like a tragedy, our experience played out in three acts: in three phases. The first phase was anticipation and preparation, the second was crisis management,

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and the third was reflection and adjustment. We further organized our activity into three interdependent layers that we describe as patient-specific clinical ethics consultations (CEC), service practice communication/interventions (SPCI), and organizational ethics advisements (OEA).

While this report is a first draft of our history, we share it knowing that others will be faced with this public health emergency as the virus spreads across the United States. We hope that our account will help others prepare to meet the normative challenges the pandemic poses for patient care and organizational life and reveal the layered way we tried to contribute during the COVID-19 surge.

METHODS

We conducted a multicenter, retrospective review of all ethics consultations and activities that occurred from 16 March through 10 May 2020 at the New York Presbyterian-Weill Cornell Medicine hospitals. These hospitals include New York Presbyterian-Weill Cornell Medical Center (NYP-WCMC), a large academic medical center on the Upper East Side of Manhattan; NYP-Lower Manhattan Hospital (NYP-LMH), a community hospital affiliate in lower Manhattan; and NYP-Westchester Behavioral Health Center (NYP-WBHC), an affiliated psychiatric hospital located in a nearby suburb. In addition, during the surge, the Division of Medical Ethics provided emergency backup to NYP-Queens (NYP-Q) and NYP-Brooklyn Methodist Hospital (NYP-BMH). We also collaborated with Hospital for Special Surgery (HSS), a specialized orthopedic and rheumatology hospital repurposed to provide additional beds for NYP-WCMC. HSS was also designated to receive citywide orthopedic trauma patients from Emergency Medical Services. During the pandemic, eight attending clinical ethicists, one nurse ethicist, and two clinical ethics fellows provided consultative services. All were credentialed by the NYP-WCMC medical board following criteria described in *The Journal of Clinical Ethics*.² The service provided 24/7 coverage, as per our usual practice.

We provided three types of services: clinical ethics consultation (CEC), service practice communications/interventions (SPCI), and organizational ethics advisement (OEA). CEC was defined as a traditional ethics consult involv-

ing an individual patient for whom a medical record number (MRN) was known. Analysis and recommendations were made and often documented in the medical record with demographic data retrieved from the electronic medical record (EMR). Divisional CEC logs were reviewed and analyzed for thematic content by two of the ethicists who provided consults during the study period (authors BJH and DM). Both are clinical psychologists with more than 20 years of experience in clinical ethics. Using a previously published template, they prospectively modified themes for data analysis during the COVID-19 surge.³ These themes were:

- Allocation of resources,
- Capacity,
- Code (related to cardiac arrest or cardiopulmonary resuscitation—CPR),
- Discharge,
- Futility,
- Goals of care,
- Legal (pertaining to public health law or executive orders),
- Life-sustaining treatment (forgoing intubation, bipap, hi-flow oxygen, dialysis, blood, pressors, surgery),
- Pain,
- Proportionality (risks/benefits as they pertained to the patient and/or other),
- Refusal,
- Surrogate decision making, and
- Visitor restrictions.

Cases were independently analyzed based on the EMR, divisional records, and notes, and then assigned up to three codes per case. Initial inter-rater reliability was calculated at 75 percent before the reconciliation of final codes.

A second layer of ethics activities, that we have termed SPCIs, pertain to groups of patients or questions related to care on a clinical unit. An example would be providing guidance to staff in an intensive care unit (ICU) about the prioritization of ventilators when the supply or available personnel was limited. SPCIs often shared features of case consultations and organizational issues, but emerged as a distinct type of engagement.

We also provided organizational ethics advisements, or OEAs, at the hospital, university, and systems levels. This included scheduled leadership meetings about policy issues across the enterprise to plan and respond to the changing face of the pandemic and *ad hoc* meetings

with division chiefs, department chairs, and senior medical college and hospital leadership about a crisis management in real time. OEAs were on a continuum with SPCIs when disputes between clinical units required mediation between service lines or direction about policy from senior leadership. OEAs also involved real time educational outreach with attending, nursing, and house staff about developments in New York State law and/or newly drafted hospital policies in response to changes in governmental policies, changes in admission patterns, or the availability of scarce resources. These types of activities would normally be considered to be educational interventions, but, during the surge, they had significant and immediate bearing on the provision of care and the ethical climate of the institution.

