

# COVID19 and Pandemic Ethics

Pandemic Ethics and Allocating Scarce Resources

John Dossetor

**HEALTH ETHICS CENTRE**

Public Lecture Series

April 5, 2020 (recorded)



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# Pandemic Ethics and Allocating Scarce Resources

- A Health Ethics Public Lecture
- Sponsors - John Dossetor Health Ethics Centre and Alberta Health Services
- Presenter - Eric Wasylenko MD CCFP (PC) MHSc (bioethics)
- Taped April 5, 2020

# COI Declaration

- No financial conflicts to declare from industry or research funding
- Contractor to various health agencies
- Not speaking on behalf of any agency

## Relevant Affiliations

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- Medical Director, Health System Ethics and Policy, Health Quality Council of Alberta
- Chair, Ethics Consultative Group, Public Health Agency of Canada

# Disclaimers

- Speaking on my own behalf
- Care to avoid describing plans that are underway but have not yet been communicated
- Acknowledge that information, understanding and resources change daily
- Interested in your challenges and input

# Acknowledgement

- Patients and populations
- Health systems and workers
- Countries
- Science, politics and communication
- Primary need for solidarity



## Some current references

- Truog RD, Mitchell C, Daley GQ. (2020). The Toughest Triage – Allocating Ventilators in a Pandemic. *N Engl J Med NEJM.Org*. Downloaded March 27, 2020 from [nejm.org](https://www.nejm.org) DOI:10.1056/NEJMp2005689
- Emanuel EJ, *et al.* (2020). Fair Allocation of Scarce Medical Resources in the Time of Covid-19. *N Engl J Med NEJM.ORG*. Downloaded March 24, 2020 from [nejm.org](https://www.nejm.org) DOI:10.1056/NEJMs2005114
- Koonin LM, *et al.* (2020). Strategies to Inform Allocation of Stockpiled Ventilators to Healthcare Facilities During a Pandemic. *Health Security* Vol 8 No 2 Mary Ann Liebert, Inc. DOI:10.1089/hs.2020.0028
- Hick JL, *et al.* (2020). Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2. *NAM Perspectives*. Discussion paper. National Academy of Medicine. Washington DC. DOI: 10.31478/202003b
- Parhar KKS, *et al.* (2020). Optimizing provision of extracorporeal life support during the COVID-19 pandemic: practical considerations for Canadian jurisdictions. *CMAJ* (early-released March 26, 2020 at [www.cmaj.ca](https://www.cmaj.ca)) DOI: 10.1503/cmaj.200448
- Ireland Department of Health. (2020). Ethical Framework for Decision- Making in a Pandemic



## Some previous and very relevant references

- Winsor S *et al* (2014). Identifying Prioritization Criteria to Supplement Critical Care Triage Protocols for the Allocation of Ventilators during a Pandemic Influenza. *Healthcare Quarterly* (17) 2:44-51
- Kaposy C *et al.* (2010). Adapting the Hamilton Health Sciences critical care pandemic triage protocol. *Healthcare Quarterly* (13):60-3
- Many more in the Canadian, American and worldwide literature



## What I hope to address

- Address a range of allocation issues during a time of substantial scarcity using the lens of ethics
- Make some claims and a few pleas for you to consider

## Context update – CoVID-19

### Deadly disease for some, higher mortality rate than with seasonal influenza

- hospitalization rates for those with CoVID-19 ~ six per cent; ~ two per cent require critical care; ~ one per cent of cases are fatal. May be a large mismatch between need and resources.
- Variable case fatality rate in specific populations – emerging epidemiology

No vaccine available

No known treatments yet

Care is supportive

# Ethics considerations with overwhelming scarcity – balanced interests of planners

Scarce and  
necessary  
equipment and  
supplies

Scarce and  
necessary space

Scarce and  
necessary people



## Scenario A - PPE

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Copyright: John Locher/AP Photo

## Scenario A - PPE

- Federal government has stockpiles of an emergency supply of masks and other personal protective equipment (PPE) and is ordering more.
- More will undoubtedly be needed and you are sourcing available supply around the world
- All provinces/territories are asking for an allotment
- The provinces/territories are in the early stages of the pandemic response, trying to manage public health and clinical delivery issues.



