Statement on Ethical Triage Guidelines for COVID-19

World Emergency COVID19 Pandemic Ethics (WeCope) Committee (31 May 2020)

Rationale

This is our statement, as experts from many fields, cultures and nations across the world, having realized that tens of thousands of people have died in grim situations of the COVID-19 pandemic not only from the lethal susceptibility that some people have to this novel virus, but also because of insufficient infrastructure, human resources, protective equipment, and/or a lack of clear triage decision making protocols. The severe shortage of resources in response to the overwhelming number of patients needing life-saving treatment has reduced the ability of most healthcare systems to organize a reasonable and ethical method for triage. There have been instances of denial of access of critically ill persons to basic medical care from hospitals, excluding patients above a certain age from receiving life-saving treatments in overwhelmed Intensive Care Units (ICU), and instances where the poor and underprivileged were not given equal and fair access to quality healthcare.

In this context as an independent, multidisciplinary and cross-cultural committee, we urge all to reflect again on the moral foundations of the widely accepted principle of triage, and the reality of healthcare systems unable to cope with the pandemic. We here provide simple, practical, and defensible ethical guidelines for triage management of COVID-19 patients based on the principles of love of life, respect for human dignity, distributive justice, fairness, non-discrimination, shared decision making, and beneficence. The ethical challenges of COVID-19 include observance of the duties to care, promotion of moral equity, planning for uncertainty, support for healthcare workers, protection of vulnerable groups, and provision of practical and ethical policy guidelines. Under no circumstances should the existence of the triage protocol justify negligent public health strategies.

> **Recommendation 1:** ***People need to know the ethical basis and moral justification when they, or their loved ones, are denied treatment or access to scarce resources such as ventilators or denied admission to a hospital.***

Ethical Foundations of Triage

Triage is the sorting and allocation of treatment to patients, according to a system of priorities designed to maximize the number of survivors. It involves articulation of a policy by medical administrators, and/or an assignment by medical professionals of degrees of urgency to patients to decide the order of treatment when there is a large number of them. There are different ethical theories to guide the process of triage in hospitals overwhelmed by COVID-19 patients in need of life-saving treatment. Egalitarianism seeks to treat patients equally; utilitarianism aims to maximize the greatest benefit to the greatest number, measured by the remaining life years that a decision may save; and prioritarianism argues for treating the sickest first, which is the usual practice at emergency rooms in the majority of healthcare settings.

Particularities of Triage for COVID-19

Generally, patients who may be saved through immediate medical attention are treated first; others who can wait are given a lower priority, and those who are unlikely to be saved may not receive treatment with scarce resources that are needed to save lives in the first group. The provision of treatment, therefore, depends on available resources. The difficulty with emergency medical ethics is that the time required for emergency healthcare professionals to make decisions in case of any ethical conflict is limited. Patients may thus be divided into the three categories of *emergency cases* who require immediate treatment, *priority cases* with priority in the queue for rapid assessment and treatment, and *non-urgent cases* who can wait their turn in the queue for assessment and treatment. In COVID-19, the separation of *emergency cases* from others is based on the presence of serious respiratory distress, severe dehydration or shock, mental status changes, and chest pain. In light of reports of people who were not admitted to hospital, rapidly deteriorating when left unsupervised at home, absence of monitoring of COVID-19 patients needs to be carefully considered in the context of the duty of care.

Ethical Objections to Selection of Patients

Selection of patients based on personal characteristics (age, gender, profession, ethnicity, nationality, number of dependents, disability, and so on) violates two fundamental ethical principles: the principle of human dignity which values every human being equally, and the principle of social justice which requires equal opportunities for all. None of the risk factors for predicting a grave outcome in COVID-19 has been proved as definitive in terms of prognosis and thus treatment should not be denied based on an underlying condition. Using old age as an excuse to deny treatment is discriminatory, unethical, and in contradiction with basic social and cultural values. The use of a 'simple cut-off' policy on age constitutes direct discrimination because comorbidities may put a younger person at a disadvantage compared with an older but healthier patient. There should neither be any race, gender or culture-based discrimination so that everyone is treated fairly, as all human beings have inherent dignity.

Recommendation 2: ***Triage committees should be formed in hospitals in preparation for times of crisis, to help assist healthcare professionals decide which patients would get scarce resources based on clinical data.***

Triage Committees in the Context of Bioethics Committees

The healthcare system should establish independent, multi-disciplinary ethics committees, if they do not already exist. Bioethics and triage committees should wherever possible make the difficult decisions, not the bedside health professionals who will keep doing their best for each and every patient. The triage committee should be a small but always available group of 3 highly respected professionals, with two healthcare professionals, for example a physician and a nurse, plus an ethicist. The availability of an ethics committee 24/7 helps in making unbiased decisions and reduces the burden of choice on the healthcare team, who at the time of triage are tasked with saving as many lives as possible.