Identification of SPCIs and OEAs was based on a retrospective analysis of notes, emails, calendars, phone logs, and notebooks. Consultants were asked to review their records to reconstruct their activities during the study period, much as an historian would conduct archival research. These efforts were collated to avoid duplicate reporting when two consultants were involved in the same discussions. In reporting these consult types we have had to borrow from historical methods to reconstruct the activities of the chairs of ethics committees at NYP-WCMC, LMH, and HSS (authors JJF, EG, and DG/RCM, respectively) and the clinical director of the ethics consultation service (BJH).

This study was approved by the Weill Cornell Medical College and the Hospital for Special Surgery Institutional Review Boards.

FINDINGS AND DISCUSSION

There were 93 CECs logged during the study period. We conservatively estimate the total number of SPCIs and OEAs to be well over 2,500, based on the aforementioned archival review.

CEC demographic data were self-reported by patients on admission (demographic data were unavailable for five of the 93 patients). The patient population ranged in age from 23 to 99. The average age was 71, with a median age of 74. Most of the patients were male (55 percent); 40 percent were female (the gender of 5 percent was unknown). Race/ethnicity was recorded as 47 percent White, 9 percent Asian, 9 percent Black/African American, 1 percent Hispanic/Latino, 8 percent other, and 26 percent did not

report their race/ethnicity. Although many patients did not report their religion (38 percent), 22 percent reported being of a Christian denomination (Christian, Roman Catholic, Protestant, Baptist), 18 percent were of the Jewish faith, 13 percent were without religion, 4 percent were Muslim, 1 percent were Buddhist, 1 percent were Jehovah's Witness, and 3 percent were other. Marital status was reported as single (46 percent), married (28 percent), unknown (11 percent), widowed (10 percent), and divorced (5 percent).

The incidence of themes coded in the CECs were as follows:

- Surrogate decision making (63),
- Goals of care (47),
- Code (38),
- Proportionality (23),
- Life-sustaining treatment (17),
- Refusal (15),
- Capacity (13),
- Discharge (11),
- Futility (11),
- Legal (eight),
- Allocation (seven),
- Pain (four), and
- Visitor restriction (two).

Common themes were identified as key aspects across all three phases of the surge. However, cases with similar codes were experientially and substantively different as the context changed. Illustrative CEC narratives are woven into the depiction of the temporal evolution that follows.

Temporal Evolution

By utilizing CEC, SPCI, and OEA data we have endeavored to provide a temporal depiction of our work during the pandemic to convey a sense of how dramatically things changed over the time frame we describe. The weekly incidence of CECs is depicted in figure 1. We note that there were times during the height of the crisis when serving in the role of a clinical ethics consultant felt unfamiliar. This created a sense of dis-ease amongst the consultative group as we responded to rapid transitions in circumstances with concomitant ethical challenges sometimes as novel as the coronavirus itself. This challenge was mitigated by harmonizing activities across the three spheres of activity that we describe, and through frequent and coordinated communication within the division. Departing from our usual practice, the full divi-

sion met three times weekly during the crisis.

In this section we depict the predominant and defining issues of each phase of the pandemic, recognizing that there is considerable overlap between the phases. The ethical issues described were selected as representative of our experience as the crisis evolved.

The first phase, anticipation and preparation, covers the early days of the study period, from 16 March to 29 March 2020, as the magnitude of the global pandemic and the imminent crisis that was looming over New York City became apparent. At the organizational level, this phase focused predominantly on ways to address impending resource shortages and to plan for remote ethics consultation. Efforts included work on the formation of triage committees to support clinicians' decision making regarding the allocation of ventilators and resuscitation. During this phase ethics consultants began to write 12 iterations of a triage protocol, as the institution attempted to anticipate guidelines from the New York State Department of Health (DOH),⁴ and with a nondiscrimination policy towards people with disabilities.⁵ In the end, no guidance was promulgated by the DOH and the hospital did not institute triage committees.

Another major effort undertaken in this early phase was to recruit additional ethics consultants and to strengthen collaborations within the NYP enterprise, as well as with colleagues at

HSS. The HSS service was incorporated into the NYP-WCM Division, and their ethicists were emergently credentialed by the NYP-WCM medical board.⁶

As the number of patients who required isolation rapidly increased, we fielded a number of SPCIs and CECs from clinicians concerned about the discharge of patients who would be unable to isolate in the community and about patients' requests to leave against medical advice as their results of COVID-19 testing were pending. Prototypical issues included:

