Santa Clara County Medical Association Bioethics Committee

Ethical Principles to be Considered in Establishing Policies for Allocation of Scarce Medical Resources in a Public Health Emergency [In Response to the Covid-19 Pandemic]

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The SCCMA Bioethics Committee has developed advisory guidelines for its member-hospitals developing their own policies on allocating scarce resources in a pandemic public health emergency. While, of course, the Committee hopes that there will be no need for such policies, it is imperative to prepare for the possibility of emergency-caused scarcity. Such allocation policies would be implemented only in a governmentally-declared state of emergency, and only when there are not enough scarce resources to meet the needs of all patients.

We encourage those developing allocation policies to aim for fairness broadly understood. Fair policies require inclusive development, transparency, and consistent application. Fair policies acknowledge the range of ethical values at stake, and tragic tradeoffs between them that can arise in conditions of scarcity.

The Committee understands that allocation policy must be established and approved at the hospital level. We recognize that member hospitals have varying patient populations and inventories of resources, and may be bound by policies established by the hospital systems to which they belong. We are aware that the actual management and distribution of resources may lie in the hands of hospital administrations.

At the same time, we feel that, ideally, it would be helpful to have uniform allocation policies developed at a regional (county or state) level. This would reduce concerns about variations in allocation at individual hospitals which might to lead to real or perceived inequities in the distribution of scarce resources. It could also lead to innovative efforts at emergency resource-sharing to meet regional needs as best as possible in a pandemic crisis.

Although currently there are no authoritative guidelines on allocation from the federal, state, or county governments, we have considered many sources in developing our guidelines, including frameworks and model policies proposed by various healthcare institutions and governmental entities (see references). We recognize that broad community input should inform allocation policies for resources that can be a matter of life and death. Given the time-urgency of the need for guideline-development, we aimed to be as inclusive of different perspectives as possible by considering results of previous public engagement processes on fair resource-allocation in pandemic emergencies (New York State taskforce; Johns Hopkins community simulation).

We believe the ethical principles that we outlay in these guidelines should be considered by all member institutions. Our goal is to (a) provide an ethical framework that could be utilized in the establishment of the policies, and (b) articulate some prioritization and balancing of ethical goals that we believe reflect wide consensus, without attempting to advocate a more detailed allocation policy.

In conditions of tragic scarcity, dearly-held ethical values may conflict with each other. Our advisory guidelines integrate a descriptive articulation of important ethical principles with an argument for an initial orienting consensus on tragic tradeoffs. They also elaborate the basic structure of procedures necessary to implement hospitals' final allocation policies fairly, recognizing that hospitals could embody those structures in diverse administrative approaches.

For clarity, we have sought to distinguish (a) our presentation of principles from (b) our argument for a proposed consensus on some basic tradeoffs **by italicizing the latter**, though we discuss both together in each section.

In summary, we consider the following ethical principles important to consider:

- Procedural justice;
- Distributive justice;
- Duty to care;
- Respect for persons, including but not limited to respect for patient autonomy;
- Non-maleficence;
- Beneficence;
- Solidarity;
- Social worth (we ***reject*** as a principle);
- Social function.

We argue that:

- In pandemic conditions, saving the most lives possible should be the priority goal of triage and allocation.
- Non-medical factors should **NOT** be considered in assessing which patients are suitable candidates to receive scarce resources. In other words, there should be ***no exclusion criteria*** other than those based on objective clinical measures. Assessment of degree of medical need, and of likelihood to survive with the scarce treatment, should define the candidate pool.
- ***When there are not enough resources for needy candidates with similar need and probability of survival,*** three potential "tie-breaking" strategies, representing different weightings of relevant ethical values, can be considered by those developing final institutional allocation policies. There are ethical arguments for and against each of these. We expect that determining what factors will be used as "tie-breakers" will be one of the most challenging decisions faced by those finalizing specific institutional allocation policies.

    1. Favor those whose social functions are essential to pandemic response, such as (but not limited to) front-line medical responders, to demonstrate reciprocal care for them and to enable their return to pandemic response.
    2. Favor younger patients (the so-called "life cycle approach"), to try to save more life-years when more lives cannot be saved. This approach places ethical weight on the goal of enabling as many people as possible to live a full human lifespan.

