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Tragic Choices in Humanitarian Health Work

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ABSTRACT

Humanitarian healthcare work presents a range of ethical challenges for expatriate healthcare professionals, including tragic choices requiring the selection of a least-worst option. In this paper we examine a particular set of tragic choices related to the prioritization of care and allocation of scarce resources between individuals in situations of widespread and urgent health needs. Drawing on qualitative interviews with clinicians, we examine the nature of these choices. We offer recommendations to clinical teams and aid organizations for preparing and supporting frontline clinicians in their efforts to determine the least-worst option, and in their responsibility for making such choices.

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Many health professionals travel to other countries to participate in humanitarian aid work in contexts of armed conflict or extreme poverty, or in the aftermath of disaster. The provision of care, as well as many other facets of living and working in low resource and sometimes insecure settings, is associated with a range of logistical, clinical, and personal challenges. Clinicians are also confronted by ethical questions and dilemmas, and their training and experience in "ordinary" practice contexts may provide limited reference points for assessing and resolving them—particularly if their home countries are resource-rich and relatively stable politically. A clinician from Canada characterized the settings where international humanitarian aid is delivered, and the scope of available resources to meet local needs, as situations in which "People need a lake and you

are offering a glass of water"[1]: a profoundly "second-best world"[2] where local and international actors seek to address priority concerns but where the collective response is frequently insufficient to meet many pressing and competing needs.

A prominent set of ethical issues that arises in such circumstances, and that must be responded to by clinicians, encompasses decisions to prioritize care and allocate resources between individuals.[3] In this article we draw on qualitative interviews conducted with clinicians who have participated in humanitarian aid projects to illuminate the nature of these decisions and how they are frequently experienced by clinicians as inescapable tragic choices.[4] Such decisions represent an important source of ethical uncertainty in humanitarian work for which clinicians often feel ill prepared. We offer recommendations for how clinical teams and aid organizations can help prepare and support those responsible for making such choices.

INESCAPABLE TRAGIC CHOICES

Alex de Waal has described the humanitarian's tragedy as the reality that well-intentioned efforts to provide assistance to communities in need are associated with escapable and inescapable cruelties.[5] He sees the "escapable" as the negative consequences that arise from technical failings and miscalculations of humanitarian actors. Such lapses and their impacts can and should be reduced by improving operational planning and implementation, and enlarging the evidence base of humanitarian aid. De Waal describes another set of situations as "inescapable cruelties," when assistance must be prioritized between individuals who all have significant and pressing needs. He pictures surgical triage as the most representative case, where patients are sorted by a prioritization scheme and surgical interventions are allocated in consequence. Such allocation choices are not limited to surgery. Humanitarian healthcare practice involves decisions on allocating medications, blood, and other finite resources, as well as staffing and beds. Some patients who, in other settings—including the home countries many of the expatriate workers come from—would in due course receive a particular resource,[6] would not have access to it due to the scarcity of resources in humanitarian settings and the elevated health needs of the population. Decisions to allocate limited resources between individuals may thus be unavoidable for local teams. Micro-level allocation choices are, however, unfamiliar to many clinicians who are new to humanitarian health work, nor are all such situations resolved more easily with experience.

In considering the nature of decisions to allocate limited resources in humanitarian healthcare, it is important to underline that the need to make such decisions is related to how the world is organized—the (un)availability of resources is shaped by a range of external features and decisions. So while teams struggle with limited resources and make seemingly inescapable choices, at a broad level situations of scarcity are not "natural."[7] For example, if the international community has been slow to respond to the signs of a developing famine, the opportunity to address the crisis early on will be missed, leaving aid teams that respond at the height of the famine with inescapable choices of whom to prioritize. It is in such contexts that de Waal describes how "the impulse to ameliorate suffering leads humanitarian workers and institutions into the unwelcome situation of acting cruelly," resulting in dissonance between their goals and effects.[8]

Clinicians who are involved in humanitarian work strive to provide assistance and alleviate suffering. They do not wish to be associated with cruelties. Those who are not selected or prioritized in a local project might well experience the prioritization schemes, narrow project mandates, or cutoff points established by humanitarian practitioners, including clinicians, as callous. Some expatriate clinicians who are expected to make these judgments also describe feeling that some of the decisions that they must make are indeed cruelties.[9]