# Tehran convention centre

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Copyright: Ebrahim Noroozi/AP  
Photo



## Scenario B - programs

- You are a health system trying to sort out how to configure your available resources to best serve the public.
- It is obvious there may be severe resource constraints ahead if the pandemic hits locally anywhere near as severely as other countries have faced



# Scenario C – ICU

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Source: [https://ahtribune.com  
images/coronavirus\\_China\\_8e8d8.jpg](https://ahtribune.com/images/coronavirus_China_8e8d8.jpg)



## Scenario C – access to ICU

- You are an ICU physician leader trying to determine how you might decide who to treat if at some point you do not have enough critical care resources to treat everyone who could potentially benefit from your unique resource



## Primary goals for managing a crisis

- Save lives
- Minimize the overall burden of illness
- Minimize societal disruption

## But who should we treat if we can't treat everyone?

- Fundamental premise that all people have equal worth, so we will view people as equal, and generally everyone gets a chance for their health to improve through our efforts.
- We apply this notion in all stages of a resource crisis, but we might reach a stage where we need more distinguishing criteria simply because we do not have the resources to treat all.
- So we next revert to applying our scarce resources to maximize our ability to save lives – and a key notion here is survivability.
- Should we challenge this? What about all others who need care, or other types of care?





## Medical corps

Source: [www.stuffyoushouldknow.com](http://www.stuffyoushouldknow.com)

# Concept of battlefield triage

- Dr. Dominique-Jean Larrey
- Surgeon-General of the Imperial Command for Napoleon Bonaparte
- Established field ambulances and a triage (Fr. *trier* = to sort) mechanism to determine which wounded soldiers should be operated on, when and where
  - Who needed the most urgent help
  - Who could be saved





Ethics framing  
Broad considerations

# Setting the table



Substantive concerns

– the what



Procedural concerns

– the how

## How can ethics deliberation assist

- Utilize the ethics lens to think about values and principles that can inform the question – all things considered, what seems to be the right thing to do?
- Establish defensible processes that help us include the right people and fair methods
  - Inclusive
  - Transparent, and make the criteria to be used explicit
  - Evidence-informed
  - Revisable
  - Appeals mechanisms

## Some ethics principles/values

Proportionality

Reciprocity

Solidarity

Transparency

Least intrusive  
means

Subsidiarity

Revisability

## Early management phase and ethics considerations

Community as partner

Preparing workers

Communicating with public

Disadvantaging other services and health care access – what do we forego?

Procurement and distribution of resources



Some strengths we  
have in Alberta

- Harmonized delivery system
- Aligned with Public Health
- Advance crisis planning
- Coordination structure well established
- e-SIM training
- Commitment to unified messaging

## Back to our first scenario – PPE – national stockpile

- Duty to plan involves
  - knowing when to trigger
  - Procuring necessary supplies/equipment
  - Storing and making readily accessible



## PPE – making it available

- What is the mechanism to allocate the supply
- How will we distribute the supply
- How should it be deployed
- Should the supply be rationed in any way

## Mask availability – an example

- National stockpile
- Distribute by greatest need or proportionally to population?
- What other commitments federally?
  - Federal health responsibilities (eg First Nations, military, RCMP)
  - International solidarity

# Considerations – what to decide and how to decide

Duty to protect

Security of all  
players

Fairness

Balancing of all  
interests (including  
advantaging the  
least advantaged)

Process of  
deciding

Revisability

# What to do amongst competing priorities

- Argument for
  - equitable allocation amongst jurisdictions
  - distribution to other populations directly responsible for
  - a degree of holdback or rationing (crisis allocation/future/unanticipated)
  - assurance of a plan for deployment by receivers
  - considerations for international solidarity



## Scenario B - programs

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- Source: Fort Riley Kansas 1918 - file photo Canadian Press



Singular focus on  
CoVID-19 –  
risks of harm...