3. Use a lottery, to testify to the belief that all human lives are equally valuable.

Procedural Justice

In order to ensure fairness and public trust, there must be a transparent and inclusive process, including community input, to develop explicit policies for allocating scarce resources. Administrative mechanisms must be developed to implement their application consistently.

Distributive Justice

In pandemic circumstances, giving to each patient according to need may not be possible. How one conceives of the ethical good to be distributed through emergency allocation will influence interpretations of distributive justice.

We believe distributive justice generally requires prioritizing saving those most likely to survive in order to save as many lives as possible, and enabling continued functioning of society. In other words, the goods we seek to distribute fairly are lives saved and social stability. Those two goods are usually, but not always, mutually supportive of each other.

Duty to provide care

Physicians and other health-care workers have an obligation to provide care despite significant risks to their own well-being.

This duty is a duty of the profession as a whole. It is morally defensible for healthcare institutions to consider the interests of particular staff who may have atypical or extraordinary vulnerabilities when making overall staffing assignments.

The society as a whole has a duty to support the healthcare profession as it takes risks for the benefit of patients and community. This includes the development of surge-planning logistics that necessarily reach beyond the level of any one institution. It also includes the provision of adequate personal protective gear to medical providers working with exposed patients.

Respect for Persons, Including but Not Limited to Respect for Patient Autonomy

During a severe pandemic, clinical decisions may be public-centered to achieve societal benefit and thus may override traditional ethical weight placed on respecting individual patient-autonomy. At the same time, the ethical ideal of respect for persons still generates obligations for healthcare professionals that should be actualized to the extent possible. In other words, overriding an ethical duty for the sake of a greater one under narrowly-defined circumstances should be distinguished strongly from negating that duty—which is never defensible.

Developing and consistently following publicly transparent guidelines for the allocation of scarce resources is one way to honor the principle of respect for persons under emergency

circumstances, even when decisions based on individual patient autonomy may be outweighed by public health goals for allocating scarce resources.

Respect for patient autonomy should be maintained as much possible despite the legitimate recognition that it becomes secondary to public health goals in emergency allocation. For example, a patient's values related to treatment choices should be considered to the extent possible even when some treatments may be denied by emergency allocation policies.

Some people argue that respect for persons requires that when other factors relevant to just allocation are equal, a lottery is the fairest way to distribute scarce resources.

We believe that argument is cogent. However, people disagree about "when all other factors are equal." That assessment will depend on what factors are deemed relevant to just allocation.

Non-maleficence and Beneficence

Healthcare professionals are forbidden to harm their patients, and are obligated to do all they can to promote the well-being of their patients. Those obligations do not cease in a pandemic. However, in a pandemic, healthcare professionals' obligations directly extend to preventing harm and promoting good for the population as a whole. In some circumstances, their patient-focused and community-focused obligations will conflict. This is not only tragic for patients, for whom there may not be enough resources to go around, but also for healthcare providers, who endure acute moral distress when they cannot fulfill both of these compelling ethical obligations. Thus, it is a matter of fairness both to patients and to healthcare professionals that institutional allocation policies be developed and implemented in ways that prevent the necessity for "ad hoc" bedside rationing decisions by individual physicians or healthcare teams.

Nonmaleficence

Non-maleficence requires that physicians and other healthcare professionals refrain from treatments or actions that they expect likely to harm the patient. This duty holds in all circumstances, but takes on added urgency in pandemic situations. In a pandemic, the psychological pressure to try to rescue a patient without fully considering a treatment's likely ratio of harm-to-benefit may be greater, while providing a resource likely harmful to one patient may mean another who could benefit does not receive it.

In a pandemic, special efforts should be made to avoid providing medically-ineffective interventions so that scarce resources can be reserved for the pool of patients who, based on objective clinical metrics, might benefit from them. At the same time, psychological or administrative temptations to describe rationing decisions as determinations of ineffectiveness should be resisted. Favoring allocation to a patient with higher probability of survival to one with a lower probability is not the same as determining the scarce resource would be medically ineffective for the latter. A worthwhile check on transparency is to ask whether the treatment at issue would be considered medically ineffective for a patient's clinical circumstances if there were no pandemic-related scarcity of resources.

