



Thinking Through the Rationing of Ventilators

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When ventilators are in short supply, several key ethical principles can assist clinicians:

- 1) Ventilators should not be rationed based on categorical exclusions such as a patient's age, disability (e.g. being paraplegic) or other secondary traits, but rather on the basis of clinical data including likelihood of survival, organ function and other clinically relevant medical data or test results. Various medical "scoring tools" can be used to objectively evaluate this information about a patient's status and to make comparisons among patients.
- 2) If two clinically similar patients arrive at the emergency room, the allocation of a ventilator to one patient over another can be done on a first-come-first-served basis, a lottery or another randomized approach.
- 3) It is generally immoral to take away without consent the ventilator of a patient still in need of it in order to give it to another patient who may die without it.
- 4) In situations where a patient on a ventilator is clearly deteriorating, and where Covid-19 and its complications can reasonably be expected to cause the pa-

tient's death even with continued ventilator support, dialogue should be initiated with the patient or his designated health care agent to obtain consent to remove the ventilator. Obtaining free and informed consent helps resolve nearly every problematic angle in the ventilator rationing process. Scoring tools can be used to decide which patient's health care agent should be approached first. Attention must always remain focused on establishing and maintaining honest and open communication with the patient, family and the health care agent throughout difficult triage situations.

- 5) Patients who relinquish a ventilator in triage situations, or who cannot be given a ventilator due to lack of availability, should receive not only suitable alternative forms of medical treatment and palliative measures to manage their discomfort, but also spiritual support rooted in their particular religious tradition. This would include visits from a pastor, minister, priest, etc. where final requests, last sacraments, and other needs can be attended to.

Making Sense of Bioethics

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During the Covid-19 crisis, some commentators have recommended taking tough choices out of the hands of front-line clinicians, and handing them over to dedicated triage officers or triage committees to decide. In a recent article in the *New England Journal of Medicine* (NEJM), for example, Dr. Robert Truog and his collaborators offer this approach as a way to “protect” clinicians:

“Reports from Italy describe physicians ‘weeping in the hospital hallways because of the choices they were going to have to make.’ The angst that clinicians may experience when asked to withdraw ventilators for reasons not related to the welfare of their patients should not be underestimated — it may lead to debilitating and disabling distress for some clinicians. One strategy for avoiding this tragic outcome is to use a triage committee to buffer clinicians from this potential harm.”

The main goal during triage, however, cannot be to “buffer clinicians” or “soften the angst” of what is clearly a difficult and challenging set of decisions. Nor is it to “save the

most lives possible in a time of unprecedented crisis,” as proposed in the NEJM article. Nor is it to favor those with “the best prospects for the longest remaining life,” as others have suggested, by relying on a utilitarian calculus that favors the young and the strong.

The goal must instead be to make allocation decisions based on evenly applied practices, as fair as possible, across the spectrum of patients, without turning to biased “quality of life” assessments. Even in a pandemic, the first priority remains the provision of outstanding patient care.

Triage scenarios involve emergency situations. In an emergency, as the plane’s engines flame out, the captain should not be sidelined in favor of a remote “landing committee” working to bring the plane to a safe touchdown. Instead, passengers should be able to entrust themselves to a pilot with professional skills, instincts and expertise, somebody who is fully invested in the critical task at hand. The pilot’s personal involvement in the fate of his passengers mirrors the physician’s accompaniment of his patients in a time of crisis, with these front-line clinicians properly assuming a key role in mak-

ing decisions about the allocation of limited medical resources.

Rather than trying to offload responsibility to a committee to “mitigate the enormous emotional, spiritual, and existential burden to which caregivers may be exposed,” as the NEJM article phrases it, front-line clinicians, together with their patients and/or health care agents, should manage these critical decisions, with triage committees serving in advisory, rather than decision-making or adjudicating capacities.

If rationing becomes necessary, sound ethical principles not only enable responsible triage decisions to be made, but can also help clinicians to avoid panic and calmly accompany each patient entering a health care facility, including those facing their final days and hours.

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