ABSTRACT: Critical care professionals in the United States are experiencing distress and frustration during the recent delta-wave of the coronavirus disease 2019 pandemic. This wave feels different because most, although not all, patients suffering with the sequelae from coronavirus disease 2019 who enter ICUs are unvaccinated. Since vaccines in the United States are safe, effective, and widely available for people 12 and older, severe cases of coronavirus disease 2019 are now considered preventable. However, even when a disease is preventable, critical care professionals still have remaining role-based, ethical obligations to their patients. Developing additional mechanisms for reflection and resilience, in spite of accumulated frustrations from otherwise preventable mortality, may help the professional and those they care for. In this essay, we propose a number of questions that recognize the existential frustrations critical care professionals experience, while also uncovering the ethical obligations that remain. Rather than becoming comfortable with silence or frustration, these reflections intend to bridge the gap between feeling frustrated and building relationships that benefit both the patient and the critical care professional during this pandemic.

KEY WORDS: autonomy; critical care medicine; equity; ethics; moral distress; pandemic medicine; professionalism

Many critical care professionals in the United States have become frustrated when treating patients suffering with coronavirus disease 2019 (COVID-19)–related ailments (1). In March of 2020, countless Americans expressed their appreciation for healthcare professionals’ dedication by taking recommended precautions to minimize the spread of the COVID-19. Over a year and a half later, critical care professionals are again living through the myriad challenges of providing ICU care under pandemic conditions. But there is an important difference between now and the waves of new cases experienced in 2020: most adults and adolescents in the United States have had the opportunity to receive vaccinations. Critical care professionals may find their frustration increasing since hospitalizations due to COVID-19–related illnesses are often, although not always, preventable by safe, effective, and accessible vaccines (2, 3).

Critical care professionals may be experiencing frustration given their proximity to the harm the pandemic is causing and their familiarity of their institution’s limited supply of critical care supplies and staffing. For these professionals, this essay aims to help you reflect on these feelings in order to improve communication and promote a beneficial relationship between you and your patients.

REFLECTING ON YOUR FEELINGS

To begin, consider your emotional state. You may feel frustrated by many facets of the pandemic, including your patient’s decision to remain unvaccinated.
You would not be alone, as public officials across the political spectrum have recently expressed similar sentiments (4, 5). You may also feel anger, disappointment, fear for your health, resignation, or detachment. You may experience moral distress—the feeling that you know the right thing to do but you feel powerless to do it (6). Burnout of ICU intensivists and other critical care professionals is undeniable (7). The question, “What emotions am I feeling?” could be an expedient place to start. Taking time to identify your emotions may help you appreciate and normalize them. If you have felt professional frustrations, anger, or dismay in the past, it may be helpful to think back and consider the ways these emotions helped you get through the experience, or, if they were not helpful, how you got through the situation nonetheless. Consider speaking with colleagues, institutional resources, or mental health professionals if these feelings have become overwhelming.

Next, consider what is within your control. Negative emotions may be the result of feelings a loss of control over the situation, such as the flood of new COVID-19 patients, patients’ past decisions, ongoing requests for ineffective interventions, or unruly behaviors. You cannot control the progression of a pandemic. The question, “What about this situation is within my control?” can assist in discovering what you can influence. You can continue to use personal protective equipment and accept vaccination boosters to mitigate self-risk. You can integrate updated medical recommendations into your practice. Also, taking a few minutes for intentional breathing is within your control. Importantly, although the patient or family’s perspective is not within your control, being a conscientious and charitable healthcare professional is.

An additional question to consider is, “What is my goal during further conversations with this patient or their family?” Be honest with yourself. If your goal is to prove yourself right or superior in your reasoning to the patient, then this may not serve to build a beneficial relationship. Neither would scolding nor shaming serve the relationship, although a diatribe might serve as a personal catharsis. If you need space and time to express these feelings, consider discussing your feelings in a safe, off-stage space with colleagues. Your colleagues may also be looking for a safe place to vent their feelings, so sharing your feelings with them, instead of allowing them to orient your relationship with the patient, may serve you, your colleagues, and the patient better. The struggles you are experiencing are real and understandable. Your institution will have failed to protect the integrity of their critical care professionals if they do not have additional resources available for professionals experiencing moral distress and psychological injury due to the pandemic—including resources to address conflict.