De Waal identifies these clinical and operational choices as tragic, as well as inescapable.[10] Such decisions are tragic in the ancient Greek

sense that acknowledges that aspects of human suffering and catastrophe may be insoluble.[11] In such settings, the ideals held by humanitarians and health professionals collide with the harsh reality of crisis or catastrophe. Often clinical practice in such settings does not permit the simple resolution of ethical issues through application of idealized moral principles and values because the contexts themselves are inherently unjust.[12] Technical expertise and the material and human resources of humanitarians are often dwarfed by the scale and magnitude of a major disaster or protracted civil conflict. Contextual demands such as security needs, cultural differences, historical antecedents, and political instability may be additional sources of challenge. Healthcare needs also intersect with other needs of the population. This reality is highlighted in an interview with one of the Canadian physicians providing care in a post-conflict setting. She asserted that access to medications was not the only relevant concern, saying that patients need "access to clean drinking water to wash down [their] antiretrovirals."[13] Providing quality care to all in need is obstructed in such contexts.

Tragic choices are ones in which all options are morally problematic in some way and that, whatever choice is enacted, something of moral significance will have been lost.[14] There are multiple ways in which tragic choices are manifest in humanitarian healthcare practice, such as situations when providing needed care to a patient exposes others to security risks. A prominent set of tragic choices includes situations when clinicians must decide who amongst their patients will receive priority assistance when all need urgent help, or more poignantly still, to select some to receive a particular treatment or resource that is in short supply while others who also are in need will not receive it at all. For their part, clinicians may be seriously distressed by having to make these choices, when their professional ideal of providing quality care for all patients conflicts with making best use of a shallow pool of resources—and when "best use" is by no means clearly defined. They may experience regret or angst. Others burn out or do not continue with humanitarian work. Obviously, the consequences are much graver for those who cannot access the help or care they need. The heaviest costs associated with allocation decisions are borne by those who are not prioritized for, or do not receive any, assistance.

NARRATIVES OF ALLOCATING RESOURCES, PATIENT SELECTION, AND TRAGIC CHOICES

We have conducted three qualitative studies with Canadian health professionals with experience in international aid work, including the provision of care in settings of acute disaster or armed conflict and post-disaster or post-conflict reconstruction.[15] In total, we interviewed 45 doctors, nurses, and allied health professionals. Across the narratives of these clinicians there were many stories of tragic choices involving micro-level resource allocation and dilemmas of "patient selection."[16] Dilemmas of patient selection include situations when clinicians consider not providing care to a patient or group of patients because of the scarcity of resources, as well as scenarios in which organizational policies, public health rationales, or project mandates direct that clinicians not treat some individuals who are ill or injured.[17] For example, some participants were involved in programs that focused on a single disease, and in which treatment was reserved for those individuals whose diagnosis matched the externally defined priorities of the project. Some of these clinicians struggled with implementing these policies or considered providing care to patients whose conditions fell outside the clinical focus of the project.

In other settings, only individuals whose injuries were the direct result of a disaster were eligible for treatment, and clinicians sometimes sought to provide care to individuals with health needs not related to the disaster event. A range of situations also arose when clinicians needed to select which patients would receive particular forms of assistance and to allocate resources between patients, also sometimes weighing the needs of current patients against future patients. In the latter type of cases, clini-

cians typically reflected like so: If we use this resource now it won't be available for a patient who arrives one hour from now, and who may need it more or have a better chance of survival if the assistance is given. Should we preserve the resource?

Clinicians related these stories as ethical challenges—and in describing their choices, they explicitly or implicitly invoked a range of factors, including likelihood to survive, maximization of benefits across communities, degree of need or vulnerability, personal relationship with the patient or family, their own identity and commitment as a health professional, their acceptance (or not) of agency mandates to deny or limit treatment in certain circumstances, or prioritization based on patients' age, as rationales for their decisions. This list demonstrates the diversity of features included in decisions that are related to access to resources. Widely accepted distributive criteria including clinical considerations such as likelihood to survive, as well as population health considerations such as optimizing benefits across a community, were prominent. Other features were also raised in discussions around resource allocation, including prioritization of children over adults. In some instances, clinicians also acknowledged that a feeling of compassion for a patient or family influenced a decision to provide a resource outside of agency policy or standard procedures. In other cases, social considerations influenced decision making. For example, a nurse reported arguing with her colleagues that they should provide care to a child because the child was the last survivor amongst her siblings.

