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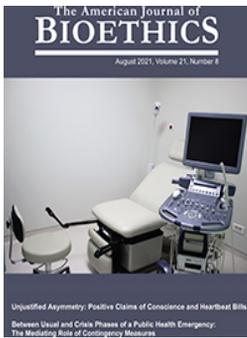
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Neither 'Crisis Light' nor 'Business as Usual': Considering the Distinctive Ethical Issues Raised by the Contingency and Reset Phases of a Pandemic

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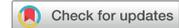
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Neither ‘Crisis Light’ nor ‘Business as Usual’: Considering the Distinctive Ethical Issues Raised by the Contingency and Reset Phases of a Pandemic

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INTRODUCTION

We have been researching the distinctive ethical issues raised by what we have called “the reset period,” when non-Covid services resumed alongside the continuing pandemic in the UK. In this commentary, we will first consider the similarities and differences between the reset and contingency phases, as described by Alfandre et al. We will then unpack Alfandre et al.’s position that the contingency phase should be characterized by operating a standard of care that is functionally equivalent to “usual” practice, arguing that in the reset and contingency phases, the standards of “usual” care may be unobtainable and, in these circumstances, we cannot fall back on the primacy of “patient centered care.” Consequently, different ethical principles and balancing strategies are needed when care is neither “crisis light” nor “business as usual.” We will conclude by reflecting on what these should be.

RESET AND CONTINGENCY PHASES OF PANDEMICS

In the UK, with the advent of a national lockdown in March 2020, all non-urgent, non-Covid related health provision was suspended or significantly reduced. When the government issued a statement in April 2020 (NHS England 2020) that required non-Covid-19 clinical services to resume alongside the continuing

response to waves of Covid-19 infections, the UK entered a new phase of the pandemic; what we have called the “reset phase.” This phase combines both response and recovery phases as health systems have to reinstate non-Covid services, address the backlog of delayed care, *and* manage the healthcare needs created by the ongoing pandemic. Disaster planning generally assumes a temporal sequence—preparedness, response, recovery, and mitigation. Whereas, the phases of the Covid-19 pandemic have not been linear, with phases overlapping and often occurring simultaneously (Fakhrudin, Blanchard, and Ragupathy 2020). Alfandre et al, drawing on Hick, Barbera, and Kelen’s (2009) work, present an alternative taxonomy to capture phases in public health disasters, such as Covid-19, where the sudden increase in demand for health services challenges or outstrips existing capacity: conventional (or usual), contingency and crisis phases. The contingency phase, as Alfandre et al understand it, is not “crisis light” but a distinctive phase where the “augmentation of staff, space and supplies (i.e. conserving, substituting, adapting, and re-using) are deployed to forestall critical scarcity” (5). These contingency measures are designed to ensure continuity of an organization’s operations to support its capacity to respond to another crisis phase, or to move into the recovery phase. As Alfandre et al, and

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we have noted (Baines et al. 2020), discussions of the ethical issues raised by crisis and response phases have been extensive, whilst less attention has been paid to the contingency and reset phases of a pandemic, and Alfandre et al.'s paper is a welcome addition to the literature.

The contingency phase has similarities with our reset phase: it operates between “usual” practice and the “crisis” phases of a pandemic. There are, however, important differences between the two; contingency planning focuses on maximizing a hospital’s capacity and its ability to maintain services, whereas the reset phase incorporates elements of recovery *and* reimagining future health services. Furthermore, the contingency phase operates temporarily between “usual” practice and the “crisis” phase, whereas the reset phase operates alongside and continues after the crisis phase. For the purposes of this commentary, we will focus on the key similarity between contingency and reset phases of a pandemic: the way that both, “mediate the tensions between the two ethical orientations of usual and crisis phases, operating to balance the values of both patient-centered care and public health” (Alfandre et al. 2021, 5). It is this mediation between patient-centered care, underpinned by clinical ethics; and public health concerns, underpinned by public health ethics, that present the “ethical challenges that are specific to the contingency phase” (6). In the crisis phase, approaches that prioritize the greatest good for the greatest number understandably come to the fore, whereas in the contingency and reset phases, concerns for individual patients and their care resurface.

