Care Delivery and Treatment Decision Making

Bioethical and nursing considerations during and after the COVID-19 pandemic

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BACKGROUND: The disruption in the supply chain of resources and interruptions in cancer treatments caused by the pandemic presented tremendous challenges to the healthcare system.

OBJECTIVES: This article describes the National Academy of Medicine–defined states of medical and nursing care delivery for which local plans should be drawn and the shifting and evolving systems framework that can guide decisions to optimize the crisis standards of care.

METHODS: A case study is presented to describe the process of shifting the state of medical and nursing care delivery and bioethical nursing considerations during the pandemic and beyond.

FINDINGS: An evolving and shifting systems framework for crises rooted in deontology, principlism, and the ethics of care model provide meaningful guidance for establishing priorities for patient care.

KEYWORDS
COVID-19; coronavirus; pandemic; care delivery; treatment decision making

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THE FOLLOWING CASE IS A DEPICTION OF A HYPOTHETICAL SEQUENCE of scenarios that have been developed by the authors based on anecdotal stories shared by oncology nurses and nurse practitioners who were at the front line, simultaneously treating the deadly coronavirus and the various cancers that also threaten the lives of their patients. The scenarios were thoughtfully framed and critically examined to depict a real-life case situation if a crisis like the COVID-19 pandemic continued to soar unabated, reaching the contingency level of a crisis.

C.J. is a 75-year-old Latino man who presented to a suburban emergency department (ED) in the northwestern region of Illinois about 30 miles from Chicago for acute, severe lumbar-sacral pain. The computerized tomographic imaging studies revealed multilevel compression fractures at L3 and S1 with innumerable lytic lesions in the thoracic and lumbosacral vertebrae. His laboratory blood tests showed mild anemia with hemoglobin at 11 mg/dl and mild renal insufficiency with serum creatinine of 1.4 g/dl. While at the ED, his nephrology workup showed monoclonal IgG kappa protein in the immunofixation tests with a corresponding monoclonal spike (M spike) of 4.7 g/dl in the serum protein electrophoresis. The 24-hour urine protein electrophoresis showed 2,100 mg per 24 hours of monoclonal lambda light chain or Bence–Jones proteinuria. C.J. was sent home after the completion of a nephrology consultation and workup, and he was referred to a local hematologist in one week to complete a diagnostic workup for possible diagnosis of multiple myeloma (MM).

A local hematologist evaluated him, and additional tests were performed. They showed a 104 mg/L (0.26–1.65 normal reference range) kappa-lambda free light chains ratio with a normal glomerular filtration rate of 72 (Schmidt-Hieltjes et al., 2016). His unilateral bone marrow biopsy showed 60% kappa-restricted plasma cells consistent with the diagnosis of MM. Genomic expression analysis of bone marrow–derived MM cells showed high-risk MM disease features such as 1q deletion, 17p deletions, chromosome 13 deletion,