Non-maleficence also imposes special duties on healthcare professionals to avoid harming wider institutional or societal efforts to be fair to all medically-needy persons in emergency circumstances.

In this sense, non-maleficence imposes a strong duty on physicians and other healthcare workers not to harm patients or the community by acting outside of, or making exceptions to, publicly transparent allocation-guidelines.

Beneficence.

Beneficence requires physicians and health professionals to provide physical and psychological benefit to their patients. In a pandemic, special obligations to consider benefit to the community as a whole may result in outcomes unfavorable to an individual patient. Emergency conditions, resource-scarcity, and publicly-transparent triage processes may dictate that a patient who could benefit is not eligible for ventilatory support or other intensive care interventions. This tragic circumstance does not relieve physicians or other health-workers from maintaining duties of beneficence to their individual patients.

Maintaining duties of beneficence to individual patients is important to public trust in medicine and to physician integrity. Physicians should not be placed in a position where they, individually, feel they must make a decision to refrain from working fully toward their patient's benefit for the sake of a broader social good. Institutional guidelines and assessments by independent triage committees should protect both patients and healthcare professionals from such "ad hoc" decision-making. To avoid conflict of interest, attending physicians should not make rationing decisions for their own patients.

When triage policies deny a scarce resource such as a ventilator to a patient who otherwise might have benefitted, physicians and healthcare professionals retain a duty to benefit that patient as much as possible. They must actively strive to provide available indicated and/or alternative supportive treatment, including palliative care.

Emergency pandemic circumstances require that physicians and healthcare workers shoulder additional duties of beneficence toward the community as well as to their own patients. These duties require: (1) abiding by fair triage policies even when they disfavor one's individual patient; (2) supporting profession-wide and societal-wide efforts to develop fair policies; and (3) conducting clinical assessments that may impact allocation decision-making accurately.

We interpret beneficence to the community as the most direct communal corollary of individual patient benefit: minimizing harms and maximizing benefit by saving as many lives as possible. This requires prioritizing allocation of scarce medical resources to those whose lives are in danger without the treatment and who are the most likely to survive with the treatment. We believe allocation policies should prioritize heavily the good of saving as many lives as possible. At the same time, we acknowledge there are also other community goods threatened by pandemic.

Objective clinical measures should be used to assess probabilities of survival, with ranges of medical uncertainty recognized. (Different scoring systems have been developed for such assessment. One of the most validated and widely used is the Sequential Organ Failure Assessment, SOFA.)

Solidarity

Solidarity refers to a willingness to bear burdens as individuals and as groups so that all people, and the community as a whole, can flourish; or so that widely-endorsed community values can be maintained under emergency circumstances.

Solidarity in a pandemic emergency might mean, for example, social willingness to expend extra resources to maintain commitment to vulnerable individuals or groups. It also might mean a focus on allocation policies seeking to maximize ethical goods other than the number of lives saved, such as the number of life-years saved. A solidarity approach might lead to an emphasis on policies that enable as many people as possible to live a full average life-span.

While we argue for a priority on beneficence in terms of maximizing lives saved during a pandemic, we recognize moral pulls of solidarity in two ways. First, we advocate that ventilators (or other scarce resources in a pandemic) being used outside of acute-care facilities to support people with long-term chronic illness or disability in the community not be subject to conscript for the pool of ventilators in acute-care settings.

Secondly, when there are not sufficient acute-care ventilators or other resources for people medically similarly-situated in terms of odds for survival with treatment, we believe it is ethically defensible for those developing allocation policies to consider invoking solidarity approaches to define tie-breakers-- either to maximize life-years saved, or to maximize social stability in ways that enhance the full community's capacity for flourishing.

Social Worth

Social worth is the relative value society places on a person. Such assessments are inherently subjective and are often influenced by the biases and prejudices of those making the determination. Attempts to assess social worth contradict widely-held community values that hold all people have inherent worth and dignity, and are ethically indefensible.

*We **reject** explicit or implicit assessments of people's social worth as a criterion for allocation. Our rejection of social worth assessments accords with major findings in public engagement on pandemic rationing. Community participants feared excluding any social groups from consideration for scarce resources based on non-medical factors.*

Assessing which candidates could benefit from a scarce resource, and their probability of survival with it, should be based strictly on objective clinical factors. This reliance on clinical prognostic factors best supports the overall goal of maximizing lives saved.

