Organizational Ethics Support for Health Care Leaders during the COVID-19 Pandemic and Beyond

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Abstract

Organizational ethics programs can help senior health care leaders align an institution's decision-making to its stated mission and values. The optimal ways organizational ethics can and should support senior leaders, however, are evolving. To inform that conversation, we discuss how organizational ethics has supported senior leaders in two tertiary hospitals during institutional responses to the COVID-19 pandemic. This real-time process of organizational ethics program development has helped characterize the types of support organizational ethics can provide to senior leaders and has identified how organizational ethics can be embedded in leadership processes to ensure the recognition and management of ethical challenges in health care.

Introduction

Organizational ethics can be described as the organization's efforts to define its core values and mission and to embed both into a health care organization decision-making and practices. Organizational ethics programs thus can identify when critical values come into conflict and help resolve those tensions in fair, transparent, and consensus-driven ways. As a result, organizational ethics programs can help address ethical challenges that arise around institutional resource allocation amid scarcity, fair balance between patient needs and other institutional concerns, and thoughtful consideration of all stakeholders, including employees, in making decisions aligned to organizational mission and values. [1-3]

Despite the presence of clinical ethics committees in today's health care institutions, their focus tends to be on the resolution of bedside clinical conflicts and sometimes assistance with prevention of such issues via engagement in quality improvement projects.[4] This important work may not, however, address all institutional ethics needs, leading senior leaders to identify separate and hopefully complementary organization ethics resources.[5] These may arise from the clinical ethics program foundation [6] or arise entirely separately. Whatever the program's origins, the novelty of the role of organizational ethicists may lead to their underutilization or misutilization.

To help clarify the ways organizational ethicists can support leaders of health care organizations, we previously proposed a dashboard for organizational leaders which emphasized the need for effective organizational ethics resources and suggested some metrics that leaders can use to assess the ethical alignment of their organization and various organizational decisions and issues that could benefit.[7] The processes through which organizational ethics – a phrase we use here inclusively to indicate the work of organizational ethicists, organizational ethics programs and clinical ethicists providing organizational ethics support – helps achieve these goals in collaboration with senior leaders have not been fully explored in the ethics literature.

In 2020, health care institutions around the world have scrambled to provide safe, ethical, and financially feasible care amid the epidemic. Stressors have included the specter of few mechanical ventilators, limited hospital capacity and human resources, disrupted personal protective equipment (PPE) supply, testing and pharmaceutical shortages, and the need to balance patient, fami-

ly, and caregiver safety via visitation policies and employee health monitoring.

From crafting Crisis Standard of Care (CSC) guidelines for COVID-19 to providing guidance for the use of scarce personal protective equipment to supporting the formulation of visitation policies and beyond,[8] we show how organizational ethics resources can and have helped institutional leaders deliver on their mission and values during the COVID-19 pandemic. In this way our pandemic response can illuminate how organizational ethics resources can support leaders of health care organizations even in ordinary times.

How COVID-19 pandemic helped demonstrate the value of organizational ethics

As a team of ethicists and senior leaders of two New England tertiary care centers, in this article we illustrate how leaders can harness organizational ethics expertise to align organizational decision-making to mission and values. We summarize how the COVID-19 pandemic influenced our institutions and we depict how organizational ethics helped us make challenging decisions during the pandemic, from fair ventilator allocation, PPE equity, visitation policies, protecting resuscitation team safety in the event of PPE shortages, management of patient refusal of masks and testing, addressing staff moral distress and management of learners. (The contributions of organizational ethics to leadership management of these marquee issues in the COVID-19 epidemic is depicted on the next page in **Figure 1**.)

Central to our institutions' responses to each of these ethically challenging issues was the need to shift from a limited clinical ethics approach centered on individual patients to a broader focus on ethical decision-making across the entire system of health care delivery during a time of crisis. Beyond the specific issues with which organizational ethics supported senior leaders, in this paper the following concrete examples illustrate how organizational ethics supported senior leaders in hopes that enables future implementation of such systems of support even in ordinary times.

Fair, transparent and community response allocation of mechanical ventilators

Many states already had crisis standards of care on file to address shortages of mechanical ventilators and other medical resources during an influenza pandemic, or other public health crises, while others had none. For those that had crisis standards, they were often dusted off and revised during COVID-19, including in Vermont where one of our institutions are located. Key challenges of developing guidelines for insufficient mechanical ventilator supply include need to allocate limited resources fairly and transparently using pragmatic ranking systems that are usable and aligned to existing systems of bed allocation, the duty to insulate staff who are making such heartbreaking decisions from moral distress, and our desire to respond to valid concerns from the disability community as well as advocates for people of color who rightly feared such policies could perpetuate historical health care inequities.

