Framework for Ethical Resource Allocation to Minimize Moral Injury during the COVID19 Pandemic

Why consider a Framework for Rationing?

- Reduce avoidable moral injury during anticipated COVID19 resource rationing
- Prepare in advance to avoid biased or arbitrary decision making at time of crisis
- Ensure you consciously consider only ethically relevant factors and intentionally ignore ethically irrelevant factors in your clinical decision making
- ↑public trust through transparency and fair resource allocation

Ethical Concepts: *ref:* White et al Ann Int Med 2009

During "usual times" focus is on "Hippocratic" service of individual patients

During Public Health Emergency, focus shifts to public health ethics

- Priority becomes promoting common good over individuals
- Allocation (rationing) decisions are responsibility of public health, implemented by Health Authorities, hospitals, clinicians

USEFUL:

Utilitarianism: greatest good for greatest number (save those who can be saved), determine prioritization using prognostic tools (e.g. CFS)

*Note that "first come first served" and "sickest first" principles are *inconsistent* with greatest good for greatest number (∴ not used)

Life Cycle ("Fair Innings"): goal is to give everyone equal opportunity to live through the phases of life→ prioritizes the young, who have not had that opportunity yet

Maximizing Life-Years: consider years of life saved in addition to number of lives saved. Consistent with Utilitarianism. Potentially a fairer way to consider prognosis than exclusion criteria.

Equity: reduce avoidable differences that are unfair/unjust. Recognize that issues such as systemic racism, language barriers + social determinants of health persist during a pandemic→ inequities likely to be heightened. Be mindful how large scale decision may inordinately burden vulnerable populations

CONTROVERSIAL:

Exclusion Criteria: categorically excludes groups of people by selectively applying automatic exclusion criteria only to them, not to everyone.

e.g. age over 85, vegetative state, end-stage organ failure

Risks include: violates principle of justice, erodes public trust by implying some lives are "not worth saving" (already seen w COVID19 - UK NICE guideline update Mar 25)

NB: Exclusion Criteria don't change allocation outcomes much, but create ethically problematic inequity of eligibility between patients for the application of Utilitarian (prognosis-based) allocation principles. Pts in exclusion groups, if made eligible, would often still be individually denied resource because of poor prognosis.

Allocation Frameworks: (*review your local Health Authority policy*)

Abide by principles of Respect, Minimizing Harm, Fairness, Least Coercive Means, Working Together, Reciprocity, Proportionality, Flexibility, Procedural Justice (including openness and transparency, inclusiveness, accountability and reasonableness) (COVID-19 Ethical Decision-Making Framework, British Columbia Mar 28, 2020)

Hover and ctrl+click over the links below to go to source sites:

A Model Hospital Policy for Allocating Scarce Critical Care Resources (University of Pittsburgh)

[British Columbia Ventilator Allocation Framework (placeholder -2012*being updated*)]

UK NICE guideline (updated Mar 25)

White et al Ann Int Med 2009: Who should receive life support in a Public Health Emergency? Multi-principle allocation strategy that prioritizes based on combo of:

- Most lives saved
- Most years of life saved
- Life cycle principle

- unclear how to weight each item, but potentially more fair than single criteria "most lives saved" strategy;

Resources to talk with patients and families:

1. ***Serious Illness Conversation Guide (Ariadne Labs)*** (see over for *COVID19 Adaptation from Providence Health, Vancouver*)
2. ***VitalTalk COVID19 communication skills*** at www.vitaltalk.org *Conversation guides for Triaging, Admitting, Counseling, Goals of Care, Rationing, Anticipating and Grieving*, plus "SHARE" talking map when rationing:

   Show the guideline: "Here's what our institution / system / region is doing for patients with this condition." (the part directly relevant to that person.)

   Headline what it means for the patient's care: (Note that you talk about what you *will* do first, then what you won't do)

   Affirm the care you will provide: "We will be doing [the care plan], and we hope you will recover."

   Respond to emotion: "I can see that you are concerned."

   Emphasize that the same rules apply to everyone: "We are using the same rules with every other patient in this hospital / system / institution. We are not singling you out."