- To all others requiring care and the programs that regularly provide care or diagnostic investigation
- Especially consider those who are most vulnerable in usual times
- Dimensions of Proportionality
  - Diversion proportionate to risk/prevention regarding overall societal harms
  - proportionality regarding risk/prevention of suffering of individuals

Context of CoVID -  
suffering and  
potential death

- How to best prepare
  - With more ventilators and space and personnel?
  - Yes, but...



Let's remember to  
think about...

- Symptom management and palliation
  - Skills in palliative care and in conversations
  - People resources: well-deployed teams to all locations where required
  - Adequacy of supply and availability of medication/equipment

## Advance Care Planning and Goals of Care Designations

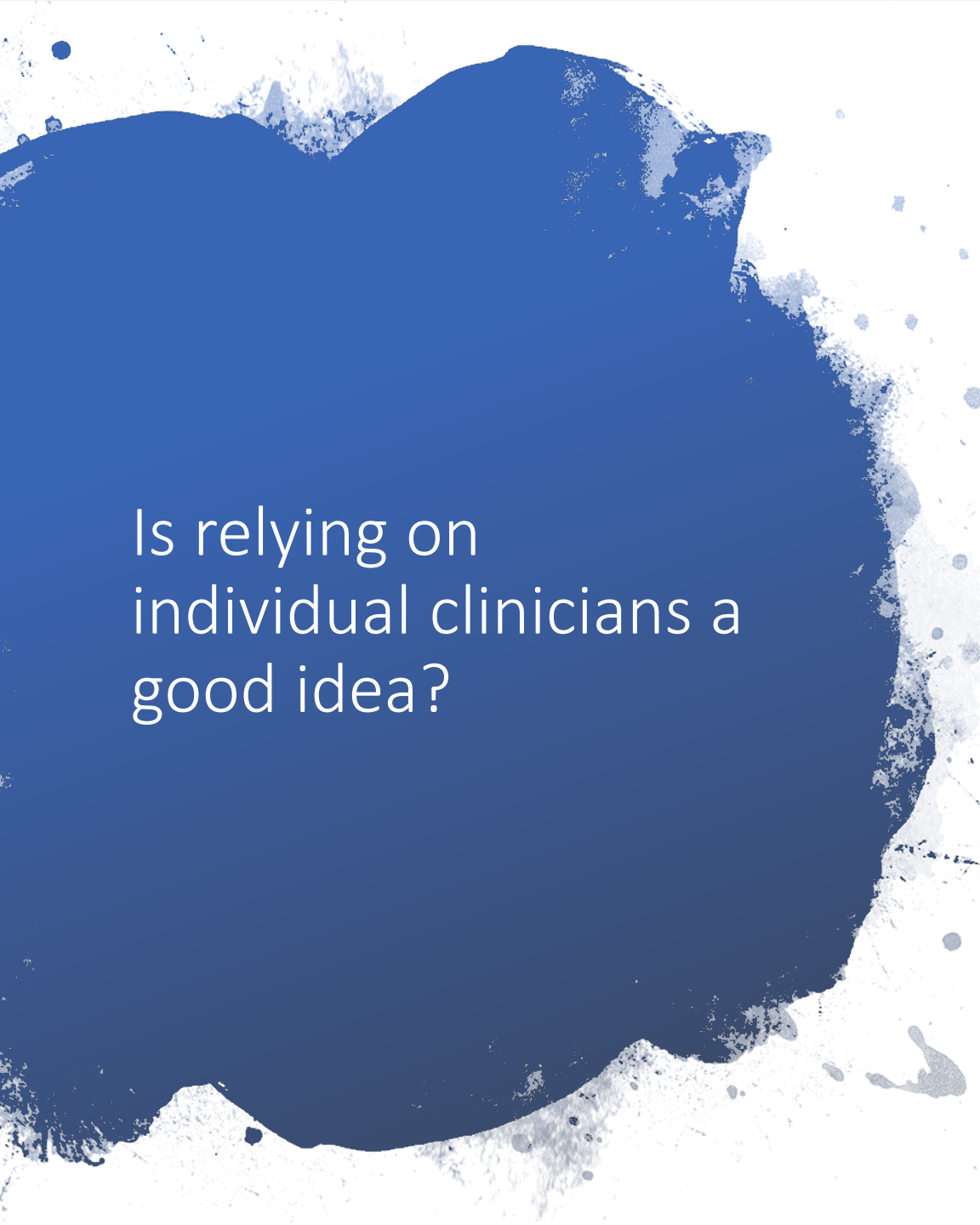
- Think about your values for the type of care you might wish to have, in various scenarios, and based on reliable information
- Discuss with your physician and communicate your wishes to loved ones
- Document them in Alberta's mechanism as well as in your Personal Directive
- [www.conversationsmatter.ca](http://www.conversationsmatter.ca)
- Strong adaptations posted for the CoVID-19 environment