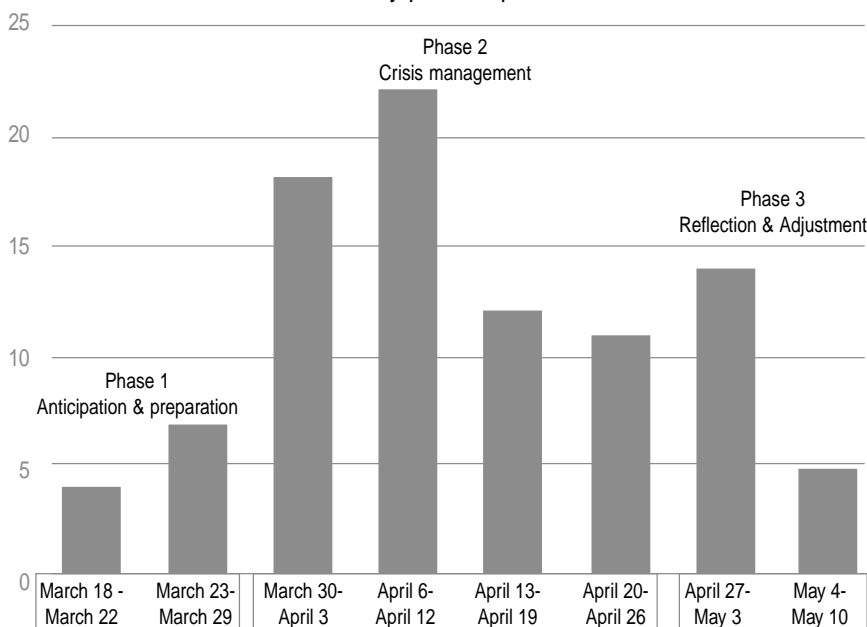
- Isolation over objection,
- The use of restraints for patients who required isolation, and
- The ethical complexities of providing one-to-one observation of patients who were COVID-19 positive.

Ascertaining patients' understanding of the recommended isolation precautions was challenging, given that isolation guidelines were changing daily and there was a lack of background scientific literacy about these evolving issues.

The most common clinical ethics consultation cases that arose in this phase involved code status discussions with surrogates. Such consultations presented familiar elements, but were different during COVID-19.⁷ Discussions about resuscitation occurred in the shadow of a looming shortage of ventilators, prognostic uncertainty about the efficacy of resuscitation, and careproviders' concerns about the risks of contagion from aerosolization during intubation and/or resuscitation—a risk that was augmented when personal protective equipment was limited.

During this phase, we also participated in establishing goals of care teams that involved colleagues from ethics, palliative care, social work, psychiatry, and other services.⁸ The teams assisted frontline clinicians who were hard pressed by the intensity of other clinical de-

FIGURE 1. Weekly patient-specific incidence



mands to devote the needed time to end-of-life conversations with families who were, by necessity, off-site due to visitor restrictions to minimize the spread of the virus.

These restrictions complicated surrogate decision making, which compounded the challenges of power disparities, health literacy, and emotional burden. With visitor restrictions in place, surrogates had to more heavily rely on what they were told by clinicians, and had only limited contact with their loved ones.⁹ This took place in a context in which surrogates were themselves socially distancing and sometimes self-isolating due to exposures. In addition, the choices that surrogates were given were limited, due to crisis standards of care. For clinical ethicists who were used to highlighting the patient's voice and supporting surrogates, these challenges began in phase one and continued during the entire study period.

The second phase, crisis management, took place between 30 March and 26 April 2020, when the pandemic surge was in full force. This phase was characterized by the dramatic convergence of a rapid increase in the number of critically ill patients, a growing scarcity of resources, and the reassignment/redeployment of staff outside their specialty areas (for example, the use of general internist-hospitalists in pop-up ICUs and pediatric intensivists who covered adult ICUs.)

This reconfiguration of staffing, coupled with reassignment and the sheer intensity and volume of extremely sick and dying patients, led to an intensifying sense of moral distress amongst frontline clinicians, and affected young and seasoned clinicians alike. Their distress manifested as profound sadness, grief, frustration, and fear, related to their inability to fully meet the needs of all of the patients. Ethicists sometimes assumed the role of a "priest-confessor"—reminiscent of Al Jonsen's depiction of the origins of casuistry in clinical ethics¹⁰—to provide reassurance that clinicians were doing the best they could under extreme circumstances. In these interactions, we often stressed that the goal was not the usual standard of care but a "sufficient" standard of care, as articulated by the Society of Critical Care Medicine.¹¹ Clinical ethics case consultations during this phase were characterized by their unusual acuity and intensity. At times the inability to fully satisfy these concerns due to systemic constraints weighed heavily on ethics consultants as well.