Organizational ethics support for development of these guidelines illustrated key ways organizational ethics can support leaders of health care organizations in general. Examples include synthesizing the ethics literature regarding wise resource allocation, framing the plan-making process around values at play such as moral equity and fairness, solicitation of input from diverse stakeholders, and contributions to public messaging about guidelines including to state officials, reporters, and representatives of interested communities such as advocates for disability rights and people of color.

As an example of how organizational ethics supported senior leaders through the resource allocation policy development process, in both Vermont and New Hampshire, disability advocates were concerned that patients with congenital neurological impairments, cystic fibrosis and other preexisting medical conditions would be disproportionately disadvantaged by the guidelines. We engaged with advocates, incorporated language they suggested in evolving guidelines and reassured them with concrete factual information that their concerns were valid and more fully addressed in updated guidelines. This helped promote not only improvements to our institutional resource allocation guidelines but also, we hope, fostered more trusting relationships between the institution and the communities it serves.

Fair and equitable allocation of personal protective equipment (PPE)

As scientific data regarding optimal health care worker protection from COVID-19 evolved, there was natural variation in PPE usage. Some clinicians used PPE more aggressively without regard to the degree of exposure risk. Others were more targeted in their PPE use, choosing the most protective equipment only for high risk exposures. Nationwide PPE shortages then emerged, forcing the question not only of fair allocation of a scarce medical resource but also regarding how a single complex health care organization can assure fair access across potentially competing departments that typically have complete discretion regarding PPE utilization. This dynamic was complicated by disparate recommendations of national guidelines released by bodies representing different procedural fields. [9, 10] Infection control departments took the lead in such negotiations, providing scientific evidence for a unified approach to PPE utilization and conservation. Senior leadership nonetheless had to balance competing values such as departmental independence and wise network-wide utilization of a shared resource amid evolving

	Frame issues around organizational values	Synthesize ethics literature	Contact and negotiate with reluctant stakeholders	Write and promulgate policies	Support public messaging about organizational decisions making	Support staff wellbeing and resilience	Identify preventive measures for recurrent ethical tensions
Fair allocation of mechanical ventilators	X	X	X	X	X	X	X
Unified utilization of personal protective equipment	X	X	X	X			X
Policy restricting hospital visitation	X		X	X	X		
Balancing staff safety with obligation to provide care	X	X	X	X	X	X	X
Management of patient refusal of infection control measures	X		X	X	X		
Support for staff resilience amid COVID-19 related moral distress	X					X	X

Figure 1. The contribution of organizational ethics to leadership responses to the COVID-19 pandemic.

data. To support senior leadership, organizational ethics contributed by framing the dilemma at hand in terms of shared but potentially conflicting values, conducting outreach to departmental leaders with misgivings, helping frame communications about network-wide decision-making around values such as fairness, teamwork and encouraging the development of accountability systems based on PPE run rates in order to inform next steps in leadership oversight of policy implementation. The organizational ethics perspective thus helped inform conversations about when evidence was sufficient for safe reuse of N95 masks and use of procedure masks for lower risk procedures as part of institutional PPE conservation strategies. Consistent with the observation that organizational ethics thinking can ameliorate costly organizational conflicts,[11] the conversations that allowed implementation of network-wide policies regarding PPE utilization and conservation helped promote enhanced leadership connections across the network at a time in the formation of a relatively young network of hospitals when individual affiliate autonomy and sense of connection to the larger network were still being built.

Visitation policy development

Visitation of hospitalized patients by loved ones is crucial to recovery and to the concept of patient- and family-centered care. Visitation can also risk transmission of SARS-CoV-2 to employees and other patients. It complicates significantly the space engineering challenges inherent to waiting rooms, inpatient rooms with more than one bed, cafeterias and all social distancing and disinfection requirements; and as such visitation restrictions have been a major component of infection control and social distancing in health care institutions during the COVID-19 epidemic. The management of visitation restrictions amid COVID-19 as local epidemiology changed also made consistent communications a challenge, especially as inevitable edge cases arise. Should visitation restrictions be loosened for loved ones wanting to visit a dying patient or children or the birth of a child? Making exceptions on one hospital unit can risk perceptions of unfair application of rules on other units. Are any who call themselves health care workers considered visitors, e.g. interpreters, doulas, and clergy or should the hospital define who does and who does not qualify as a member of the health care team?