It has been accepted for years in triage that the most important criterion is survivability, so that only patients who are unlikely to live, even with medical intervention, would be kept off scarce resources such as ventilators, and the highest priority would be for patients who are likely to recover with ventilator support. Ideally, the committee should examine each patient anonymously, and factors like race, ethnicity, and status should not influence their decision. If the committee gives a priority for children who are in the early phases of a normal lifespan compared to an older person in otherwise identical circumstances, it should be a public policy decision of the wider community, noting that it is a form of ageism. as discussed above. Fairness as well as transparency over triage rules are important so that the public can trust the healthcare system in respect with rationing decisions.

Independence of Review and Resources

We recommend separating the clinicians providing care from those making triage decisions through a "triage officer" who communicates the decision to the clinicians, patients and their family, regular review of decisions by a centralized monitoring committee to ensure that there are no inappropriate inequities, and regular review of the triage algorithm to update it based on new information. Sufficient resources should be provided to enable such a system including shared decision making, especially now with the hindsight that we have after months living with COVID-19.

Recommendation 3: ***The protection of the vulnerable is a core ethical principle.***

There should be an upfront commitment to core values at the start of any triage statement. Under certain circumstances, triage is needed to optimize the benefit of the healthcare system to the citizens, when the number of severely sick patients needing intensive care is more than the capacity of the healthcare system to try and save them all. Some frail patients may not be good candidates for aggressive live-saving treatments, especially when the chance of success is dim. We recommend trying to have an informed discussion with frail patients and relatives of the patient before making difficult decisions.

Palliative Care

Triage should prioritize patients who are most likely to benefit from intensive care, in order to maximize the number of lives that can be saved. Triage policies must consider palliative care for patients whose triage decision does not include life-sustaining care, as well as those who are likely to die from COVID-19. Patients who are in a medically futile situation must not be ignored, and can be provided with palliative care to ensure they are pain free. The available usual basic care considered as non-

extraordinary measures, such as food or fluids should not be withheld, either. When patients are severely affected by pre-existing conditions, end-of-life care ethics do not necessarily consider that treatment should be initiated, when it may result in additional suffering, burden or distress for patients. If treatments are expected to aggravate patient suffering, level of care decisions may allow the choice of palliative care without aggressive treatment. Openness and transparency of communication facilitate the difficult discussions about end-of-life decisions. Efforts need to be made to allow family members to be present at the time around the end of life, as regrettably many persons have passed away separated from family members.

Recommendation 4: ***Age, gender, race, ethnicity, existing disabilities, morbidities and/or chronic background conditions should not be used to exclude and/or deny the needed treatment or care to COVID-19 patients.***

Only certain situations may be ethically considered as a priority in triage. Such a consideration should be based on clinical and objective factors, and comply with the protocol approved by a hospital, regional, or national ethics committee[1], in consultation with the broader community, as follows:[2]

a) A competent patient may make an autonomous decision on level of care, such as choosing palliative care over intubation/ventilator use when the chance of success is very low. Patients can also provide an advance directive, or a 'durable' power of attorney as their surrogate, in case they succumb into a more serious situation in later stages.

b) After a patient has been provided with mechanical ventilation, the ventilator may not be withdrawn unless the treatment is determined to be futile and it is needed to try and save another patient who may benefit from it.

c) Do-not-resuscitate-orders are an ethically acceptable practice for patients when medical doctors have good reason to judge resuscitation would be futile.

d) When a number of patients are being considered for allocation of a rationed resource such as ventilators, priority is with those who are more likely to benefit from it. Estimation of likely healthy life-years saved may be included in determination of the potential benefit. This is the only situation where age may be considered, not to deny treatment, but to decide saving whom may significantly increase the life-years saved. The difference in the predicted healthy life years saved should be significant to justify such a consideration.

f) Healthcare workers engaged in the care of COVID-19 patients who get sick and need a rationed resource such as ventilators, can be given priority over non-healthcare workers, because saving them will be to the benefit of many other patients.

g) Prioritization in the form of affirmative action may be considered by the committee as discussed above under "*Ethical Objections to Selection of Patients*".

h) Prioritization in the form of affirmative action may be considered for other emergency responders who become sick while performing their duties to save the lives of others.

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[1] In some countries there may be national laws that restrict the choices suggested in these recommendations; however, these are addressed to persons at all levels including policy makers, administrators, practitioners, patients and family members. We do not suggest persons break their national laws, but reflect and consider legal and administrative reforms.
[2] Deviations from the protocol should be accepted only when approved by the ethics committee, but we note that in some places across our globe, there may be critical human resource constraints. We also note that including a member of a patient rights representative would be an advantage to a triage committee.

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References are available in the background paper:
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