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# Surgeons, Ethics, and COVID-19: Early Lessons Learned



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In response to the COVID-19 pandemic, surgeons are being forced to shift from patient-centered ethics to public health ethics. This shift will inevitably cause moral distress for surgeons as they are forced to alter elective surgical schedules and shift to other aspects of patient care. It is imperative that we realize the changes that are occurring in the current international setting of absolute scarcities so that surgeons are best equipped to navigate these challenging ethical waters.

The world is currently facing a public health crisis not seen since the Spanish flu pandemic of 1918. Across the globe, medical institutions are being challenged by the large volumes of patients presenting for treatment. Physicians and other healthcare providers are asked to care for large numbers of patients, often with limited resources. At the same time, much of the public throughout the world is being asked to curtail their activities in the hopes of minimizing the spread of COVID-19 infections and “flattening the curve” of infected individuals. All of this has led to significant distress across the globe.

Surgeons have not been immune to this distress. It has been manifested in several ways in the past weeks to months, depending on where one lives. A central focus of the distress for surgeons has been the need to change our usual focus from trying to benefit our individual patients to focusing on the benefit of the community. This shift from patient-centered ethics to public health ethics has occurred in multiple ways throughout the country. The shift in ethical framework has been, perhaps, most obvious in the need to stop, or at least curtail, elective surgery to open up hospital beds for future COVID-19 positive patients and to reduce the use of personal protective equipment (PPE), which is in short supply in all of the hard-hit areas of the world. As we have seen elective surgical schedules decimated, surgeons have been asked to prioritize operations that are both medically necessary and time sensitive to

perform. Although none of us likes cancelling surgery for a patient who clearly needs an operation, the necessity to choose which operations to proceed with and which can wait is an unusual circumstance for most US surgeons. For most of us who have trained in the US, we are rarely asked to make decisions in the face of an absolute scarcity of resources. However, operating room time and PPE are both scarce resources in much of the country today.

Another source of moral distress for many surgeons has been the mandate to stay home unless we are specifically called upon to render direct patient care. Suffice it to say that staying home in the midst of a crisis does not readily fit with the personality of most surgeons. Most of us, used to rigorous operating room schedules and long clinics, are not accustomed to waiting at home to be called in to help out. However, in a setting in which we anticipate many physicians and other medical workers will be infected with COVID-19, staying at home allows us to preserve the medical work force in anticipation of shortages in the future.

As many of us sit at home waiting for our shifts or to be called to provide other medical care in the hospital, it is difficult not to consider the challenging ethical problem of what is optimal and what is acceptable. This is not a new issue; often night-time surgical coverage is provided by surgeons who, although fully qualified to treat a broad range of surgical emergencies, would not normally be asked to treat many of the same patient problems in an elective setting. In the face of potentially absolute shortages of medical providers, many surgeons will be called on to provide medical care that is outside of their usual comfort zone. Although challenging for us individually, we must remember that as surgeons, we likely have the ability to help many patients, even if we are not practicing within our limited subspecialties.

Another source of potential moral distress for surgeons will likely be the shift to a greater level of paternalism than we have been used to in previous decades. Most surgical care is rendered in the context of shared decision making, where surgeons explain operations to patients and respect for patient choices is given high priority. In contrast, as scarcities increase, we will increasingly be in a position in which we cannot respect all of our patient's wishes. Certainly, in many places, surgeons have cancelled their

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patients' nonurgent operations, even when patients have stated that they are willing to accept the risks of having surgery with unknown COVID-19 status. As scarcities increase, we will likely find that we are frequently unable to respect patient choice as much as we have traditionally done.

One of the most challenging ethical issues with the current COVID-19 pandemic is that the scarcity of PPE and the risk of contracting the virus force many healthcare providers to consider what our true ethical responsibilities are. As physicians, I believe that surgeons have a professional and ethical responsibility to render care to our patients in whatever capacity is needed to assist with the public health effort. Such a belief therefore requires us to put aside our concerns of personal safety if called upon to manage patients in a COVID-19 unit or operate on COVID-positive patients. However, it is not our responsibility to provide such care without appropriate

PPE. In different circumstances than the present, for a physician to put himself or herself at added risk to benefit patients would likely be seen as a heroic act. However, in the present scenario, in which physicians themselves are at risk of becoming a scarce resource, for a physician without appropriate PPE to risk caring for a patient is irresponsible rather than heroic.

As we look to the future of the COVID-19 pandemic, we may yet face the challenges of rationing ventilators and ICU beds, but at the present time, few of us have had to take these difficult steps. Undoubtedly, we will all look back on this crisis some day and realize many lessons that are not yet apparent. However, as we look toward a period of even greater stresses on the medical systems in the US and elsewhere in the near future, we should not lose track of the changes in our ethical assumptions and how these affect our ability to care for our patients.