CoronaVirus Disease 2019: Withdrawing Mechanical Ventilation to Reallocate Life Support Under Crisis Standards of Care—Nonequivalence of the Equivalence Thesis

To the Editor:

Nonequivalence of the Equivalence Thesis

The CoronaVirus Disease 2019 (COVID-19) pandemic has, in hot spots, overwhelmed our ability to provide lifesaving interventions, including mechanical ventilation, to all critically ill patients (1–3). This unfortunate reality begets complicated bioethical scenarios discussed in a recent article by Sprung et al (4) as part their comprehensive recommendations for adult ICU triage recently published in *Critical Care Medicine*. One particularly difficult question raised in these recommendations and other published allocation frameworks (5, 6) is the following: "Is it ever ethical to remove a ventilator from a patient in order to reallocate it to another we believe would derive more benefit from it?"

Most allocation frameworks involve triage teams who operate in isolation from the team caring for patients and who assign a priority score to patients based on the likelihood of survival. This ensures consistency, objectivity, and respect of the fiduciary relationship between providers and patients (3, 7). Their adoption by healthcare institutions is predicated on their alleged consistency with both consequentialist (i.e., what generates the best results) and nonconsequentialist ethical principles (which emphasize the intrinsic morality of certain actions) (3, 5, 6, 8, 9).

Under such allocation frameworks, withdrawal of ventilators may be permissible to reallocate them to patients who may derive more benefit from them, as assessed by independent triage teams. Such reallocation is often justified by the "equivalence thesis: all things being equal, it is ethically justified to withdraw a life-supporting treatment that could conceivably have been withheld in the first place" (10). While relatively uncontroversial when aligned with the patient's wishes (11), this principle has been tentatively extrapolated to crisis standards of care to mean that it is morally permissible to withdraw life-supporting measures for reallocation purposes, even against the individual patient's wishes and best interests (12). Claims of moral equivalence in this new situation need to be justifiable to avoid the charge of moral expediency. We propose the following three points that we believe need further study and clarification, as examples of the need for inquiry into this burgeoning controversial issue.

First, the equivalence of withdrawing and withholding life-prolonging care is not as settled as it seems. There is indeed a broad consensus that, in cases when the patient wishes to forego life-prolonging care or the medical team deems such care inappropriate, withdrawing and withholding this care are morally equivalent. Nevertheless, healthcare professionals and the community consistently seem to view withholding life-supporting measures as less problematic than withdrawing them (13, 14). Proponents of the equivalence thesis suggest that the reluctance to withdraw life support is due to flawed moral reasoning, psychological bias, and social conventions. *Our moral intuitions may be misguided and subject to the 'omission bias', that is, the tendency to consider the consequences of omissions as morally less serious than that when due to direct actions* (15). On that view, not initiating life-supporting measures resulting in patient death would be mistakenly construed as more acceptable than causing a patient death by withdrawing life support. An extensive ethical and legal debate about such moral intuitions led to the consensus that honoring a patient's wish to discontinue a life-prolonging therapy has the same moral status as honoring a wish not to initiate it. This new situation of reallocation, possibly against a patient's wish, warrants a new discussion about these moral intuitions.

Second, a tenet of the equivalence thesis, which posits the moral equivalence of withholding and withdrawing life-supporting measures in usual circumstances, is the "all other things being equal" clause (10). This would include not only the intentions of those performing the actions, but also risks and predicted outcomes. However, the application of a reallocation process will necessarily ignore the obvious fact that the predicted outcome of the patient, who in this new situation is still benefiting from life-support measures, is better than before they were initiated, that is, all things are not equal. *Withdrawal of a ventilator to reallocate it to another person may very well be justified in some situations, but the equivalence thesis will not be enough, and appeal to other ethical principles, such as fairness and distributive justice, will need to be convincingly argued.*

Third, entering into a physician–patient relationship commits physicians to accept a number of responsibilities toward their patients (beneficence, nonmaleficence) that they would not necessarily be responsible for before entering into that privileged relationship (12). *Imposing a triage decision on a physician before she/he commits to the care of an individual patient may be substantially different from imposing it after that fiduciary relationship is established.* While justification for such reallocation may be argued during crisis standards of care, its adoption does appear to require a substantial revision of the moral standards framing the physician–patient relationship.

Unless we take a purely consequentialist approach to the ethics of scarce ventilator allocation, we need to have discussions about several issues:

1. Does the ventilated patient have a different moral claim on the ventilator than the person who is not yet on the ventilator but needs it?
2. What obligation does the medical team have to the patient they are already treating compared with the patient whom they have not yet started treating?
3. What is the relative moral (and legal) blameworthiness of not saving a person's life that could be saved versus physically stopping something that is keeping someone alive if the wish of the patient is to stay alive?
4. How do we weigh the moral valuations we make from answering the previous questions with the obligation to maximize the number of patients who survive?

These are the questions we must urgently debate and about which we must attempt to develop consensus. Merely assuming "withdrawing and withholding are equivalent" short-circuits the needed debate. We agree that allocation frameworks should generally satisfy both utilitarian and rule-based models but worry that the particular scenario of "withdrawing to reallocate" has been primarily justified on utilitarian grounds. Thus, we suggest a cautious approach to withdrawing life support, one that is individualized rather than protocol driven and includes all key stakeholders (triage team, care team, patients, and their loved ones). Until a consensus emerges, the principle of caution should apply in case of disagreements. This approach is consistent with that proposed by Sprung and colleagues, which we believe balances uncertainty with flexibility (4).

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