Point: Healthcare Providers Should Receive Treatment Priority During a Pandemic

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Potential catastrophic surges in coronavirus disease 2019 (COVID-19) are leading to more patients requiring intensive care unit beds than are available, prompting hospitals to prepare to activate crisis standards of care (CSC). These guidelines manage the sobering process of determining which gravely ill patients will have access to limited ventilators, critical care specialists, and other essential hospital personnel. As a member of the CSC triage team at Brigham and Women’s Hospital, Boston, Massachusetts, during the initial surge, I was taught how to follow procedures to those workers willing to risk serious illness by providing care during a pandemic because the community has a special obligation to justify prioritizing HCPs for early access to vaccines during a pandemic. To underscore these issues, imagine a scenario in which, because of serious illness among HCPs, there were not enough workers with requisite expertise to care for the rest of the community in which a virus was rapidly spreading. Prioritizing HCPs could mitigate this sequence of events by preventing them from becoming infected through early access to vaccinations or promoting their recovery from the illness, which might allow them to return to work caring for others.

The Role of Special Obligations

Although the utilitarian argument has merit, my primary reason for advocating the prioritization of HCPs reflects a different ethical framework that emphasizes the reciprocal obligations between HCPs and the community. Obligations of physicians have been framed in terms of the commitments made to their self-chosen profession and the putative social contract that has been constructed with the community. These principles are well articulated in the American Medical Association’s (AMA’s) Code of Medical Ethics, which states, “Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters… even in the face of greater than usual risks to their own safety, health, or life.” Although the AMA qualified its position by indicating that this obligation is not unconditional, it still formulated exceptions within the overarching structure of professional duty, allowing physicians to “balance immediate benefits to individual patients with ability to care for patients in the future.”

If one accepts that HCPs have a professional obligation to take care of sick members of the community, even in perilous situations, what, if any, reciprocal obligation does the community have to its HCPs? Reciprocity is a fundamental ethical principle, serving as a foundation for the Golden Rule, which is a component of almost every ethical tradition. At its core, reciprocity asks us to treat other people as we would want to be treated. It requires endeavoring to take the perspective of others. Within this framework, a strategy for generating a just policy about treatment prioritization is to develop it under the assumption of not knowing which role one would end up playing in a situation. It is critical that if the positions of the individuals involved were reversed, the same rules and obligations would be accepted as fair. I suggest that if members of the community put themselves in the shoes of HCPs who are willing to risk exposure to a potentially deadly virus, they would acknowledge the legitimate expectation of HCPs to receive prioritized care if they became ill from the infection.

In most cases, reciprocity is not construed as requiring an identical exchange, but a fair one in which, for instance, sacrifice is returned in kind. Obligations can be viewed as debts that

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Published online first February 17, 2021.
Received: October 29, 2020; Revised: January 7, 2021; Accepted: January 21, 2021
© 2021 Society of Hospital Medicine DOI 10.12788/jhm.3596
we either owe or are entitled to receive.15 In the current context, reciprocal obligations are derived from the relationship between HCPs and the community in which they serve. HCPs have a special set of obligations to carry out their work with a high degree of professionalism. If circumstances demand they take on substantial risk for their community, the community, in turn, has a special obligation to take care of them.

To highlight this perspective, imagine HCPs who become ill with COVID-19 and make claims for treatment priority despite having been unwilling to work with patients who are sick with COVID-19. We would consider such claims to be unjust because our moral intuition suggests that individuals are owed a debt for the actual risks they have taken, not for the potential ones they have avoided. A corollary of this view is that HCPs who have demonstrated a willingness to risk their lives contracting COVID-19 have a legitimate claim for prioritization.

IMPLEMENTATION

Acknowledgment of the community’s special obligation to HCPs does not negate competing claims for prioritization, such as trying to save the most lives or accounting for a patient’s pregnancy status and stage of life. Rather, there is a need for CSC guidelines to also include recognition of the special obligations owed HCPs by improving their priority score in the calculus used to triage care. Operationalizing the process would need to be worked out. One possibility would be for HCPs directly caring for patients ill from COVID-19 to have their priority score improve by 2 points, and HCPs directly caring for patients without known disease (but who could still be infectious) to benefit by 1 point. At a minimum, recognition of the risks taken should serve as a tiebreaker in favor of these workers.

TO WHOM DOES THE COMMUNITY HAVE A SPECIAL OBLIGATION?

If we acknowledge that during a pandemic, the community has a special obligation to HCPs because of the risks they are taking to serve others, by the same logic, this commitment should be extended to any personnel linked to the healthcare system (eg, employees in environmental services) or frontline workers providing essential services (eg, grocery store workers) who are taking similar risks that involve exposure to potentially infected individuals. Conversely, HCPs who are working exclusively from home via telemedicine should not receive treatment priority. An approach that extends treatment prioritization to other relevant workers mitigates concerns raised about prioritizing scarce critical care resources to an already advantaged class of individuals (ie, HCPs) as well as the negative optics of a committee of “deciders” in a hospital who are privileging care to their own members.12

CONCLUSION

Reciprocity, a critical component of our notion of justice, should be incorporated into CSC guidelines. The community’s reciprocity to HCPs and frontline workers needs to be commensurate with the sacrifice made by these groups. Although public demonstrations of gratitude may be much appreciated, such displays alone are not adequate for honoring the community’s special obligations. If, during a pandemic, HCPs or frontline workers deliver direct care or services to members of the community, despite serious risk to their own lives, the community has a reciprocal obligation to these individuals to prioritize their access to critical care. HCPs and frontline workers should be prioritized not because their lives have higher intrinsic worth or solely as a reflection of their instrumental value to the community, but out of recognition of the special debt owed them. This is not an unconditional obligation, but one that should be built into the complex, multifaceted decision-making process underlying the allocation of scarce medical resources in a pandemic.

Acknowledgments

The author deeply appreciates the thoughtful comments on the essay from William Snyder, PhD, Melissa Frumin, MD, Brittany McFeeley, BS, Lise Bliss, MBA, and especially Seth Gales, MD, and remains grateful for the guidance and support he received early in his academic career from his first mentors, Carol Gilligan, PhD, and Michael Walzer, PhD.

Disclosures. The author has nothing to disclose.

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