STANDARDS OF CARE

One of the central features of Alfandre et al.'s contingency phase, is that a standard of care *functionally* equivalent to “usual” practice should be provided. Much hangs on the definition of “functionally equivalent” care, which they define as “the care delivered using ‘different methodologies, medications, and locations’ [that] is clinically indicated and intended to provide benefit to patients comparable to what they would receive during the usual phase” (6). It is difficult to assess whether care is functionally equivalent *a priori* and a detailed knowledge of each case would be needed to make this assessment, but the examples given by Alfandre et al are helpful in showing how an organization might weight the different considerations. It is worth noting that the contingency phase rests on the assumption that there is spare capacity in the system or organization to augment and forestall critical scarcity, so organizations will be able to provide healthcare that

is functionally equivalent. The UK National Health Service (NHS) for example, to the contrary, normally operates at or near to capacity (see for example bed occupancy rates (NHS England 2021)). Further, Covid has put extreme pressure on many healthcare systems, “bringing to light the sub-optimal resilience of even those classified as high-performing.” (El Bcheraoui et al. 2020) Hence, the level of resourcing needed to be able to have a contingency phase characterized by functionally equivalent care may not always be available (Blumenthal and Seervai 2020).

A key feature of functionally equivalent care for Alfandre et al. is that, “patient centered decision-making remains the priority.” They quote the Institute of Medicine’s disaster response framework, which states that although institutions should consider the greatest good versus individual needs, “patient-centered care decision-making is still the focus.” A potential problem for Alfandre et al.’s definition of the contingency phase is that if it is characterized as encompassing the planning and deployment of resources to forestall critical scarcity, so that it is still possible to deliver care that is functionally equivalent then, arguably, the ethical tensions largely disappear. This focus on patient centered care, or clinical ethics considerations, merely echoes the type of ethical decision-making that would be used in the “usual” phase. The specific ethical concerns that Alfandre et al want to highlight are thereby seemingly resolved. Contingency ethics just becomes ethics as usual. However, it is in situations where patient-centered functionally equivalent care either *cannot* be achieved, or what counts as functionally equivalent care is contested (i.e. it is equivalent in one respect but not in another (see our example below)), that the interesting, and arguably distinctive, ethical issues and dilemmas arise.

Our Reset Ethics project (Frith et al. 2021) has explored the tension between clinical and public health ethics through qualitative interviews with healthcare professionals and managers, carried out in large hospital trusts in England during the reset phase. We have found that providing so-called “gold-standard” care—usual care—has often not been possible. Healthcare professionals are providing the best care they can in the circumstances; care that is limited by infection control measures in how it is delivered, what can be offered, and the length of waiting times. Patients receive “‘good enough’ care, what could be termed ‘silver-standard’ care” (Horne, James, and Draper 2021), which ensures that the health system as a whole can function. Thus, in the reset phases, our research suggests that patient-centered care may not be possible, as what is provided for individual patients

has to be balanced with public health priorities. It is the tension between patient-centered and public health imperatives that creates the difficult, and arguably, distinctive ethical issues.

Our work has identified differences between reset and “usual” care. The caring aspects of treatment—an essential component of patient-centered *care*—have been an immediate casualty, due primarily to infection prevention and control measures. We understand care as embracing the interpersonal relationships between the patient (and their family) and the healthcare provider, and as an ethically important dimension to healthcare delivery. Our participants, for example, reported that while treatment delivered wearing personal protective equipment can largely attain “functional equivalence,” providing *care* faces significant barriers. Care from behind a mask or a ventilated hood is experienced differently by both healthcare professionals and their patients, even where treatment meets the patient’s clinical needs. Accordingly, it is clear that balancing public health concerns with the “human” aspects of patient-centered care is a crucial factor for decision-making during the contingency and reset phase, when care is neither “crisis light” nor “business as usual.” It is here that the distinctive ethical tensions arise for healthcare professionals and decision-makers aspiring to “gold standard care” in a “silver standard” context, and where “functional equivalence” is surely ethically lacking if treatment fails to attain the relational, caring, and *human* dimensions of healthcare.

