Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Surgery 168 (2020) 392–393

Contents lists available at ScienceDirect

Surgery

journal homepage: www.elsevier.com/locate/surg

Medical resources are scarce, but theories about their allocation are not

How to allocate scarce medical resources is a timely and important subject worthy of discussion.[1] Although the coronavirus disease 2019 (COVID-19) era has forced scarce medical resource allocation to the front of our consciousness, it has always been with us, and will still be with us when COVID-19 has been vanquished.

1. The authors' discussion of utilitarianism is oversimplistic here. First, there are many different ways in which the utilitarian value of an action or choice can be calculated. Second, and more pertinently, this discussion ignores the notion of rule utilitarianism and all of the implications that can be drawn from that, either directly or by implication. For instance, if doctors start extubating patients to let them die, a rule utilitarian would ask not whether extubating patient A to save patient B is a good thing but whether extubating patients under some specific circumstances outlined in a rule about extubation, if always done, would result in more good than bad. This would include a discussion of the effect on the doctor–patient relationship that would occur if doctors always did this and it was known that such practices occurred. Even a basic nonrule utilitarian would consider not only the consequences for patients A and B but also the consequences if the act became known for that doctor, for all doctors, and for all patients. Variations on themes of utilitarianism and rule utilitarianism in medical allocation have recently been reviewed.[2]
2. There is also room here for a discussion of theories of justice and social contract[3,4] and how these might influence a decision as to the right option. For instance, John Rawls[3] has argued in a much more sophisticated fashion than I shall express here that justice is best determined by asking what people would want if they were blinded to their own role. For instance, would people believe that mortally ill patients should be extubated prematurely to save other patients if they did not know whether they would be the mortally ill patient to be extubated, the patient to be saved, or even the doctor?
3. Indeed, numerous other deontologic rules have been or could be proposed to guide various decisions of allocation, including egalitarian random allocation, first-come first-served, and prioritizing existing patients over new patients based on the doctor-patient contract.[5,6]
4. The authors conflate to some extent the notion of allocating ventilators up front with the notion of extubating a patient to give the ventilator to someone else. These conditions should be clearly separated. If it is the authors' intention to primarily discuss the latter, then (recognizing that arguments about the former are also somewhat relevant), they need to clearly state this up front and then focus on the question of extubation. As it is written, the article seems to end by arguing that physicians should not be allocating ventilators because that is "playing God," but allocation is inescapable in conditions of scarcity, even if it is only first come first served (or some more sophisticated version). We routinely ration care when we send a patient out of the intensive care unit early to make room for another patient, choose not to offer a screening colonoscopy to a healthy and asymptomatic but anxious 35 year old man (who certainly conceivably could have a colon cancer, but it seems unlikely and thus the procedure seems not cost-effective), or debate United Network for Organ Sharing procedures for allocating organs for transplantation.[5,7]
5. The argument about medical futility,[8,9] is important and given too short a shrift here. Even if the authors wish to argue that it is inappropriate to extubate a patient who has a poor but real chance of survival to give the ventilator to a different patient with a better chance of survival, they need to consider separately the notion of extubating a patient who is clearly not going to survive (futile care) in order to free up a ventilator that could be used to save a patient if available now, but would not be useful later. The authors may wish to reject this as well, but it should at least be considered as a distinct case.
6. Overall, one wonders if the article would be better served by laying out the arguments for and against whatever choices the author is attempting to discriminate among (see no. 3 above) rather than being framed as an editorial that makes a dogmatic statement about the "correct" answer. These are truly challenging issues. Moral intuitions about how to make such choices vary with the case and among different people of good intent.[10] Surely there is room for debate and disagreement here?

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Accepted 4 May 2020

https://doi.org/10.1016/j.surg.2020.05.001

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