Organizational ethics can help define foundational principles that justify visitation restriction policies as well as exceptions to them. It has helped leaders of specific institutional units like labor and delivery and pediatrics develop fair and consistent local rules that can be explained elsewhere by an organizational ethicist conducting shuttlecock diplomacy. Organizational ethics can help reassure staff who feel guilty about denying visitation in a particular instance by helping them understand that such challenging decisions are justified by other potentially more preeminent values in the moment such as the protection of safety of other patients. Inevitably decision-making and institutional communications about visitation can identify breakdowns in the institutional system of accountability and in turn yield system improvements if pointed out by organizational ethics. For instance, if a given department is violating institutional visitation policies without coordination with senior leadership, organizational ethics can catalyze connections between departmental and organizational leadership that yield a shared resolution that in turn can lead to concrete improvements in institutional culture. This aligns to previous findings that organizational ethics involvement can support staff sense of institutional morals and likelihood of retention.[12, 13]

Balancing staff safety from COVID-19 with obligation to provide the standard of care

Health care workers experience elevated risk of COVID-19.[14] Naturally, then, staff safety can come

into tension with other values such as the provision of the standard of care.

There is no single solution to this balancing of values, and after developing generalizable guidelines, institutions can partner with employees to develop individually appropriate plans.[15] For instance, the infection control team can develop expectations of PPE that apply to everyone while human resources may work with older or immunocompromised staff who are at higher risk of developing severe COVID-19 to consider reassignment if desired.

Nowhere is the tension between staff safety and the standard of care as evident as in the moments before cardiopulmonary resuscitation. If adequate PPE are not available when the cardiopulmonary resuscitation team arrives at the door of a COVID-19 patient's room, should they risk their own safety to save a life or risk the patient's wellbeing while awaiting PPE? Grappling with this question – which has innumerable permutations from the conduct of elective procedures on COVID-19 patients to decisions to undertake high risk thoracic procedures on COVID-19 patients amid PPE shortages – can pit individual clinicians' sense of professional obligation against leadership's mandate to assure a safe workplace. If individual clinicians opt to resuscitate, others may feel coerced to do the same, thus making policy development influential on local team culture.

Organizational ethics can help identify the emerging literature regarding deferral of cardiopulmonary resuscitation in COVID-19 patients until adequate PPE are available, can help clinicians with different intuitive resolutions of the tension in values to reach consensus and can identify preventive approaches to avoid the ethical tension in the first place such as avoiding such harrowing decisions via creative investments in adequate PPE for all cardiopulmonary resuscitations.[16, 17] Ultimately, we guided clinicians to ensure adequate PPE were present to assure staff safety before attempting resuscitation in accordance with subsequently published national and international guidance. Fortunately, organizational ethicists were able to reassure clinicians that with adequate PPE available the risk of contracting COVID-19 was extremely low.

Management of patient refusal of masks and asymptomatic testing

Some patients or visitors will refuse to comply with hospital COVID-19 infection control policies, such as screening for symptoms and temperature, mask mandates, physical distancing rules and pre-procedural testing for COVID-19, which in turn can require caregivers to make potentially unaccustomed decisions about whether to discontinue care in order to enforce those rules vs. accept personal risk in order to deliver care.

These decisions involve similar ethical tensions as those regarding cardiopulmonary resuscitation with inadequate PPE but with a new overlay of patient duty to engage productively in their own health care. In addition, to justify mandatory testing, the benefits of mandatory testing must outweigh any downsides in terms of loss of patient autonomy or access to care, with that balance of risks and benefits highly dependent on the pretest probability that the COVID-19 test will be positive.[18] Here organizational ethics can help by framing the problem not only in terms of which institutional values are in tension but also outlining factors that influence this risk-benefit calculus and contributing to communications to community members about the new testing policy. This ultimately has an impact on the patient experience so is of relevance to the institution's chief experience officer as well, bringing the organizational ethicist into collaboration with a wide array of senior leaders.

Addressing staff moral distress

The provision of clinical care in extremely stressful circumstances under conditions of scarce resources can foster moral distress, a major contributor to health care worker burnout, depression, and potentially PTSD related moral injury.[19] The COVID-19 pandemic, therefore, is likely to be followed by a new epidemic of health care worker moral distress.[13, 20, 21, 22]

Organizational ethics can ameliorate the risk of moral distress amid the COVID-19 pandemic in two ways: (1) by ensuring the difficult moral decisions made by health care workers responding to COVID-19 are part of a coherent, transparent, palpable institutional moral culture that includes a defensible organizational ethics decision-making process [13] and (2) by supporting healing conversations with caregivers who have confronted such situations.[23, 24] For example, senior leaders and ethicists met with frontline clinicians responding in Vermont to a nursing home outbreak in part to ensure adequate provision of health care resources, reinforce the need to utilize surge team replacements, and importantly to provide a forum for discussion of emotional reactions to the experience and any moral misgivings that arose during the course of care. In New Hampshire, the group formed to develop crisis standards of care embedded written guidance within the standards regarding the need to address moral distress in the clinician workforce. Using the clinical ethics committee as subject matter experts to articulate the potential roots of moral distress that were anticipated, this group then used the consultative arm of their committee as a mechanism to detect, via rounding on inpatient units, any developing moral distress in the clinicians and intervene when necessary. The clinical ethics committee developed additional resources for the workforce including

information on how to access employee assistance, chaplaincy, and other clinician supports.