**REFLECTING ON ETHICAL AND PROFESSIONAL RESPONSIBILITIES**

Now that you are aware of your emotional state, consider it relative to your professional responsibilities. Established professional and ethical obligations compel critical care professionals to care for unvaccinated patients with the same sacrifice, skill, and compassion they would give vaccinated patients with breakthrough infections. The mere fact a patient’s illness may have been preventable doesn’t dissolve the need for creating a beneficial relationship that places the patient’s interests and well-being above other competing factors. But this ethical standard may be difficult to achieve at the bedside even if one intends to meet it. The following questions can serve to help you reflect on your enduring ethical and professional responsibilities by considering how vaccine refusal affects notions of autonomy and equity.

It may be tempting to assume that your unvaccinated patients are anti-mask activists or hucksters promoting misinformation. But generalizing about the nearly 80 million American adults eligible but unvaccinated may not be a helpful starting point. Many Americans are uninterested or apathetic (8). Others have concluded that the potential side effects of the available vaccines can create economic burdens if they cannot work for several days. Some have undoubtedly had bad experiences when seeking medical care and are now skeptics of any medical recommendations. Others may be reluctant because they are part a group that American medicine has excluded, oppressed, or stigmatized (9). Just as your positive experiences and ability to trust in clinical and research medicine played a role in your decision to become vaccinated, many unvaccinated people have not had positive experiences. None of these reasons negate the public health consensus about the benefits of vaccination, of course, and some may be explanations rather than justifications. But it’s clear that not all unvaccinated patients have the same
motivations. Asking, “Why might this patient be unvaccinated?” might minimize the inclination to make assumptions about “all” patients who enter the ICU unvaccinated.

Patients routinely refuse recommended medical interventions. What makes unvaccinated patients different? Why is accepting the patient’s decision to forego vaccination so difficult? Perhaps it is because many now view COVID-19 as a preventable illness. But critical care professionals routinely encounter patients with preventable illnesses. We wouldn’t consider withholding ventilatory support from a patient with acute on chronic respiratory failure secondary to smoking simply because their disease may have been preventable. Likely, we would accept their request for life-sustaining technologies if they were in favor of them, and we anticipated the intervention would provide more benefit than harm. The same reasoning applies to a patient with COVID-19, despite the possibly preventable nature of their illness. Of course, accepting a patient’s choice is easier when you conclude that their refusal is informed rather than uninformed. But even when a patient’s decision is uninformed, critical care professionals have an obligation to offer interventions that maximize benefit and minimize harm.

A good deal of your frustration may have to do with resource scarcity. Do concerns about justice, fairness, and equity play a role in your frustrations? Equitably distributing resources properly is one of the challenges that COVID-19 surges place upon critical care professionals and others (10). Maybe you have read stories of patients who would have received prompt, ICU-level care if their local ICU were not full. Perhaps you have seen how limits on staff, space, and materials have led to care of a lower quality than you are accustomed to delivering. Additionally, you may feel responsible for making difficult decisions about who receives scarce resources. But consider, with whom are you frustrated? The target of your frustration may be patients, but many institutions and governments have failed in their ethical obligations to plan adequately and implement crisis standards of care (10). You might be practicing at one such institution. Ethically and professionally justifiable allocation and triage measures exist to assist critical care professionals in making difficult decisions. Given the weight and ethical complexity of these decisions, controversy surrounds the proper allocation of scarce resources during times of crisis (11). However, there is agreement that process standards that promote consistency, transparency, and formal modes of prognostication are preferable to individual, ad hoc decisions (12). Luckily, unlike your frustrations with unvaccinated patients, here you may be able to act and directly ameliorate this situation. Consider speaking with your unit, section, and hospital leaders about implementing crisis standards of care so that you feel you can meet your professional obligations to promote equity. Your front-line, critical care experience may provide an important perspective in these issues.

**REFLECTING ON BENEFICIAL RELATIONSHIPS**

Whatever the results of these reflections, you will still have the task of building beneficial relationships with patients and their families. The following reflections could help you build these relationships, despite feeling frustrated. A curious, nonjudgmental, and charitable attitude can promote a beneficial relationship and also represents a virtuous action. Cultivating this attitude can be difficult in times of stress and distress. But given the complex elements that factor into every medical decision, erring on the side of tolerance and empathy demonstrates charity even when you are frustrated. Therefore, building on your previous reflections and asking “What is a charitable interpretation of the patient’s decisions or actions?” may help promote a disposition upon which to build the relationship.

