Ethical Considerations

An Ethical Framework for the Allocation of Resources in the Event of Shortages

The American College of Surgeons (ACS) Ethics Committee has developed an ethical framework regarding disbursal of critical patient care resources to individuals who need them most during the COVID-19 pandemic. Decisions must be made in accordance with the principles of medical ethics and with the primary goal of saving as many lives as possible, with the secondary goal of saving the most life years possible. Health care leaders need to use objective measures provided by validated mortality prediction tools to aid in decision making and ensure that patients who require scarce resources resulting from other illnesses still have access to them. To manage triage in a clear and consistent manner, the ACS suggests that all hospitals and health care systems develop clinical triage teams that can be activated for imminent or existing scarcity situations.

During this current crisis, we are currently facing, or may soon encounter ethical dilemmas regarding the allocation of scarce resources among the most critically ill patients in our own facilities. In the event that the availability of ventilators and other resources become critically short, we will be faced with making decisions about starting patients on mechanical ventilation or continuing life support on patients already receiving such treatments. We must make these decisions in accordance with the principles of medical ethics and with the primary goal of saving as many lives as possible. Our secondary goal is to save the most life-years possible, if further triage decisions are called for.

Allocation of resources do not refer exclusively to ventilators, but also to intensive/ respiratory care unit beds, IV pumps and the human resource represented by respiratory assistants/ nurses, physiotherapists, physician, specialists and all other individuals requested in the chain of the specific health care provided. This allocation is inherently dynamic, the situation may change not only day to day, but hour to hour. When we consider extreme resource scarcity, we should not only attempt to pool institutional pediatric and adult critical care resources, but also consider centralizing care and resources in our communities across independent health care institutions. In this way, we can ensure a concerted effort to achieve our core goals.

We must utilize objective measures, provided by validated mortality prediction tools such as APACHE II, SAPS II, SOFA and PELOD to inform our decision making for individual patients. Although there are no ideal tools, objective data are ethically preferable to arbitrary decisions made at the bedside. Generally, SOFA or PELOD for adults or children respectively have been used as predictors of mortality in triage situations. Further, this strategy has been adopted by many states for the allocation of critical care resources and triage as proposed by the Society of Critical Care Medicine. In order to manage triage in a clear and consistent manner, we suggest that a Clinical Triage Team be developed in all hospitals and health care systems. The Triage Team would be activated in times of imminent or actual resource scarcity, and report to the hospital or health system incident command center.

We must consider that the availability of ventilators affects patient populations other than those who are critically ill due to COVID-19. During this time, we will continue to care for patients who are critically ill for other reasons. Patients who require ventilation due to illnesses other than COVID-19 still deserve access to scare resources. There should be no special priority for COVID-19 critically ill patients over those with a similar expected outcome based on objective measurements. Fairness and transparency are mandatory. Furthermore, patients who are

already dependent on home ventilators or respiratory support should not have their home equipment removed or reallocated to other patients, regardless of the scarcity of resources. Home ventilators are not community property. We must take extra care to avoid triage practices that would discriminate against patients with disabilities, based on personal judgments of an individual's functional limitations. The decision to withhold or withdraw critical care should be based solely on the potential for survival, and the potential for life-years saved when decisions between 2 patients with equal chance of survival must be made. We must also be mindful that the COVID-19 pandemic will expose and exacerbate health disparities within our health care system. The Clinical Triage Team should be tasked with real time evaluation of triage decisions to mitigate unduly biased decision making against particular groups or patient populations.

We should maintain adherence to the following principles:

Beneficence: in this acute setting of pandemic, the concern for beneficence of all the members of a society outweighs the concerns for any individual, best represented by the dictum "do the most good for the most people"

Justice: The application of this principle is reflected in the fact that the triage guidelines should be clear, concise, and explicit.

Fidelity: Trust is generated by consistent use of triage practices for every patient who needs the scarce resource.

Veracity: "Telling the truth" and the known facts help in the decision making.

Respect for persons: Within constraints of allotted resources, patients should be provided opportunities to express their will.

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