The Triage Stalemate During the Coronavirus Disease 2019 Pandemic: Losing Fairness to Ethical Paralysis

To the Editor:

As coronavirus disease 2019 (COVID-19) has ravaged our nation and the international community, widely varying paradigms have been advanced re both how to best manage the virus' burden on the healthcare system as a whole and on the role of intensive care physicians at the center of the crisis. Triaging is inevitable when relatively scarce resources become finitely scarce in comparison with medical need. Ventilators, for example, are a relatively scarce resource under normal circumstances. But during the COVID-19 pandemic, the number of patients requiring ventilators has exceeded available ventilators, forcing hospitals to practice "some sort of triage" (1).

In a recent article in *Critical Care Medicine*, Sprung et al (2) have outlined the major considerations for ethical ICU triaging under pandemic conditions, highlighting deviations from decision-making protocols followed during nonpandemic circumstances. Their recommendations offer practical translations of the ethical considerations for allocation of scarce resources proposed by Emanuel et al (3). Their conclusions are supported by major societal guidelines, rigorous philosophical and bioethical inquiries, and the practice of organ allocation in transplant surgery (4–7). Our own academic medical center has formulated a triage protocol that is closely aligned with the recommendations of the authors.

And yet, it is our understanding that systematic triaging has not been implemented in any of the healthcare institutions in the United States. Was there no actual need for systematic triaging? Reports from severely affected areas suggest otherwise (8, 9). Why, then, have we not triaged as planned?

Some insight might be gained from reviewing letters to the editor in response to the article by Sprung et al (2). Ashkenazi and Rapaport (10) argue that the locus at which life and death decisions are made should not be in the ICU. They frame the COVID-19 pandemic as a public health concern not just for those infected with the virus but for their communities and ultimately the nation. They point out that the causalities of the pandemic are not restricted to the ICU; rather, they include the increasing numbers of victims of suicide, domestic violence, unattended chronic diseases, and general economic crisis. Decisions about systemic interventions and lines in the sand as to what we, as a society, consider "an acceptable loss" should be based on public opinion, openly acknowledging that some patients must be lost in achieving the desired gain for the quality of the lives that remain and for the integrity of our society. ICU and ventilator triaging, they claim, will simply become a moot point once we place societal limits on the extent to which we will allow our healthcare system to stretch.

We applaud the authors for illuminating the less readily visible victims of the pandemic and for including them in the calculus of public health objectives. We also agree that when decisions concerning the life or death of citizens are tightly linked to value judgments instead of professional medical recommendations, as in the case of the proposed definition of "acceptable loss," such evaluations should be conducted in open, public, and democratic discourse. Unfortunately, even when time for action is not as restricted as in our current situation, the democratic process regarding healthcare resource allocations has been shown to fail in the United States (11). Oregon's failure to enforce previously agreed upon allocation guidelines on a state level does not bode well for our capacity to ratify allocation rules encompassing the values and priorities of our 50 heterogenous states. Ethics scholars have suggested the organization of healthcare communities: healthcare units in which citizens share their concepts of fairness and therefore are mutually both protected by and accountable to each other (12). In the current pandemic, however, we are left to rely on political and administrative leaders in geographic regions in which no democratic body is likely to take on the task of delineating rules for the allocation of scarce resources.

Diametrically opposed to the solution proposed by Ashkenazi and Rapaport (10) is the interpretation by Zivot (13) of our ethical imperatives during the pandemic in his editorial. He asserts that the triaging methods outlined in the article by Sprung et al (2) will not lead to more lives saved overall and frankly rejects the notion that withholding or withdrawing a life-sustaining resource against the patient's consent could be ethically justified. Zivot (13) calls into question the ethical (and legal) validity of ranking life-years saved over lives—young or old—since doing so, he argues, would impose value judgments on a person's worth and experience. He concedes that rationing certain resources may be necessary, but triaging as described by Sprung et al (2) would be illegal and unethical. He favors the "First Come, First Serve" approach supported by the American Thoracic Society and considers removing ventilators from patients without their consent to be homicide (14).

Although we disagree with the author's conclusions re the ethical superiority of the "First Come, First Serve" method to ICU triaging because of the disparities that exist in access to care for minorities and vulnerable populations, we commend his description and emphasis on the moral dangers and gravity of making life-ending decisions for patients with nonfutile prognoses (15). Although definitions of futility vary, there are clinical, ethical, and legal precedents for withdrawing or withholding treatment despite lack of patient or surrogate consent

Copyright © 2020 by the Society of Critical Care Medicine and Wolters Kluwer Health, Inc. All Rights Reserved.

Copyright © 2020 by the Society of Critical Care Medicine and Wolters Kluwer Health, Inc. All Rights Reserved.

(16–18). The unifying hallmark of these decisions, however, is that the intervention withheld or withdrawn is only delaying the dying process or conflicts with the patient's values and goals, thus no longer providing any medical or desired benefit. In the triaging strategy proposed by Sprung et al (2), it would not only be permissible but ethically mandatory to remove some patients from ventilators whose use may not be futile, in order to make them available to others who are either "more likely to benefit, or are likely to benefit more." "More" may mean more life-years or it may mean a greater chance at survival. The withdrawing of life-sustaining care in nonfutile patients, without patient consent, is unprecedented in the United States.