The patient may not have a healthcare professional they trust. They may reject scientific consensus, lack health literacy, or believe the field lacks necessary research on safety. Your patient’s decision to trust in resources other than official guidance is not unique (13). Asking the patient or their family about in whom they place their trust can help you avoid making assumptions about their resources or their reasoning. Unless clarified, these assumptions may lead to entrenched misunderstanding. Perhaps you might consider aiming to become an additional source of information the patient can trust. Becoming a trusted resource appears more feasible than dislodging entrenched sources.

Finally, returning to self-reflection again, attention to the question, “How can I build a beneficial, trusting relationship?” might help alleviate your frustration by focusing on the tangible tasks required when caring for unvaccinated patients. Introducing yourself, inquiring,
and showing your respectful investment in their care may help you become a trusted resource for the patient or their family. Without trust, the patient will have scant reason to accept your future recommendations. If you are directly responsible for the patient’s care, then having an equal voice amongst other voices would be a considerable accomplishment when co-creating the relationship. Members of the healthcare team who are not directly responsible for the patient’s care (e.g., bioethics consultants, social workers, and chaplains) can become additional resources as well. If they see that you are invested in their health, they may become more open to recommendations, and you may find your frustrations decreasing since you are now caring for a “person” rather than “the unvaccinated COVID-ARDS in bed 13.”

LOOKING FORWARD

These questions should not replace support from trusted colleagues or mental health professionals. Although self-reflection will not completely resolve the lingering challenges associated with caring for those with COVID-19, a thoughtful evaluation and discernment of your cognitive, behavioral, and emotional processes can facilitate awareness of your motivations, perceptions, and actions. This kind of awareness may improve your capacity for developing and sustaining beneficial relationships with your patients.

1. Center for Medical Ethics and Health Policy, Baylor College of Medicine, Houston TX.
2. Houston Methodist Hospital, Houston, TX.

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For information regarding this article, E-mail: bibler@bcm.edu

REFERENCES

1. Gore L: Alabama Doctor Says He Won’t Treat Unvaccinated People: ‘COVID Is a Miserable Way to Die.’ 2021. Available at: https://www.al.com/news/2021/08/alabama-doctor-says-he-wont-treat-unvaccinated-people-covid-is-miserable-way-to-die.html. Accessed August 17, 2021
2. Bahl A, Johnson S, Maine G, et al: Vaccination reduces need for emergency care in breakthrough COVID-19 infections: A multicenter cohort study. Lancet Reg Health Am 2021 Sep 9. [online ahead of print]
3. Klein NP, Lewis N, Goddard K, et al: Surveillance for adverse events after COVID-19 mRNA vaccination. JAMA 2021; 326:1390–1399
4. Rogers K, Stolberg SG: Biden Mandates Vaccines for Workers, Saying, ‘Our Patience Is Wearing Thin.’ 2021. Available at: https://www.nytimes.com/2021/09/09/us/politics/biden-mandates-vaccines.html. Accessed September 9, 2021
5. Stracqualursi V: Alabama Republican Gov. Ivey Says ‘Start Blaming the Unvaccinated Folks’ for Rise in Covid Cases. 2021. Available at: https://www.cnn.com/2021/07/23/politics/alabama-governor-kay-ivey-unvaccinated-covid/index.html. Accessed July 23, 2021
6. Rushton CH: Moral resilience: A capacity for navigating moral distress in critical care. AACN Adv Crit Care 2016; 27:111–119
7. Azoulay E, De Waele J, Ferrer R, et al; European Society of Intensive Care Medicine: Symptoms of burnout in intensive care unit specialists facing the COVID-19 outbreak. Ann Intensive Care 2020; 10:110
8. Wood S, Schulman K: When vaccine apathy, not hesitancy, drives vaccine disinterest. JAMA 2021; 325:2435–2436
9. Khubchandani J, Macias Y: COVID-19 vaccination hesitancy in Hispanics and African-Americans: A review and recommendations for practice. Brain Behav Immun Health 2021; 15:100277
10. Emanuel EJ, Persad G, Upshur R, et al: Fair allocation of scarce medical resources in the rime of Covid-19. N Eng J Medicine 2020; 382:2049–2055
11. Bosman J, Hoffman J, Sanger-Katz M, et al: Who Are the Unvaccinated in America? There’s No One Answer. 2021. Available at: https://www.nytimes.com/2021/07/31/us/virus-unvaccinated-americans.html. Accessed August 4, 2021