Overall, two broad sets of representations were offered around decisions to provide treatment—or not—to a particular patient.[18] On the one hand, those telling the story emphasized medication, beds, equipment, even staff, as limited resources to be stewarded for the good of the many—a justification for why not treating was right. On the other hand, patient care interventions were represented as something owed by health professionals to people who are ill or suffering—an explanation for why not treating a patient was wrong.

In the interviews with health professionals, what is striking are the stories in which both types of representations were presented as pulling in opposite directions, never fully resolved. A narrative might be offered in which resources are withheld from one patient so as to be provided to others, and that this decision was both right and wrong. A nurse described struggling with the consequences of deciding whether to transfer a child who had a severe neurological injury to the regional hospital or to send the child home without treatment, thus preserving her limited budget to be able to care for other patients: "There are a lot of kids with pneumonia that need resources and if you give them the resources they will get better. So I decided not to transfer the kid and he went home. I will always remember that kid. I think I made a right decision. I let him down. I may not have let these other kids down in the sense that those resources were available for others, but I let him down."[19]

In this quotation we hear the nurse saying both that she did wrong (by letting this particular child down, by not transferring him to where he could receive needed treatment) and she did right (by acting so as to ensure that many more children would receive treatment). In contrast, other stories were narrated where resources were provided, even though the participant felt that withholding the resource would have been more ethically defensible: "Even though the ethical choice may have been not to take her and keep the space for somebody else I still feel it was the right thing to do [to admit the patient]."[20] In this particular narrative, the rationale offered for the rightness of the decision to admit the patient was not one of efficient use of resources, but of the importance of offering some form of tangible assistance, even if it was likely to be ineffective, to a family who had suffered greatly.[21] Even in those cases when one option seems clearly preferable, a clinician may still experience distress or regret "over the frustration of other significant concerns."[22] To put it another way, even when a decision may have appeared justified, it did not always feel just.

With more details about individual cases, one might form an opinion about the decision

that was made and the judgments behind it; one could agree or disagree with the evaluation that the clinicians offer about the wrongness or rightness of an action. For the purpose of this article, what we wish to emphasize is that, in evaluating some allocation decisions, clinicians report value conflicts that cannot be tidily resolved and are sources of moral uncertainty. The presence of such tensions underscores the tragic nature of the situation in which the decision is made, indeed the tragic nature of the limited options available. During the interviews, some clinicians related such decisions as impacting on their identity as health professionals when their ideals and core professional and moral commitments were challenged by the choices they faced.

PREPARING AND SUPPORTING HEALTH PROFESSIONALS FOR TRAGIC CHOICES IN HUMANITARIAN WORK

Clinicians engaged in humanitarian work and facing dilemmas of patient selection or needing to prioritize limited resources between individuals will struggle, almost inevitably, and this struggle is exacerbated when there is a lack of guidance or support. De Waal notes that this topic is not "one that humanitarian workers are trained to anticipate and cope with."[23] In practice, teams are faced with and make such decisions about how resources will be allocated. For example, participants in our studies related stories about project teams who developed their own processes for making allocation decisions, including a team who established criteria for allocating their dwindling supply of transfusable blood, and another team who faced recurrent choices of which patients would receive oxygen from their only oxygen machine, which was run by a single generator that could not function continuously. Decisions of this type were often grim, and sometimes the source of conflict within a team.

There is an emerging literature related to ethical issues in humanitarian work and disaster response, including discussions of resource allocation and supports for humanitarian workers.[24] We wish to conclude by drawing links between the reflections offered so far and approaches to address tragic choices in health-related humanitarian work. Some scenarios of resource allocation and prioritization are amenable to organizational policies, and clear guidance may diminish the weight of particular choices. For example, an organization might develop a guideline for how limited blood supplies will be allocated. Triage protocols adapted for disaster and mass casualty events could also provide guidance, such as the framework proposed by McCullough, which considers emergency situations when resource shortages preclude treatment for all who are injured.[25] However, it is also clear that standards and policies can't be generated for all scenarios, and that more general guidance will be difficult to apply in many particular settings. Inevitably, there is much that cannot be captured by formal guidelines due to the diversity of circumstances and important uncertainties involved in humanitarian work. Not only can policies not capture all eventualities; some moral problems may be better addressed by creating opportunities to support the ethical judgment of those involved rather than creating additional policies. Even the best allocation policy cannot expunge all feelings of uncertainty or angst, and so preparing and supporting clinicians for tragic choices is crucial.

