COVID-19 Shortages: Clear guidelines and advanced directives could ease allocation decisions

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ABSTRACT

The ethics that guide decisions on how to distribute scarce resources varies among countries and within the US. Uniformity and encouraging medical directives would ensure more fairness and a better allocation of resources.

Keywords: COVD-19, shortages, advanced directives

INTRODUCTION

Life-saving treatments represent the heart of all medical intervention. Doctors are instructed and pledge to do no harm and to help save all patients to the best of their ability, a difficult task when life-saving treatments require scarce resources. Distributional fairness is of the utmost importance when a pandemic like COVID-19 roars into emergency rooms causing a nonstop pressure for more ventilators. The production of more ventilators is a looming necessity. With so many healthcare workers struggling to maintain any semblance of work life balance, it is with great admiration that we look to them to have answers for us in this time. The ethics that guide decisions on how to distribute scarce resources varies among countries and within the US. Uniformity and encouraging medical directives would ensure more fairness and a better allocation of resources.

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ANALYSIS

Emergency room doctors in New York, which has become the United States' epicenter of the virus, are already struggling. New York has yet to reach the peak of the COVID-19 pandemic's consequences, but the limitations of its hospitals are being exposed. Invasive ventilators are used typically for trauma victims, mostly in emergency situations where the outcome might be unknown. During the pandemic, however, the outcome is starting to show a pattern. With 25 percent of patients requiring ventilation upon ICU admission at New York Presbyterian, the risk of falling short of resources necessary to save lives seems inevitable. In New York, Elmhurst Hospital in Queens has shortages already; critically ill patients died waiting for beds and hospital staff.[1] Thankfully, some efforts have been made to double the capacity for existing ventilators. Novel protocols have been developed at Presbyterian hospital to use one ventilator for two patients. These improvements are critically important and will save lives. With limited numbers of ventilators being provided by the federal government and/or the state, hospitals will reach capacity regardless of efforts to expand resources. Hospitals will need to prioritize patients and decide who will be placed on ventilators.[2] The factors that are likely to contribute to these difficult decisions will test the foundational principles of bioethics. Age, underlying comorbidities, and whether they are a healthcare worker or not are factors that may very well change the course of treatment once there is an extremely limited number of ventilators left for sick patients.

Many patients who are infected with the novel virus are experiencing symptoms for more than 14 days. Their ability to breath can be affected and as we near the apex, more of them may turn to clinical ethicists to allocate ventilators. Arthur Caplan, head of the medical ethics division at New York Medical School, is working to develop a rationing plan that will guide doctors. As more legal protections are granted to doctors and malpractice is less of a worry, it is important that all healthcare workers look to guiding principles that ensure the integrity of care they provide to patients. Guidelines established in New York help to identify patients who have a higher likelihood of surviving the acute incident as decided by a triage committee. Evaluating patients who are most likely to benefit leads to less futile treatment and more successful intervention, potentially maximizing the number of lives saved.[3]

Outbreaks of other viruses should have prepared us a bit more, but the US did not experience cases of SARS or MERS, a known impetus for other countries to boost pandemic preparation. Plans to allocate ventilators or medical care are not often shared throughout the US leaving differences between states. Striking a balance between beneficence and utility, ventilator allocation depends on factors that could limit a patient's likelihood to recover. The fewer factors, the better chance at recovery warranting use of a ventilator. Well, some states have guidelines in place already that might unfairly place more weight on some comorbidities than others. Those with AIDS or mental disabilities in Alabama would be denied a ventilator for reasons discussed in state issued guidelines from 2010. Thomas Cunningham, director of bioethics at Kaiser Permanente West Los Angeles, attempted to gather all guidelines issued across the US in order to solidify some form of national agreement. Another question that has been raised is how long to allow a ventilator to be used by a single patient when there are patients in critical condition waiting to use it. These issues have yet to be solved in the US and elsewhere, but there seems to be an unwillingness to withdraw ventilators once patients are relying on them. In the US, withdrawal of ventilators is common in ICUs when further usage is deemed futile. However, in the midst of the pandemic, withdrawal of a ventilator may come even when there is still a small chance of improvement. Making these decisions can be extremely distressful for clinicians who are otherwise not accustomed to distributing critically low resources.[4] In the Netherlands, citizens have been made acutely aware that rationing will become a reality soon. Doctors have conducted phone calls to screen patients about their end-of-life decisions and some have been accused of age-based bias that has led to improper questioning. Senior citizens made complaints about calls from doctors whom they claimed were advising against COVID-19 treatment for the elderly. However, the Health Minister, Hugo de Jonge, maintains the claims are false.[5][v] Advanced care planning is crucial and actually occurs more often in the Netherlands than in the US. These conversations often have nothing to do with the age of the individual. Importantly, the phone calls occur before

the emergency and the requirement for ventilation, and therefore the people called are not subject to undue influences or fear.

Invasive ventilation and COVID-19 treatment are not appropriate for everyone. Those who would opt out would be giving their spot to another patient in need. Phone calls reaching people before an emergency to encourage health directives are important measures that all countries might want to begin implementing. With many healthcare workers working from home and waiting for redeployment, the phone calls could be made in order to gain a clear picture of where the US population stands on advanced care planning. Upon admission to the ICU, those who wish to be ventilated if needed and those who do not can be placed in separate areas even.

Sometimes, end of life care decisions are accidentally ignored, a problem that could occur more in the mayhem of COVID-19 hospital admissions. In a situation like COVID-19 where the risk of providing someone life-saving treatments who would have refused them would also harm another who must continue to wait is unacceptable. Hospitals must make sure they are doing absolutely everything to honor health directives while saving the lives they can and should.

CONCLUSION

Next time a pandemic hits the US, national policies should be in place to address allocation of life-saving medical resources. Other countries have battled somewhat alone in the COVID-19 pandemic, forcing them to develop strategies to manage their own resources. Some countries have received help from the international community and within the US states can encourage sharing resources. However, in the COVID-19 pandemic, in some countries, the entire health care system is being suffocated and there is neither time nor resources available to rely on neighbors for help. The US should make nationwide decisions soon furthering uniformity of emergency healthcare and fair distribution of scarce resources.

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