This moral distress was coupled with growing demands from clinicians—sometimes these were plaintive pleas¹²—to promulgate formal guidelines for allocation of intubation teams and mechanical ventilation, and to rapidly launch the triage committees. Additional resource allocation issues included negative pressure rooms and the related question of cohorting COVID-19 patients to conserve resources and limit the exposure of staff.

There was also a call for policies related to do-not-resuscitate (DNR) orders and the possibility of writing them over the objection of surrogates, something that was not permitted under prevailing New York State law, absent the promulgation of crisis guidelines.¹³ During this phase, we had significant conversations about the appropriateness of performing CPR on COVID-19 patients who were decompensating even though they were already receiving maximal cardiovascular support. The discussions focused on proportionality,¹⁴ namely the very low likelihood of success of resuscitation in the patients,¹⁵ coupled with careproviders' high risk of exposure to COVID-19. This issue prompted intense deliberations. During this period clinical ethics consultations included "rapid response" conversations to help busy clinicians address goals of care and code status in real time.

Absent guidance from New York State, we recognized the need to protect frontline clinicians who would be tasked with performing triage. We therefore advocated for institutional, legal, and governmental support for triage decisions. This advocacy included engagement with our institutional leadership and professional organizations (most notably the New York American College of Physicians)¹⁶ to petition state leadership to promulgate triage guidelines and provide immunity to physicians who make good-faith decisions on resource allocation in crisis conditions. These efforts helped lead to the inclusion of limited civil and criminal immunity in the state budget under the Emergency Disaster Treatment Protection Act.¹⁷ At the same time, we wondered about potential liability for ethics consultants as we navigated these challenging circumstances along with the legal exposure of frontline clinicians.

While working within these wider frameworks, we responded to clinician's requests for urgent clinical ethics consultations to assist them in making ethically sound prioritization decisions when one or more patients arrived si-

multaneously in emergent need of a lifesaving resource for which there was an inadequate supply. A dramatic case illustrates the nature of our response and the confluence of CECs and SPCIs during this period.

Late at night we received a desperate call from a clinician who had three patients who required urgent intubation and access to only two intubation teams. Within 15 minutes there were two more patients who also required intubation. There were enough ventilators to accommodate all five patients, but there were only two teams of careproviders and their specialized intubation kits to minimize the risk of aerosolization. We advised the clinician to prioritize the patients by clinical acuity and likelihood of survival, and, to ensure fairness, to avoid bias related to social determinants. This clinical assessment was corroborated by a second attending physician. The fifth patient who received delayed access to intubation had end-stage dementia and worsening multisystem organ failure. He was maintained on high-flow nasal cannula and supported until he was ultimately intubated.

Cases like these prompted moral distress amongst clinicians who were accustomed to providing care to patients on a “first-come first-served basis,” unimpeded by the scarcity of resources. To help mitigate their distress, we drafted written guidance to help structure high-stakes decision making about allocation. The memo, released 2 April 2020, emphasized the importance of identifying goals of care and the distinction between rationing and prioritization. Under the latter, patients are not excluded from an intervention, but rather are prioritized based upon the availability and likely efficacy of treatment. This clarification reassured staff that patients who were assigned lower priority would still ultimately be intubated if and when resources became available. Our memo also encouraged clinicians to consider acceptable rather than optimal measures when they attempted to meet the needs of more patients that is consistent with what has been described as a “sufficient standard of care.”¹⁸ These initiatives were presented in the Department of Medicine Grand Rounds in conjunction with the Division of Palliative Care. This Zoom Grand Rounds took place on 8 April 2020 and was attended by nearly 500 participants. The high incidence of clinical ethics consultations proximal to these events was likely both an indication of and in response to the intensity of the crisis at that time.

Later during this period, when the renal dimensions of the COVID-19 surge began to manifest themselves clinically, equipment and personnel for hemodialysis and continuous renal replacement therapy were in critically short supply. Needed dialysis solution stores were down to two days at one point, given the unexpected surge of renal failures due to COVID-19 and the need for emergent dialysis. SPCI questions about approaches to dialysis arose, including whether to fully dialyze a few patients and optimize their chances for survival, or to provide shorter and less efficacious dialysis to all patients, some of whom were likely to die.