Claim about  
personal ethical  
responsibility

- Do this in solidarity with others –
  - appropriateness of resource consumption
  - ease decisional burden and moral harm for health care providers
- Do this out of duty to your family and those you love
- Do this out of duty for yourself

## Scenario C - allocation decisions at the bedside

- Rely on clinicians' own experience and intuition
- Rely on agreed to triage and allocation decisions developed by the unit of management (hospital or civic/area/provincial/territorial health system)
  - Assumption about the process being appropriately rigorous, evidence-informed, inclusive and transparent



Is relying on  
individual clinicians a  
good idea?

- Supports the principle of subsidiarity
- Clinicians likely do know the best
- Duty is to their individual patients
- Hard to separate that from a population-level duty
- May not be able to overcome inherent bias in meeting their obligations to individual patients
- Will not be able to treat all who present
- Morally devastating

# Fatigue and distress

Copyright: Antonio Masiello/Getty Images



## Agreed-upon process

- Develop activation levels that motivate specific allocation decisions across the system
- Identify and train decision-makers for triage
- Establish communication methods for on-the ground decisions and real-time reporting
- Establish criteria for allocation and communicate them (publicity?)
- Appropriate review in real time for revisability (command center function)



# Fundamental premise

- All individuals have equal worth
- We attempt to treat everyone who can be treated
  - and always provide compassionate care regardless of survivability
  - but what happens when resources are too scarce?

## Clinical criteria for allocation of intensive care resources




- Exclusion criteria
- SOFA and m-SOFA
  
- Might not be shown to be perfect, but certainly reduces inconsistency and arbitrariness of decision-making

## Constant clinical review

- In service of the principle of applying scarce resources to most ideal use.
- Process for regular and assured review of all patients (with any illness)
  - Those waiting for ICU
  - Those previously denied, but not about to die
  - Those receiving the resource already

## Some procedural considerations

- The triaging function needs to be separate from the clinical care function (the clinicians on-service have different obligations from those trying to manage the population)
- Triage team independent of clinician (anonymize information in some way)
- Review mechanism regarding scoring and assessment reliability
- Appeals mechanism regarding fidelity to the process, and external to providers and system (assures independence, reduces risk of bias and generates trust)



What happens  
beyond clinical  
triaging?

- A number of possibilities have been proposed for a situation in which demand outstrips supply and when a decision about which person should get the next ICU bed/ventilator cannot be distinguished on clinical grounds.

## Multiplier criterion

- Advantage those who can help in the overall goal of saving the most lives/assisting with the response effort.
- Some challenges –
  - Can such a list be developed so as to be useful?
  - Who decides comparative utility?

## Essential service worker/HCP

- In order to maximize opportunities to save lives and serve the public, advantage health care workers and other essential service workers
- Some challenges –
  - Can such a list be developed and can we prioritize more finely within such a list?
  - How do we avoid the perception of or actual conflict of interest when clinicians triage about health care colleagues?



## Fair-innings argument

- Advantage those who are in an earlier life-cycle since they have not had the opportunity to live through the various stages of life
- Challenges –
  - Is there such a thing as a ‘fair share’ of life?
  - Can we objectively separate this criterion from ageism?

## First-come, first-served

- When clinical criteria cannot distinguish between people, revert to a mechanism that removes any inherent judgement about a person, their opportunities, or their instrumental worth
- Some challenges
  - How do we do this operationally in a harmonized system serving geographically dispersed population?
  - Does this mechanism disadvantage rural, remote persons, or those without easy means to get to a hospital/systemically disadvantaged?

