RESEARCH ARTICLE

In the Eye of the COVID-19 Storm: An Ethical Analysis on Aging, End of Life, and Recovery

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Abstract

Early into the COVID pandemic, epidemiologists and infectious disease experts warned that older adults were among those most vulnerable to the disease, as multiple studies from China, Italy, Washington State, and New York City showed that age greater than 65 significantly increased the risk of severe disease and/or death from the novel 2019 coronavirus. Centers for Disease Control data through June 2020 show that nearly 81% of deaths due to COVID-19 are of people 65 years of age and older. These breakdowns indicate that, primarily, persons with advanced age and most, often, those with multiple chronic conditions are those who have died. The effects of the virus led to public health measures aimed at reducing exposures of older people and other vulnerable populations. The disease was amplified in rehabilitation centers, skilled nursing facilities, assisted living centers, group homes, and other long-term care facilities serving a primarily geriatric population. Even as parts of the country are opening up, the death toll is still climbing and affecting the older adult population disproportionately. Duty to care, autonomy and self-determination, non-judgmental regard, justice, and futility are all significant ethical principles and constructs that have arisen in the intense and real-time application of healthcare as we continue to face the present global pandemic. We use an ethical lens to examine the medical response of the SARS-CoV-2 pandemic on the older adult population and explore if society is doing enough to protect older adults, or rather, engaging in and furthering collective and systematic elder abuse.

Keywords: ethics; older adult; elder abuse; end of life; healthcare professional; covid-19; sars-cov-2; novel coronovirus-2019; geriatrics

Aims:

Since early in 2020, the US and other countries have experienced staggering losses caused by SARS-CoV-2 and our response to mitigate its effects. Duty to care, autonomy and self-determination, non-judgmental regard, justice, and futility are all significant ethical principles and constructs that have arisen in the intense and real-time application of healthcare as we continue to face the present global pandemic. We use an ethical lens to examine the medical response of the SARS-CoV-2 pandemic on the older adult population and explore if society is doing enough to protect older adults, or alternatively, engaging in and furthering collective and systematic elder abuse.

Objectives:

1. To identify and explain principles of medical ethics as they pertain to providing care to older adults during a global pandemic.
2. To illustrate how previous efforts to mitigate the effects of SARS-CoV-2 could constitute elder abuse.
3. To provide remedies for ethical treatment of older adults who are affected by SARS-CoV-2.

Introduction

As the dust settles in New York City (NYC) and other areas that survived the first outbreak of the SARS-CoV-2 virus, we are figuratively and literally looking around to see who is still standing. It is akin to searching for survivors of a viral bomb that killed more people in NYC alone than in both attacks on the World Trade Center combined. Early into the pandemic, epidemiologists and infectious disease experts warned that older adults were among those most vulnerable to the disease, as studies from China, Italy, Washington State, and then New York (NY), showed that age greater than 65 significantly increased the risk of severe disease and/or death from COVID-19. Despite just 0.5% of Americans reside in nursing homes,[1] they have suffered the greatest percentage of mortality from COVID-19, accounting for over 40% of fatalities.[2] The Centers for Disease Control and Prevention (CDC) data show that nearly 80% of deaths due to COVID-19 are of people 65 years of age and older,[3] indicating that persons with advanced age and most often, those with multiple chronic conditions, have died. Effects of the virus led to public health measures aimed at reducing exposures of older people and other vulnerable populations.

The general public was asked to avoid contact with older adults and/or those with weakened immunity, as “stealth transmission” would worsen community spread. Too slowly, many governments instituted mandatory *social distancing* to *flatten the curve* to assist healthcare institutions already inundated. Alarmingly, we had to decide who to let die, as availability of life saving equipment, staff, and space to care for patients became scarce. In many states, older adults were assumed to be expendable members of society, an often-repeated tale whenever “rationing of scarce resources” discussions are held. The disease severity was amplified in rehabilitation centers, skilled nursing facilities, assisted living centers, group homes, and other care facilities serving a primarily geriatric population. In closed and poorly ventilated quarters, the spread of the novel coronavirus proved rapid and lethal.[4] As parts of the country are now opening, the death toll is still climbing and affecting the older adult population disproportionately. The lack of resources and training in many long-term care facilities exacerbated well-known systemic problems. For months, COVID-19 mortality figures were not even included in the older adult fatalities in such facilities.[5]

Are we as a society doing all we can to protect older adults, or rather, are we engaging in and furthering collective and systematic elder abuse?[1] We use an ethical lens to examine the medical response of the SARS-CoV-2 pandemic on the older adult population.