Providing tools that will assist clinicians to reason well, and to develop ethically defensible responses in very difficult circumstances, will be a valuable support. Other supports are also necessary. Strong team relationships are important sources of practical and psychological support.[26] One strategy to support clinicians faced with tragic choices and unfamiliar allocation decisions is to create opportunities to share the weight of triage and micro-level allocation decisions, particularly in acute crisis situations. Under this approach, challenging allocation choices would be made by several team members working in partnership, rather than by individuals in isolation.[27] Teams can also establish opportunities and mechanisms for deliberating over challenging cases, such as at regular team meetings, and for debriefing difficult and recurrent issues. It is also important that clini-

cians and teams who are responsible for implementing policies and guidelines have opportunities to convey to policy makers how the policies are working, what impact they are having, and what may need to be changed—bridging the gap between headquarters and field operations (that some clinicians experience as problematically wide) and contributing to refining policy.

Pre-departure training is an important venue in which ethical dimensions of humanitarian work can be addressed. Such training presents an important opportunity to discuss the moral implications of situations of great need, where some who are needy will not receive care, communicating the types of ethical challenges and seemingly inescapable and tragic choices involved. To promote engagement with these topics, the reality of resource allocation and the nature of tragic choices should be explored, guidelines and tools presented, and discussion promoted.

One method that we have employed for creating opportunities for reflection and discussion of ethical challenges in humanitarian work is reading longer excerpts from our research transcripts—narratives selected for the way that they bring to the fore the complexity of ethical issues in humanitarian work—followed by a facilitated discussion.[28] This approach allows for a different type of discussion than a traditional case study—focusing attention not only on problem-solving, but also on the experience of struggle: struggle with the situation, with figuring out what to do, and with the tragic choices. Such an approach can help, but only partly so, to address a key limitation of ethics preparation activities: the gulf between one's ability to imagine the implications of making a tragic choice in the controlled environment of a pre-departure training activity, where case studies may be assessed in a relatively dispassionate manner, and the reality of such choices in practice.

Tragic choices are often inescapable for clinicians who take part in humanitarian work. The need to allocate limited resources between individuals who all have elevated health needs is a prominent form of such choices, and frequently a source of moral uncertainty for those responsible for making them. Providing preparation, clear guidelines and policies, mechanisms for mutual support during field projects, and debriefing opportunities will help support clinicians for these realities and assist them to make well considered and ethically defensible decisions.

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NOTES

1. M. R. Hunt, "Ethics beyond borders: How health professionals experience ethics in humanitarian assistance and development work," *Developing World Bioethics* 8, no. 2 (2008): 59-69, 64.

2. F. Terry, *Condemned to repeat? The paradox of humanitarian action* (Ithaca, N.Y.: Cornell University Press, 2002), 216.

3. L. Schwartz et al., "Ethics in humanitarian aid work: learning from the narratives of humanitarian health workers," *American Journal of Bioethics—Primary Research* 1, no. 3 (2010): 45-54.

4. We focus here on the micro-level of resource allocation decisions made within local teams. For discussion of resource allocation at the organizational level, see S.A. Hurst, N. Mezger, and A. Mauron, "Allocating Resources in Humanitarian Medicine," *Public Health Ethics* 2, no. 1 (March 2009): 89-99; J. Rubenstein, "Humanitarian NGOs' Duties of Justice," *Journal of Social Philosophy* 40, no. 4 (Winter 2009): 524-41; T. Pogge, "Moral Priorities for International Human Rights NGOs," in *Eth-*

ics in Action: the ethical challenges of international human rights nongovernmental organizations, ed. D. Bell and J.-M. Coicaud (Cambridge, U.K.: Cambridge University Press, 2007), 218.

5. A. de Waal, "The humanitarians' tragedy: Escapable and inescapable cruelties," *Disasters* 34, Supp. 2 (April 2010): S130-37.