Here then, we reach a stalemate that reveals why, despite our best-intended and ethically guided efforts to navigate the COVID-19 crisis, we as a healthcare society remain paralyzed. On the one hand, as Ashkenazi and Rapaport (10) point out, saving individual lives at the hospital comes at a significant price of morbidity and mortality for those at home and across our communities. On the other hand, as Zivot (13) illustrates, despite the prima facie appeal of wanting to save the most lives, actively ending life on an individual level is ethically and legally extremely problematic, even if done via committee.

How do we allocate our scarce resources? The reality, as demonstrated by the above stalemate, is that physicians are double agents. They have an obligation to take care of patients immediately in front of them while increasingly expected to serve as stewards of resources (19, 20). Physicians make triaging decisions daily. We decide which patients to accept to our ICUs, which patients to take to the operating room first, and how to ration medicines during shortages. The majority of these decisions are made unsystematically and without peer review, tantamount to bedside rationing. The experience on adverse outcomes of patients we turn away from the ICU or take for an exploration after finishing another operation is mostly anecdotal. We should expect that adverse effects do exist, and they are ubiquitous.

As long as we remain a society unable or unwilling to face not only our resource limitations but also the consequences of refusing to engage in serious dialogue re triaging, physicians' dual agency will continue by default. Triaging will not be systematic, will be done person to person, and will not account for individual attitudes, beliefs, and biases. You may get a ventilator one day and not the other. You may not.

The authors have disclosed that they do not have any potential conflicts of interest.

Piroska K. Kopar, MD; Douglas E. Brown, PhD,
Department of Surgery, Washington University, St. Louis School of Medicine, St. Louis, MO

REFERENCES

1. Rubinelli S, Myers K, Rosenbaum M, et al: Implications of the current COVID-19 pandemic for communication in healthcare. *Patient Educ Couns* 2020; 103:1067–1069
2. Sprung CL, Joynt GM, Christian MD, et al: Adult ICU triage during the coronavirus disease 2019 pandemic: Who will live and who will die? Recommendations to improve survival. *Crit Care Med* 2020; 48:1196–1202
3. Emanuel EJ, Persad G, Upshur R, et al: Fair allocation of scarce medical resources in the time of Covid-19. *N Engl J Med* 2020; 382:2049–2055
4. Sprung CL, Danis M, Baily MA, et al: Consensus statement on the triage of critically ill patients. Society of Critical Care Medicine Ethics Committee. *JAMA* 1994; 271:1200–1203
5. Persad G, Wertheimer A, Emanuel EJ: Principles for allocation of scarce medical interventions. *Lancet* 2009; 373:423–431
6. Reichman TW: Bioethics in practice - a quarterly column about medical ethics: Ethical issues in organ allocation for transplantation - whose life is worth saving more? *Ochsner J* 2014; 14:527–528
7. Gutmann T, Land W: The ethics of organ allocation: The state of debate. *Transplant Rev (Orlando)* 1997; 11:191–207
8. Kaiser Health News: U.S. Hospitals Don't Have Enough Ventilators, ICU Beds To Care For Surge Of Coronavirus Cases. 2020. Available at: https://khn.org/morning-breakout/u-s-hospitals-dont-have-enough-ventilators-icu-beds-to-care-for-surge-of-coronavirus-cases/. Accessed June 15, 2020
9. Alltucker K, Penzenstadler N: Too many coronavirus patients, too few ventilators: Outlook in US could get bad, quickly. Available at: https://www.usatoday.com/story/news/health/2020/03/18/coronavirus-ventilators-us-hospitals-johns-hopkins-mayo-clinic/5032523002/. Accessed June 15, 2020
10. Ashkenazi I, Rapaport C: Saving lives versus saving dollars: The acceptable loss for coronavirus disease 2019. *Crit Care Med* 2020; 48:1243–1244
11. Spicer J: Oregon and the UK: Experiments in resource allocation. *London J Prim Care (Abingdon)* 2010; 3:105–108
12. Aveling EL, Martin G, Herbert G, et al: Optimising the community-based approach to healthcare improvement: Comparative case studies of the clinical community model in practice. *Soc Sci Med* 2017; 173:96–103
13. Zivot J: Coronavirus disease 2019 triage teams: Death by numbers. *Crit Care Med* 2020; 48:1241–1242
14. ATS Bioethics Task Force: Fair allocation of intensive care unit resources. American Thoracic Society. *Am J Respir Crit Care Med* 1997; 156(4 Pt 1):1282–1301
15. El Chaar M, King K, Galvez Lima A: Are black and Hispanic persons disproportionately affected by COVID-19 because of higher obesity rates? *Surg Obes Relat Dis* 2020; 16:1096–1099
16. Solomon MZ: How physicians talk about futility: Making words mean too many things. *J Law Med Ethics* 1993; 21:231–237
17. Wanzer SH, Federman DD, Adelstein SJ, et al: The physician's responsibility toward hopelessly ill patients. A second look. *N Engl J Med* 1989; 320:844–849
18. Council on Ethical and Judician Affairs, American Medical Association: Medical futility in end-of-life care: Report of the council on ethical and judicial affairs. *JAMA* 1999; 281:937–941
19. Kopar PK, Lui F: Surgeon as double agent: Surgeon perceptions of conflicting expectations of patient care and stewardship of resources. *J Am Coll Surgeons* 2019; 229:E18–E19
20. Tilburt JC: Addressing dual agency: Getting specific about the expectations of professionalism. *Am J Bioeth* 2014; 14:29–36

DOI: 10.1097/CCM.0000000000004567

Copyright © 2020 by the Society of Critical Care Medicine and Wolters Kluwer Health, Inc. All Rights Reserved.