Principles of Medical Ethics

Philosopher Rosamond Rhodes and others have long advocated for a stepwise approach in analyzing clinical ethical dilemmas.[9] We must first identify ethical principles or duties, determine what, if any, conflicts might exist, and then assign them a priority value. As concerns the delivery of medical care to older adults during the COVID-19 pandemic, we identified the following relevant duties/principles: duty to care, autonomy and self-determination, non-judgmental regard, justice, and futility.

In order to present a successful civil action lawsuit, one required element of a tort is to establish a *relationship* between treating and treated parties. Underlying assumptions are that all healthcare professionals (HCPs) have a *duty to provide care* for their patients and that a relationship exists when a HCP agrees to provide care to a patient or, as a recent legal case has shown, as long as the HCP is in some way involved in the care of a patient. [10] In ethics, the duty to provide care represents a commitment by HCPs to provide patients beneficent and non-maleficent care in a non-discriminatory manner. Like the legal standard, this duty is predicated on assumptions that HCPs are bound by a professional duty to help all people in need of medical attention.

Healthcare institutions, which include hospitals and nursing homes, similarly have duties to provide care to those seeking medical assistance. Most countries in the world with public health systems that ensure all its citizens have access to medical care have strong commitments to providing care to their populace. These are not absolute duties, as they are outweighed by the need to conserve resources and ensure resource availability for all of society. In the United States (US), a similar duty exists--care is provided to the degree expected by a “reasonable person” provided by an “ideal” physician”.[11] Duties are established when a patient presents to a hospital for medical care. Federal guidelines in the US mandate a guaranteed medical screening examination to determine if a patient has an emergency medical condition (EMC) for all who present to an emergency department (ED), irrespective of the patient’s ability to pay, age, color, race, sexual orientation, or gender.[12] During the COVID-19 pandemic, older patients presenting to hospitals via the ED were owed a legal and ethical duty to receive care by the hospital and treating physicians. Upon finding an EMC, which, during this epidemic was almost certainly guaranteed in the older adult population, hospital and physicians’ obligations were legally bound via the Emergency Medical Treatment and Active Labor Act.[12]

The COVID-19 pandemic suggests a dereliction of the *duty to provide care* to the older adult population, as reports have highlighted abandonment of care both in nursing homes and hospitals.[13] An early instance was at the Life Care Center of Kirkland in Washington State, the first known nursing home hit by a wave of the virus--by April 2020, 37 of its approximately 120 residents died due to complications from COVID-19. The Centers for Medicare and Medicaid Services (CMS) fined the facility, citing that, for two weeks the facility failed to report an outbreak of respiratory illness, gave its residents inadequate care, and did not provide 24-hour emergency physician care. Despite a surge in respiratory illness in its resident population, the facility continued to accept new residents.[14]

Justified paternalism states that actions of the HCP to provide treatment over the objections of an incompetent patient are justified based on the "best interest" standard of what a similar competent patient would want. In treating older adults with COVID-19, it would seem paternalistic actions were instead focused on minimizing care and NOT providing care over objections. This unjustified paternalism included decisions, oftentimes made unilaterally, on frail, vulnerable, and usually incapacitated elderly individuals, many of whom were too ill to speak or express their wishes. Some older patients who were not significantly ill were assumed to have little chance of survival based on age as a primary comorbidity.[15] Consequently, they were not offered available treatment options such as admission to intensive care or other critical care services.[16,17] In many nursing facilities, a practice of "treating in place" espoused by regulatory agencies, health care providers, and academics alike, argued that hospitals provided environments inhospitable to older adults.[4] Some of these nursing facilities had neither the staff nor expertise to care for older residents afflicted with COVID-19 and other comorbidities. Some facilities transported residents to the hospital only when they were close to death rather than sending them earlier.[4,17]

Respect for an individual's *autonomy and right to self-determination* is hailed by ethicists, clinicians, patients' rights advocates, and others as one of the greatest duties HCPs must uphold for their patients and is stressed in the position statement of the American Geriatrics Society.[18] This inalienable right is also guaranteed in several amendments of the US Constitution as well as in similar constitutional or parliamentary documents in many countries around the world. To establish a right to autonomy, the person must have capacity. In severe illnesses, individuals often demonstrate a lack of decision-making capacity, and if so, autonomy cannot be established. In such cases, surrogate decision-makers or advance directive documents may guide treatment decisions for persons deemed incapacitated.

