Emergency triage of health resources and moral distress of caregivers

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> *A leper came to him and pleaded on his knees: "If you want to," he said, "you can cure me." Feeling sorry for him, Jesus stretched out his hand and touched him. "Of course I want to!" he said. "Be cured!" (Mark 1: 40-41)*

In 34 years of practice, caring for seriously ill and dying patients, I never had a colleague who failed to respond to my plea, "I am losing this child and need your help."

Teaching medical ethics, I frequently had to emphasize the moral core of medicine in the face of commodification and commercialization. But in life-threatening patient needs, my colleagues were always there. I identify strongly with Jesus and his desire to cure, but there is something of this desire in all doctors.

In this pandemic, there is a new appreciation of the selflessness of doctors in their care of the sick.

Doctors profess a duty to care for the sick and accept its risks. They are committed to saving life. When there is uncertainty regarding medical benefit, their duty is to treat until there is evidence of harm or futility.

Compatible with this tradition, triage – determining the priority of patients' treatments – in a hospital emergency department ensures the sickest are seen first.

We now have heart-wrenching stories from Milan to New York of weeping doctors and nurses who have had to practice emergency department triage because of scarce life-saving technology in this COVID-19 pandemic.

In the pre-pandemic turmoil of the clergy sexual abuse crisis, Pope Francis said, "I see the Church as a field hospital after battle" (2013).

Who would have imagined that "a field hospital" would be transformed from a compelling metaphor of the clergy abuse crisis in the Church to a global medical reality?

As military physicians and medics know well, in a field hospital life and death decisions are made in situations of great personal risk, limited resources and senses-numbing chaos. This is far from ordinary practice and can cause Post-Traumatic Stress Disorder (PTS) long after the battle.

In North America, the pandemic is projected to peak this Eastertime, overwhelming resources and requiring emergency department triage. Recognizing the spiritual trauma and moral distress of doctors, nurses and other health care personnel is a crucial pastoral need.

Moral distress in emergency department triage

"Moral distress" – distinct from moral dilemma and moral conflict – came from nurses being ordered to act contrary to their understanding of a patient's best interest.

It now describes the situation where individuals have a clear sense of "the right thing to do", but are forced to act differently by circumstances or law.

Governmental and professional bodies must make public when and how emergency department triage would be imposed and how it differs from ordinary medical practice. This is necessary to maintain public trust and to help mitigate moral distress.

Similarly, decisions at the hospital level should be shared by the patient's doctor, the head of the intensive care unit and hospital administration.

Emergency department triage protocol

The goals of emergency department triage are to minimize serious illness and death and social disruption during crisis. There is a dramatic shift from patient-centered to population-centered care and from individual autonomy and choice to the common good and stewardship of shared resources.

This requires a fair, reasonable, transparent and accountable process that respects the dignity of all patients who require medical resources including intensive care, resuscitation, ventilators, nurses and respiratory therapists. At the beginning of triage there is no automatic exclusion by age, health status, race, gender or quality of life judgments.

Canadian and American ethicists have identified values underlying emergency department triage criteria including equity, utility/benefit, proportionality, reciprocity and solidarity.

Equity is a conception of fairness that treats persons equally, taking into account relevant differences.

The Church's social teaching about the "preferential option for the poor" requires the protocol to minimize structural discrimination in accessing resources, especially for persons with chronic medical and psychiatric conditions, disabilities, refuges, prisoners and communities of color and poverty.

Utility/benefit requires standardized inclusion and exclusion criteria for resources based on medical judgment of clinical criteria for benefit and survival.

Proportionality requires that necessary and effective interventions should be the least restrictive alternative.

Reciprocity requires support for those who face a disproportionate burden in caring for the sick. It includes the crucially important housekeeping and food preparation staff in hospitals and long-term care facilities, those who have no professional duty.

There must be adequate staffing, a work environment that mitigates health risks with vaccines, antivirals and protective equipment and care for infected staff. It may include hazardous duty and overtime pay.

Solidarity and the common good are crucial elements of Church teaching. "Life and physical health are precious gifts entrusted to us by God. We must take reasonable care of them, taking into account the needs of others and the common good."(*Catechism of the Catholic Church*, no. 2288)

Sources of moral distress

Sources of moral distress lie primarily in the requirement for behavior that contradicts doctors' moral duty to care for the sick and in innovative practices and treatments without rigorous research, which can result in harm and delays in effective treatment.

Moral stress arises from concerns regarding non-abandonment of those who are dying and their families with limited palliative care and accompaniment and long term harm to patients not accessing treatments or investigations for other conditions.

Physical and emotional fatigue and ethical conflicts between duties to the sick and risks to self and family that require isolation from family escalate distress.

For Catholics, moral distress is compounded by difficult decisions regarding palliative sedation in respiratory failure and awareness of patient provided medically assisted death.

Surviving emergency department triage

In the post-pandemic period we can become more just and caring health professionals and systems. Or we will be more traumatized and distant.

Healthcare workers will need counseling to deal with the moral distress of emergency department triage in the days ahead.

I pray they find support and healing from Jesus, the Great Physician, who promises, "Of course I want to! Be cured!"

Nuala Kenny *is a Sister of Charity in Halifax, Nova Scotia and a pediatrician. An officer of the Order of Canada since 1999, she has published several books, including* Healing the Church *(Novalis, 2012) and* Rediscovering the Art of Dying *(2017). She is co-author of* Still Unhealed: Treating the Pathology in the Clergy Sexual Abuse Crisis *(Novalis and Twenty-Third Publications, 2019).*