Any allocation policy should support care for all with no restrictions based on gender, race, religion, intellectual disability, insurance status, citizenship, wealth, or social prominence.

Age

Age alone should never be a sole determinant in allocation of critical care resources. In other words, age should never be used as an exclusion-criteria for consideration of scarce resources.

Whether age may be taken into consideration in circumstances when there are not enough resources for needy patients with similar prospects for survival is a matter of debate. Some argue that in such cases, the number of years patients may be able to live if they survive (the so-called "life-cycle principle") should then play a role--favoring younger patients. While opponents of this view equate it with a negative assessment of social worth of the elderly, adherents do not consider it an assessment of relative social worth. Rather, they view it is a tragic effort to save more life-years when there is no way to save more lives. They consider enabling as many as possible to live a full human lifespan a valid secondary goal of allocation.

The U.S. Office of Civil Rights recently issued a brief statement that neither disability nor age can be considered in pandemic rationing plans. Significantly, the OCR made no distinction between exclusion criteria and tie-breaker criteria, rendering what it intends to forbid ambiguous. One prominent allocation policy --the University of Pittsburgh model policy-- that has been adopted by hundreds of hospitals nationwide does use life-cycle (age) as a tie-breaking factor.

In our view, the role of hospital ethics committees and administrations developing allocation policies in time of pandemic emergency is not to resolve legal ambiguities but rather to negotiate tragic ethical tradeoffs as best they think possible. (At the same time, we realize that developing explicit, carefully-deliberated allocation policy and processes may offer secondary effects of reducing institutional liability.) We believe that those developing final allocation policies should take into account all stakeholder interests and competing ethical values. Based on their assessment of best ethical balancing, they should draw their own conclusion about what factors their policy will use as tie-breakers under tragic circumstances-- and state and defend those criteria transparently.

Social Function

Some argue that those who work to provide acute medical care, or who provide other essential social services such as police-protection and sanitation, should receive priority in allocation policies because their roles are all the more critical to the community during pandemic.

Two kinds of supportive arguments are made. One is an argument based on moral reciprocity. Healthcare workers and some other kinds of service-providers assume particularly high risks doing their jobs during an epidemic. Giving them some priority in allocation-policy would be a way to express reciprocal commitment and gratitude.

The second argument focuses on the community's special need for their services during pandemic. Prioritizing them in allocation would aim to reduce absenteeism, and to enable sickened providers to return to work supporting ongoing epidemic response. The cogency of this argument may depend on the severity and time-line of the crisis, and other contextual factors.

Arguments for prioritization of allocation to providers of acute medical care or other essential services must be distinguished strongly from social worth arguments. Social *function* arguments are not the same as social *worth* arguments. Social function denotes role-responsibilities specifically related to emergency response.

We believe that, along with saving as many lives as possible, enabling the continued functioning of society is an important goal of allocation policy. Under most circumstances, saving as many lives as possible will support the goal of enabling continued functioning of society. But in cases of extreme crisis, those goals could come into tension with each other. It is reasonable for hospitals and hospital-systems developing institutional allocation policies to consider some priority-weighting for those playing special functions such as providing emergency medical care, but only in circumstances where there are inadequate life-saving resources to provide all among patients with similar need and probability of survival. Institutions who decide to include such a weighting-factor are obligated to describe the relationship between social function and allocation priority in ways that clearly preclude social worth considerations.

Operational Implementation of Allocation Policy

Any allocation policy must include an operational triage protocol that should be established by individual hospitals based on factors including their staffing, inventory of scarce resources, patient population, and administrative or medical staff guidelines. This protocol should support operational implementation of the institution's endorsed policy for allocation of scarce resources. Several protocols have been proposed (e.g. New York State Task Force, University. of Pittsburgh, Johns Hopkins University, Kaiser-LA) that may serve as a model in establishing the triage mechanisms.

Under separate cover is an example of a hospital policy created by members of the SCCMA Bioethics Committee for possible use by their member-hospitals in drafting their own policy.

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