Based on CDC and many state public health department recommendations, the highly contagious novel coronavirus led to the barring of visitors from most hospitals and long-term care facilities. This paternalistic isolation resulted in important goals of care and end-of-life decisions being made telephonically or via internet conferencing, compounding difficulties and adding to moral distress when discussing critical care planning.[4]

In many instances, HCPs were unable to contact or find surrogates for patients, many of whom were without any form of advance directive. In such cases, HCPs were left with few alternatives other than to make unilateral decisions on behalf of incapacitated patients to determine resuscitation code status or withdrawal/withholding of care decisions. Oftentimes, decisions were made based on the need to ration ventilator and critical care resources, whether actual or perceived. Of particular concern ethically is the use of age as the sole determinant in making such decisions for incapacitated patients. There are several reported cases of older patients who had available surrogates and advance directives requesting full access to care who were nonetheless denied on the basis of their age.[19] This clearly disrespects a person's agency as well as their autonomy. Triage decisions must be balanced, fair, and without discriminatory elements, notably ageism, defined as "stereotyping, prejudice, and discrimination against people on the basis of their age", particularly significant in healthcare decisions concerning COVID-19.[20,21]

Nonjudgmental regard is needed in order to ensure that patients' agency is respected. Along with respect for autonomy, nonjudgmental regard prevents potential discrimination and ageist concerns from arising. Non-judgmental regard means that HCPs should put aside any personal prejudices they may hold about a patient's appearance, age, ethnicity, race, color, national origin, criminal status, socioeconomic status, and treat the patient like any other person without such prejudice-inducing differences, as an "Ideal Physician" would. It is incomprehensible to accept the premise that multitudes of older patients would not be afforded the same access or opportunity to treatment as younger patients received based purely on their age.

Justice or the fair allocation of resources implies that, given equal circumstances or conditions, there should be equitable distribution of available resources. In medical triage situations, patients are sorted according to critical needs, but rarely is a triage decision ethically made utilizing age as a negative factor. In the US, and despite fears of potential shortages of beds, even the then-worst hit state and city of NY actually had enough ventilators and beds to place patients on ventilators and provide necessary care. However, a percentage of older adults were not given the opportunity to be placed on ventilators due to their age and not based on their overall health status or assessment of their quality life years. Sadly, for many who did survive COVID-19, some facilities would not allow them to return and attempted to evict a number of them.[22]

Lastly, medical futility is the subject of continued debate in the ethics community; it implies a lack of benefit to continued or proposed care and a resulting recommendation by HCPs to not provide such care. Due to the controversial nature of whose values are being utilized to make futility determinations and the means of providing patients and/or their loved ones with sufficient details to understand the HCP's determination of futility, these assessments require sufficient conversations akin to an informed consent discussion. It is unclear if this level of discussion was had and with whom, in the majority of cases, where the care of older COVID-19 patients was determined to be futile.[23,24]

Ethical Analysis on Treatment and End of Life Care

The aforementioned duties and ethical principles suggest overlapping commitments HCPs and healthcare institutions owe to individuals under their care, as well as a conflict with the *principle of justice*. The principle of justice requires equitable access to treatment for all, most importantly, fair allocation of scarce resources. An issue of major contention is whether age can or should be utilized as a criterion to determine a patient's access to scarce resources. We must side with Bioethicist Arthur Caplan [25], among many others, who have opined that age should not be a limiting factor when decisions on allocating scarce resources need to be made.

In the case of COVID-19, HCPs in NY based their information and treatment guidelines on scant literature from China and Italy as well as reports of a higher amount of severe infections amongst residents in Washington State.[26] At no point could any physician predict with 100% certainty if an otherwise healthy person over age 65 would die from COVID-19. Contrary to common medical practice, an otherwise healthy 65-year-old should be given equal if not higher chances to receive a potentially lifesaving treatment over a 45-year-old obese, hypertensive person with diabetes, for example. Undoubtedly, advanced age **with** comorbid conditions should lower patients' access to scarce resources.