In the reset phase, a commitment to privileging patient-centered care may, therefore, be unworkable and more importantly not ethically desirable. From a practitioner’s perspective asking them to continue to deliver optimal, usual care in a sub-optimal, contingency, context is opening the door to failure and potential moral distress. Alfandre et al point to the ethical importance of considering staff welfare when they discuss how adequate preparedness can mitigate moral distress (2021, 5), and that policies should incorporate the principle of utility, “[d]oing the most good across the population of stakeholders, including patients, health care workers and staff, and families” (8).

BALANCING PRINCIPLES

In light of these tensions between patient-centered care, underpinned by clinical ethics, and public health concerns, underpinned by public health ethics, different ethical principles and balancing strategies are needed when care is neither “crisis light” nor “business as usual.” “Pandemics—and public health emergencies more

generally—reinforce approaches to ethics that emphasize or derive from the interests of communities, rather than those grounded in the claims of the autonomous individual” (Baines et al. 2020). Our rapid review of ethical values guiding decision-making in resetting non-COVID-19 pediatric surgery and maternity services in the NHS (Chiumento et al. 2021) found that the values of relationality and equity came to the fore in the reset period. Relationality was “anchored in the individual and organizational mutual dependencies and responsibilities that have been starkly highlighted by the coronavirus pandemic.” Equity was reflected in calls to balance the needs of those with Covid-19 and those requiring non-Covid-19 healthcare, and measures to mitigate the health inequalities so clearly demonstrated by the pandemic.

Our findings across the rapid review and qualitative study emphasize the shift in ethical values underpinning reset decision-making away from the “usual” patient-centered framing and toward a more distinctive integration of clinical and public health ethics. “We are at a juncture where the challenges brought on by the response to Covid-19 are forcing the reevaluation of traditional clinical ethical approaches. The theoretical basis is shifting to give greater weight to the interests of the community as a whole,” and there is a need for the “inclusion of values such as solidarity and reciprocity in decision-making at both individual and organizational levels” (Baines et al. 2020). Consequently, patient-centered care needs to incorporate wider community concerns and cannot—in isolation—be seen as the overriding value, certainly not during a pandemic, but arguably not during “business as usual” either.

DISCLOSURE STATEMENT

No potential conflict of interest was reported by the author(s).

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The Divided Principle of Justice: Ethical Decision-Making at Surge Capacity

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As Alfandre and colleagues describe in “Between Usual and Crisis Phases of a Public Health Emergency: The Mediating Role of Contingency Measures” (2021), efforts to maintain standards of care during surge capacity events place unique demands on the healthcare system. We propose that an examination of their novel ethical framework for decision-making during the contingency phase of the COVID-19 pandemic reveals a deeper fracture in traditional conceptions of ethical principlism: specifically, that surge capacity unmasks the principle of justice as Janusian and prompts an ethical imperative to reconcile its opposing patient- and system-oriented faces.

The time-honored foundation of modern medical ethics is Beauchamp and Childress’s elegant and parsimonious variant of principlism, which balances four key moral concepts: beneficence, nonmaleficence, autonomy, and justice (Beauchamp and Childress 2001; Gillon 1994). The principle of beneficence guides action toward an expected beneficial outcome consistent with the patient’s values. Nonmaleficence requires the clinician to consider the possibility of potential harm—ranging in severity and proportioned moral import—that may result from action. Autonomy requires respect for patient choice, dependent on capacity on the part of the patient, and imparting the duty to the physician to provide sufficient information and space to the patient

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