The Black Art We Practice in White Coats

Practicing Disaster Medicine with COVID-19

A Physician's Personal Account

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Like so many people around the world, I awake in the tranquil quiet of the morning before the family wakes, look at the calm normalcy outside my window and hope in the back of my mind that this COVID-19 pandemic is just a hangover from too many bad movies. With a sliver of hope, I turn on the computer to check the morning updates. Alas, no. The death toll is still growing exponentially and the friends I have lost are still dead.

As an ICU Hospitalist physician, I think of what lies ahead and say a silent prayer, "Please, G_D, do not let this be the day I have to break my Hippocratic oath."

Like most physicians, I employ the Hippocratic principles daily to guide my decisions on the care of my patients. Every American physician pledges an oath to follow these principles before getting their medical degree. The main points are, "Do no harm," and do what is best for the patient.

It is a simple, ethical and effective approach. It is easy for the patient and family to understand, builds trust with the family and strengthens the doctor-patient relationship. When I am explaining care choices, I simply suggest the same treatment I would give to my own family. This approach not only helps patients get the best care but helps us all when the outcomes are less favorable. Also, when there is a bad outcome and I am mourning with the family, I can look them in the eye knowing we made the best decisions for everyone involved. This is the essence of Hippocratic training in medicine.

With Hippocratic-led medicine at its foundation, the US has provided the best individual care at any cost. We are taught to ignore prognostic indicators like age, longevity, resource availability, or costs. We offer the same treatment to every patient based on their individual disease process.

This means that a 98-year-old female with dementia will get the same care as a 40-year-old male without. We give the best care, but also the most expensive.

We have been blessed for decades with essentially unlimited resources.

All life has unlimited value, and everyone is worth saving, regardless of cost. Americans do not want to put a price on a single life or resource which leads to spending millions of dollars trying to save everyone.

A hiker may disregard warnings and head up a mountain in a blizzard—perhaps even after signing a waiver stating that they understand the risks and that help will not be provided—yet, when they get in trouble, we as a society will still spend countless resources trying to save them.

I believe this has made the US the most caring country in the world. We respond with open arms and pocketbooks to any crisis. We rebuild countries ravaged by war. Operating with the belief that you can't put a price on a life, we send resources and medical personnel around the world, doing whatever we can to save people.

The problem is that this healthcare model it is not viable in a situation with limited or resources like during a pandemic. With COVID-19, we as physicians we are forced to practice disaster medicine. This is a black art that we practice in white coats. We are forced to make decisions that we're not equipped to make. In disaster medicine, you are trained to make the best decision for a society of effected people, NOT the individual. There are limits to the resources available and, in this case, there are dangers to the caregivers.

Doctors are not taught how to deal with this new paradigm.

Traditionally, patients show up and we treat them. There is no thought about resources or percentage chance of survival or how long one patient will live compared to another. We certainly don't have to consider whether using a resource on this patient will then mean we won't be able to treat the next patient.

In this current reality, we do have to make those devastating decisions.

How do we take a thought process that is ingrained in every physician's DNA and change it overnight? How do we learn how to allocate our limited resources to not only save the most lives BUT save the most LIFE YEARS?

We also need to be prepared to make these decisions in real-time. If we don't use a ventilator on the patient now, they will die but if we do someone else will die instead. This is the nightmare that physicians and emergency responders are forced to make daily in this new COVID-19 world.

How do we possibly do this? Well, I can tell you how NOT to do it first.

You CAN'T ask the physician to make this decision. It will kill us. We can't watch a person die untreated that we can save. If this is left to the physicians, it will destroy them psychologically.

If not the physician, then who should make those decisions?

We can't use traditional ethics committees in times like these. Committee decisions take too long to make, and these are decisions that need to be made immediately.

Ideally, these decisions would be made in the field, before the patient is brought to the hospital. However, it would be extremely tough to develop a protocol that would give an EMT or paramedic the ability to allocate resources.

With that said, some decisions are already being made in the field. Do not resuscitate orders are being made in the field. When it is deemed that a patient or the transport will endanger the EMT or paramedic's life when the patient has a low chance of survival, the patient is left in the field and care is not given. This sounds like what you would expect in a war zone, not in the US.

Is there a better way to make these decisions?

I can tell you there is no easy or perfect way of making these decisions. I am also sure that the lawyers will get involved post-pandemic and try to take advantage of the situation. I just hope that collectively, we understand that physicians and other caregivers don't want to make non-medical decisions on the allocation of limited resources. I hope that we remember the context in which we are forced to make these decisions.

We are at war. We are making the best decisions that we know how to make to save the most lives and life years.

Please don't turn your backs on us when the worst of it is over.

We will most certainly suffer PTSD over what we witnessed on the front lines. We will see things that we are not prepared or trained to deal with. We will make mistakes. People will die, not because of our negligence, but because of this terrible, silent enemy. We will have to find a way to live with the knowledge that we had to let someone die that if given the resources we could have saved.

Well-thought-out protocols need to be developed and administered without exception. These protocols need to be administered by one team not involved in the direct care of the patient. The information has to be communicated by another.

All the caregivers and administrators need to agree in advance to the protocols.

The decisions need to be made before the patient is delivered to the doctor to give care. If the doctor is allowed to start treatment and then is told to stop and let the patient die because we don't have the resources to treat, that will NOT work.

Protocols also need to be developed to address the withdrawal of care.

The only thing that is worse than not providing care is to begin providing it only to later take it away. This has to be addressed in a wartime situation. If the person with the resource has less chance of survival than a person

waiting for the resource, then the resource should be taken from the one that has the lowest chance of survival and given to the one waiting with a much higher chance of survival. **If this drastic step is not taken, then it is likely that both will die.**

Outside of war, we never have to make these decisions.

There are a couple of articles that I feel are excellent at looking at the problem. One is a 250+ page document from New York which discusses these types of decisions in general. It was written several years ago and was targeted at disease processes like the flu; a slow-moving infection with a predictable course. There is another out of Pittsburgh which looks at COVID-19 and takes into account some of the intricacies of this disease in particular. This one is a focused document, only 4 pages long.

There is also a flowchart put out by Wakefield Brunswick which tries to incorporate both documents operationally.

It is incumbent on EVERY hospital to incorporate decision-making processes now as these decisions are already being made in many locations.

This article was written selfishly from a physician's perspective. This is not because we don't care about the effects that this will have on the ultimate victims, the patients. It is because we do care so much about our patients. We went into medicine because we love to care for people through the good and the bad. We become part of their families throughout their lives. This is why we feel so devastated by this unavoidable shift in the care paradigm.