Given that justice should not automatically or in absolute terms invoke age as a criterion to limit access to scarce resources, we emphasize and recommend that respect for autonomy and autonomous choices via surrogates or advance directives be zealously pursued and given precedence in medical decision-making and triage. Adherence to nonjudgmental regard should prevent ageism from arising and ensures fairness. Difficult conversations on medical futility should be had ethically and with surrogate decision-makers when possible. Ethically and legally, decisions made on behalf of older patients, those with and without representation, should include a team consisting of social workers, case management, and other stakeholders to ensure a multi-disciplinary approach that embraces principled transparency. A healthcare ethics consultation (HCEC) service is well-suited to serve this role and should be involved in planning and day-to-day operations during pandemic crisis management. Many institutions ensured 24-7 access to palliative care and HCEC services for all providers during the pandemic.

The coronavirus crisis has engendered extensive discussions regarding crisis standards of care, resource allocation, and crisis triage protocols. Adding moral injury and insult, several US states are seeking to avoid liability associated with the nursing home death toll. Several states, led by NY, have started the legislative process to prevent malpractice suits related to coronavirus deaths. We regard this as an ageist act that devalues older adults by allowing and legalizing unjustifiable treatment of some members of society. Unilateral policies to lower standards of care for certain people is discriminatory in all interpretations of the word *discrimination* and is arguably a 14th Amendment constitutional violation.

Further guidance may be obtained from the 2015 NY State Ventilator Allocation Guidelines for a potential pandemic influenza outbreak that might overwhelm ventilator resources. It was found to be overly subjective and discriminatory to use advanced age as a factor in triaging patients for scarce ventilator resources.[27] Similarly, in Italy the Società Italiana di Anestesia, Analgesia, Rianimazione e Terapia Intensiva (SIAARTI; Italian Society of Anesthesia, Analgesia, and Intensive Care) released treatment allocation guidelines during the early part of the COVID-19 pandemic, which specifically used advanced age as “ethical” criterion for scarce resource and treatment allocations.[28] It was only after the death of countless older adults that these policies were reexamined and found to be unethical. These recommendations were based on previous guidance that failed to include geriatricians in discussions and reinforces the need to include all stakeholders to review policies involving potentially vulnerable members of society.[29,30]

Recovery/A Time to Pause

Duty to care, respect for autonomy and self-determination, non-judgmental regard, justice, and futility are significant ethical principles and constructs that have arisen in the intense application of healthcare as we confront the present global pandemic. Many parts of the world reacted by taking a beneficent, protective, and highly proactive stance to quell the real dangers presented by the COVID-19 contagion. Formidable efforts to treat and mitigate its spread resulted in triaging care. As the virus raged in the early months, when medical supplies were inaccessible or inadequate, older adults became its innocent and unwitting victims.

Treatment decisions, too often made in chaos and haste, were predicated on preconceived notions of what it means to be old, poor, vulnerable, and suffer from comorbid conditions. Sometimes, wishes and preferences of older people were abrogated to the supply chain, outright fear, and a paternalistic mitigation strategy involving isolating elders from the outside world. Isolation is both a mechanism to protect older adults as well as one that harms them. Isolation, coupled with unjustified paternalism and directives for no codes, slow codes, and inattention to older adults' wishes, may, in more than a few instances, constitute elder abuse.

In our quest towards recovery or at least a pause in reopening strategies as we confront new surges of the disease, we must recognize that the paternalistic isolation of older adults, in community and in facility settings, creates another serious problem—loneliness, a fallout of imposed treatment that can leave lasting and unrecoverable harms--increasing susceptibility to declining health and hastening death. As stated in "The Storm Will Continue", we must learn from earlier mistakes.[4] Traversing the road to recovery means recognizing that chronological age is one variable in a treatment decision and that older adults prefer to exercise their autonomy and be listened to rather than acted upon. Recovery past the eye of the COVID-19 storm includes confronting what society imposed upon members of the older adult population. Going forward, we must implement approaches to care that are ethical and respects patients' preferences rather than what HCPs or institutions determine is appropriate given their perceived limited resources or assessments of futility.

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[1] The CDC defines elder abuse as "an intentional act or failure to act that causes or creates a risk of harm to an older adult (persons age 60 or older).(CDC 2020) The abuse often occurs at the hands of a caregiver or a person the elder trusts." Similarly, the World Health Organization (WHO) defines elder abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person".[7] Elder abuse can take various and multiple forms (e.g., single type, multiple, or co-occurring financial, physical, psychological sexual). It can also be the result of intentional or unintentional neglect. The WHO estimates that 15.7% of people 60 years and older are subjected to abuse, prevalence rates are likely underestimates, as many cases go unreported. Teaster and O'Brien [8] asserted that, in healthcare settings, undertreatment and overtreatment of older adults at end of life constitutes elder mistreatment.