Other issues addressed were the allocation of cardiac and respiratory monitoring equipment, an acutely limited blood supply, and assistance in staffing hospital committees for the prioritization of surgery given limited supplies of personal protective equipment (PPE) and venues for post-operative care. Clinical ethics consultations arose to help determine an approach to surgery for a given patient when the blood supply was limited.

Via SPCIs, we also mediated discussions between hospitalists and intensivists about ICU triage decisions. We listened to clinicians’ concerns that some locations within our network experienced more intense shortages than others, and advocated for a more equitable allocation of resources to assure optimal care for all patients. In response to clinicians’ concerns, we advocated for a less restrictive visitation policy for dying patients.

Reflection and adjustment was the third phase, from 27 April to 10 May 2020. The greatest challenge during phase 3 was the implementation of a process to enable clinicians to rely on their good faith medical judgment when they made decisions about the appropriateness of initiating additional resuscitation efforts (specifically, chest compressions) for patients who were not expected to survive and who were already receiving maximal support. As previously noted, New York State guidelines on triage were not ultimately promulgated, and triage committees were never activated. An important policy development was the dissemination of an institutionally codified process that allowed clinicians’ to use their own discretion regarding additional resuscitation for patients who were on maximal support. A clinical ethics consultation was an integral part of this process, to assure that criteria were applied consistently.

This period was characterized by the recognition that while the worst of the crisis was waning, its medium- and long-term consequences continued to pose immense challenges. Many critically ill patients lingered in ICU beds for three to four weeks, some intermittently on the precipice of death. We participated in discussions about developing a COVID-19 rehabilitation unit designed to optimize the recovery of patients who had a prolonged course on mechanical ventilation with tracheostomy. This unit was established for comprehensive rehabilitation.¹⁹ Considerations included whether or not criteria that were based on patients' baseline functional status and prognosis should guide the selection of patients for this unit.

Finally, this period was marked by efforts to resume educational and committee activity to discuss the lessons learned from the pandemic surge, as the acute phase of the crisis began to give way to chronic issues in its aftermath. We held a regularly scheduled NYP-WCM ethics committee meeting during this phase that focused on the COVID-19 experience and its impact on practitioners who had suffered collective trauma.²⁰

LIMITATIONS

Our study has several limitations. First, it involves case consultations from several related institutions that each has its own culture and demographics. Institutions that serve different populations have had different experiences. Nonetheless, our data came from New York City, then the epicenter of the pandemic, and thus it presents important information that might be of relevance to ethics consultants in general. Second, we did not have consistent data for the thematic analysis of our case consultations. The documentation and variety of cases were typical of a busy clinical service, rather than a research database, and we operated under our own crisis standards of care. Given this, we approached the coding process from a descriptive perspective, as clinical ethics consultants who looked over clinical data and made clinical judgments about the key themes in each case. We used historical methods to identify and analyze service-practice and organizational consults. These activities were not intended to be studied when we began our response to the pandemic in March, and they had to be recon-

structed with the use of archival methods. We feel this approach is justified because if we limited the description of our work to traditional clinical ethics consults, we would have failed to fully depict the ways that the Division of Medical Ethics contributed to our institution's response to the pandemic. To that end, we looked to the archival record to establish the evidentiary basis for our data. We believe these social science methods are appropriate to the historical reconstruction of the work done during this period and were the proper tools to engage in this analysis.²¹ We anticipate additional culling of this rich source of data and thicker descriptions of this work in the future.

CONCLUSION

It is said that necessity is the mother of invention, and without an appreciation of the full scope of the challenges we would face, the Division of Medical Ethics had to adapt to the realities of the pandemic surge. Just as critical care medicine changed with the building of pop-up ICUs, ethics consultations adapted to the urgency, intensity, and acuity of the pandemic.

In retrospect we learned that our activities far exceeded the familiar terrain of clinical ethics consultation and extended into other spheres of organizational life in novel ways that were unanticipated before the pandemic. To that end, we defined and categorized a middle level of ethics consultation, which we have termed service practice communication intervention (SPCI). This is an underappreciated dimension of the work that ethics consult services are capable of performing in times of crisis.

We believe that the pandemic surge revealed the many enduring ways that ethics consult services can more robustly contribute to the ethical life of their institutions moving forward. We earnestly hope that our description of and reflections upon our experiences provide guidance to colleagues who will be called upon to provide services to their patients, colleagues, and communities when the pandemic reaches their door. The lessons we learned were hard won and we hope will have instrumental value.

PRIVACY

Some details of cases presented in this article have been altered to protect the privacy of patients.

NOTES

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