6. Such as blood transfusion, the administration of oxygen, or admission to a hospital.

7. See T. Schrecker, "Denaturalizing scarcity: A strategy of enquiry for public-health ethics," *Bulletin of the Wo*rld Health Organization 86, no. 8 (August 2008): 600-5.

8. de Waal, "The humanitarian's tragedy," see note 5 above, p. S130.

9. Schwartz et al, "Ethics in humanitarian aid work," see note 3 above.

10. de Waal, "The humanitarian's tragedy," see note 5 above.

11. M.C. Nussbaum, *The Fragility of Goodness: Luck and Ethics in Greek Tragedy and Philosophy* (New York, N.Y.: Cambridge University Press, 2001).

12. L. Tessman, "Idealizing Morality," *Hypatia* 25, no. 4 (2010): 797-824.

13. M.R. Hunt, "Moral experience of Canadian health care professionals in humanitarian work," *Prehospital and Disaster Medicine* 24, no. 6 (2009): 518-24, 521.

14. R. Hursthouse, *On Virtue Ethics* (New York, N.Y.: Oxford University Press, 1999).

15. Hunt, "Ethics beyond borders," see note 1 above; Schwartz et al, "Ethics in humanitarian aid work," see note 3 above; Hunt, "Moral experience of Canadian health care professionals in humanitarian work," see note 13 above.

These studies were based on semi-structured, in-depth interviews with Canadian health professionals who had worked with international non-governmental organizations in a range of low-resource settings in the global south in situations of disaster, armed conflict, or extreme poverty.

16. The term "patient selection" is drawn from R.C. Fox and E. Goemaere, "They call it 'patient selection' in Khayelitsha: The experience of Medecins Sans Frontieres-South Africa in enrolling patients to receive antiretroviral treatment for HIV/AIDS," *Cambridge Quarterly of Healthcare Ethics* 15, no. 3 (2006): 302-12.

17. Hunt, "Ethics beyond borders," see note 1 above; C. Sinding et al., " 'Playing God because you have to': Canadian health professionals' experiences of rationing care in humanitarian and development work," *Public Health Ethics* 3, no. 2 (2010): 147-56.

18. Ibid.

19. Hunt, "Ethics beyond borders," see note 1 above, p. 64.

20. Ibid.

21. The ethical evaluation of providing treatment, knowing that it will be ineffective, but with the goal of providing some measure of comfort to a suffering family, would need to be conducted in relation to what might be lost by this strategy, such as lack of resources to treat other individuals who stood a better chance to benefit. However, the assessment of such situations will also differ from other rationales to provide ineffective care such as doing so for more instrumental goals including political objectives.

22. Nussbaum, *The Fragility of Goodness*, see note 11 above, p. 27.

23. de Waal, "The humanitarian's tragedy," see note 5 above, p. S132.

24. See for example, J. Sheather and T. Shah, "Ethical dilemmas in medical humanitarian practice: cases for reflection from Médecins Sans Frontières," *Journal of Medical Ethics* 37 (2011): 162-5; N. Ford, R. Zachariah, E. Mills, and R. Upshur, "Defining the limits of humanitarian action: Where, and how, to draw the line?" *Public Health Ethics 3,* no. 1 (2010): 68-71; O. Merin et al., "The Israeli Field Hospital in Haiti—Ethical Dilemmas in Early Disaster Response," *New England Journal of Medicine* 362 (March 2010): e38.

25. L.B. McCullough, "Taking seriously the "What then?" question: An ethical framework for the responsible management of medical disasters," *The Journal of Clinical Ethics* 21, no. 4 (Winter 2010): 321-7.

26. D. Hilhorst and N. Schmiemann, "Humanitarian principles and organisational culture: Everyday practice in Médecins Sans Frontières Holland," *Development in Practice* 12, no. 3-4 (2002): 490-500.

27. O. Merin et al., "The Israeli Field Hospital in Haiti, see note 24 above, p. e38. However, such an approach may be more time consuming and could lead to delays in the provision of care if decisions are contentious.

28. C. Sinding, L. Schwartz, and M. Hunt, "Staging ethics: The possibilities and perils of research-based performance," *Canadian Theatre Review* 146 (2011): 32-37.