Ethical Approaches to Who Receives Lifesaving Treatment First

By JUXTA FRANK

How do doctors and patients decide who gets potentially lifesaving treatment and who doesn’t?

A lot of thought has been given to just such a phenomenon, well before critical shortages from the coronavirus pandemic. “It would be irresponsible at this point not to get ready to make tragic decisions about who lives and who dies,” said Dr. Matthew Wynia, director of the Center for Bioethics and Humanities at the University of Colorado.

Facing this dilemma recently — who gets a ventilator or a hospital bed — Italian doctors sought ethical counsel and were told to consider an approach that draws on utilitarian principles.

In layman’s terms, a utilitarian approach would maximize overall health by directing care toward those most likely to benefit from the most from it. If you had only one ventilator, it would go to someone more likely to survive instead of someone deemed unlikely to do so. It would not go to whichever patient was first admitted, and it would not be assigned via a lottery system. (If there are ties within classes of people, then a lottery — choosing by lot — is what ethical recommend.)

In a paper in The New England Journal of Medicine published on Monday, Dr. Ezekiel Emanuel, who has written extensively about the global initiatives and chairman of the Department of Medical Ethics and Health Policy at the University of Pennsylvania, and his colleagues offer ways to apply ethical principles to rationing in the coronavirus pandemic. These too are utilitarian, favoring those with the best prospects for the longest remaining life.

In addition, they say prioritizing the health of frontline health care workers is necessary to maximize the number of lives saved. We may face a shortage of such workers, and some have already fallen ill.

In a recent article in The New York Times, a British researcher said, “There are arguments about valuing the young over the old that I am personally very uncomfortable with,” adding, “Is a 20-year-old really more valuable than a 50-year-old, or are 50-year-olds actually more useful for your economy, because they have experience and skills that 20-year-olds don’t have?”

Dr. Emanuel disagreed with that interpretation. “The 20-year-old has lived fewer years of life; they have been deprived of a full life. If they have roughly comparable prognoses, then the fact that the 20-year-old has not had a full life counts in their favor for getting scarce resources.”

Some organizations, state and federal agencies have anticipated challenges like these and developed resources and guides for hospitals and health systems.

The Hastings Center has created a list of resources that health care institutions can use to prepare for responding to the coronavirus, including for shortages. In 2013, the New York Department of Health released a report on the logistical, ethical and legal issues of allocating ventilators during a pandemic-created shortage. This and many other states’ plans are modeled on guidance from the Ontario Ministry of Health on critical care during a pandemic.

Federal health agencies, including the Department of Veterans Affairs and the Department of Health and Human Services, have also published guidance that includes approaches for allocation of scarce resources during a pandemic.

A study in Chest in April 2019 imagined a 1918 flu pandemic in which there weren’t enough intensive-care beds and ventilators to meet demand. The authors engaged focus groups in Maryland about views on how to ration care. The preference of the focus groups? Direct resources to those with the greatest chance of survival and the longest remaining life spans — in other words, also the pragmatic utilitarian approach. This study stemmed from work for a Maryland report on allocating scarce medical resources during a public health emergency.

“Key is to be transparent about the principles, save as many lives as possible, and ensure that there are no considerations such as money, race, ethnicity or political pull that go into allocation of lifesaving resources such as ventilators,” said Dr. Tom Frieden, president and chief executive of Resolve to Save Lives and former director of the Centers for Disease Control and Prevention.

Another principle recommended by medical ethicists is to take tough choices out of the hands of from-line clinicians. Instead, have dedicated triage officers decide. Also, decisions should be made by levels of financial considerations or the social status of patients, something that seems to have been violated in the provision of scarce ventilators to N.B.A. players, for example.

“Ethically speaking, rationing by ability to pay is the worst way to allocate scarce medical resources in an emergency,” said Dr. Jerry La Forgia, chief technical officer of Acena Global and former lead health specialist for the World Bank.

Nevertheless, precisely this kind of rationing is commonplace in the U.S. health system, with more, not fewer, tough decisions needed as case numbers rise. Health economists have also thought deeply about how to allocate finite health care resources for instance. Often there are winners and losers in these calculations — some treatments covered and some not — but they’re not always individually identifiable.

During a pandemic, the winners and losers are clearly identifiable. They’re to right in front of the doctor at the same time.

“This shifts the ethical and emotional burden from the severity or government to the clinician,” said Christopher McCabe, a health economist and executive director and C.E.O. of the Institute of Health Economics in Alberta. “There’s no perfect way to choose who gets lifesaving treatment. At times like these, society may be more forgiving of utilitarian decision making.”

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