Balancing learner safety with their educational interests

The incorporation of learners in the clinical environment during the COVID-19 pandemic has been controversial.[25] In some cases, learners may be dispensable to the provision of clinical care yet have the potential to increase the bandwidth of an already overtaxed clinical workforce. Furthermore, learner safety might be endangered by participation in clinical care, particularly for patients with COVID-19.

In response, some hospitals excluded learners from the clinical environment in order to protect learner safety and conserve scarce PPE. Other institutions felt student participation in COVID-19 and other care were critical to future education regarding the sustainability of the health professions and included them despite downsides. Each institution may need to strike its own balance in collaboration with its educational affiliates in light of local epidemiology. In Vermont and New Hampshire, organizational ethics ameliorated the COVID-19 risk to learners and faculty by converting all large group preclinical learning from in-person to virtual, enforced strict mask-wearing policies for small group in-person learning, and included learners in the clinical environment only once PPE supplies were assured. Neither facility allowed medical students to participate in hands-on care of patients with COVID-19. In both New Hampshire and Vermont, senior leaders appreciated the opportunity to address a surge in COVID-19 cases with expanded clinical bandwidth accomplished in a fashion that was nonetheless safe for learners and appropriate to their level of training.

The issues addressed in relation to balancing learner safety with educational and clinical needs included ensuring that learners such as residents who remained on clinical duty always practiced within the scope of their license, asking medical students who were relieved from ordinary clinical duties to volunteer in other contexts that were appropriate to their level of skill while still educational.

Beyond COVID-19: Toward durable organizational ethics support for senior leaders

Organizational ethics requires adequate institutional support in order to support senior leaders in the fashions outlined above. This institutional support can take many forms depending on the structure of the organizational ethics team and its reporting relationships to senior leaders. Whatever the local approach, key components of adequate organizational ethics support pertain. These have been partly identified and clarified by our organizations during the COVID-19 response.

People working in organizational ethics need adequate protected time to join meetings, draft policy statements, and meet with stakeholders. The amount of protected time required for that work likely varies substantially from organization to organization and may change in response to evolving engagement of organizational ethics expertise. For instance, some organizations may employ a solo organizational ethicist who joins senior leadership meetings, others may form organizational ethics committees that are either integrated with clinical ethics committees or separate from them.[5,6,7] To ensure engagement with senior leadership decisions organizational ethicists should report to specified senior leaders such as the chief medical officer or chief executive officer and have key accountabilities such as policy ownership, committee oversight, or success metrics that are reviewed regularly.

Incorporation into leadership processes is also needed to assure organizational ethics has the opportunity to engage issues with ethical ramifications whether or not senior leaders identify those ramifications up front. People doing organizational ethics work can be consulted on an as needed basis to engage some leadership decisions while other meetings (such as COVID-19 incident command groups) likely benefit from standing ethics expertise. We recently clarified how organizational ethics programs can grow from programs that formerly focused solely on clinical ethics [6, 26] and which organizational issues may benefit from organizational ethics involvement. [7]

In Vermont, we embedded an organizational ethicist in our COVID-19 operational organizational response and in both states clinical and organizational ethicists participated in subgroup meetings focused on Crisis Standards of Care development. In both settings, organizational ethics had a fundamental impact, helping to readily anchor the conversation in explicit discussion of how to balance the good of individual patients with the good of the whole population during a pandemic. Having organizational ethics present to name and reaffirm the balance of fundamental ethical values complemented input from clinicians and operational subject matter experts in conversations about crisis standards of care, PPE use, visitation and testing policies and beyond and helped bring clarity and supported quick, reliable and coherent decision-making. Organizational ethics thus served as our "true north" and helped alleviate staff moral distress about difficult decisions that had to be made very rapidly during the institution's COVID -19 response.

To be effective at supporting senior leaders, people doing organizational ethics work may require training outside of typical clinical ethics expertise including in health care financing, health care delivery science, population-wide communications and familiarity with how

health care is delivered beyond what most clinical ethicists may be familiar with from direct clinical ethics consultation. This training can be obtained with mentorship from senior leaders as well as through complementary roles held by the same individual, such as the practicing clinician leader who is also a health care ethicist. Graduate level training in health care delivery science also can enable the acquisition of such skills. [27]

Conclusion

Organizational ethics can support senior health care leaders in the alignment of institutional decision-making to organizational ethical values. Organizational ethics support for senior leaders during the COVID-19 pandemic has helped encode and integrate the types of support organizational ethics can provide to senior leaders as well as how organizational ethics can be positioned to provide that support most effectively.

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