# Lottery

- Amongst those eligible patients, choose purely by lottery (sometimes proposed after first-come, first-served has been applied), in the interests of fairness
- Some challenges –
  - Can it be gamed?
  - Removes all notions of science/clinical experience/judgement from clinicians
  - How to measure against currently treated people, doing relatively poorly

## Advantage systemically disadvantaged persons

- Give priority to those who have been marginalized from accessing the goods of society
- Some challenges -
  - Can an inclusive list be generated that does not create more unfairness?
  - Is there a way to rank order from within such a list?

## Many examples of triage/allocation schemes now exist

- Currently for CoVID - Regional, provincial, national, other countries
- Some publicized (contend that all should be once ready)
- All explicate the principles and values they are based on
- Lots of harmony amongst the basic principles, applications arising are not universally held
- Some general defenses for particular approaches, advantaging certain principles and values, are in the literature

The New England Journal of Medicine

n engl j med nejm.org 1 downloaded March 24, 2020

*Fair Allocation of Scarce Medical Resources in the  
Time of Covid-19*

Ezekiel J. Emanuel, M.D., Ph.D., Govind Persad, J.D., Ph.D., Ross  
Upshur, M.D., Beatriz Thome, M.D., M.P.H., Ph.D., Michael Parker,  
Ph.D., Aaron Glickman, B.A., Cathy Zhang, B.A., Connor Boyle,  
B.A., Maxwell Smith, Ph.D., and James P. Phillips, M.D.

## Key values arising from their analysis

- Maximize the benefits that can be achieved from the use of the available resources
- Treat people equally
- Promote and reward value that individuals bring that are inherent to the collective effort (instrumental value)
- Prioritize those who are worst off
- These values are not independent of each other and cannot be self-sufficient in determining courses of action



## There will be some disagreement about their recommendations


- For instance, consider how you feel about several contentions...
  - “Worst off” includes young people who may not get to achieve a full life, and so they can be prioritized
  - Withdrawal of life saving interventions can be justified in order to provide it to others with a better chance of survival – but thresholds are not proposed; also are potentially trading a known response for a ‘trial of therapy’
  - HCW have instrumental value to the pandemic response so should be prioritized for resources
  - Advantage those who have been research subjects (when requiring a tie-breaker to choose)

**Calgary Remand Centre inmates terrified about potential COVID-19 outbreak in jail, say lawyers**

Kevin Martin Calgary Herald [News](#)

**Spread of coronavirus accelerates in U.S. jails and prisons**

Brodie Thomas Calgary Herald [World](#)



## Some claims – Especially vulnerable people

- Let's not forget about especially vulnerable populations.
- There are many such populations
  - Rural, remote
  - Indigenous
  - Socially isolated
  - Disability communities
  - Incarcerated
  - Marginally housed
  - Congregate living at risk

## Some claims – Patients in Complex Care Pathways

- In most situations, we should not begin a complex care pathway for a patient if the resources will not be available to complete what is necessary and safe, to achieve intended therapeutic success.

## Some claims – Solidarity with organizational decisions

- Solidarity in a time of uncertainty, unfamiliarity and potential crisis is laudable
- Perhaps is just a hair short of an obligation on an organizational decision level
- Too much risk for chaos, which serves no one
- Does not imply subjugation of critical thinking and contrary input

## Some claims – we should signal we will always provide care

- All those waiting for care, some of which is also life-saving, must understand they will not be forgotten, and should have alternative means, where available to reduce disease burden and deterioration.

## Some claims – we should tap citizen wisdom

- Use community awareness of this crisis in order to generate interest for citizen engagement towards planning effectively for future crises
  - Public deliberative processes regarding values –
    - System must create the opportunity
    - Citizens should take the opportunity to participate
    - When the time is right...



## Some things all of us can do

- Advance Care Planning/Goals of Care Designations – talk about this [www.conversationsmatter.ca](http://www.conversationsmatter.ca)
- Plan for your family communication and support mechanisms
- Access reliable, trusted community evidence and information
- Be in Solidarity

Thankyou.



**Discussion**



**Feel free to contact me with  
questions, challenges, ideas:**

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