Preliminary and Resource Allocation Statement - Executive Summary

Health care systems and health care professionals (HCPs) should be prepared for public health emergencies (e.g., mass casualty, local epidemics, and pandemics) as have occurred throughout history and will certainly occur in the future. During a major health emergency, HCPs have an ethical duty to provide compassionate and competent care, including making life-and-death decisions as rationally and transparently as possible. This requires advance planning, such as designing decision-making tools and disseminating contingency protocols to alleviate uncertainty and moral distress.

Guiding Biblical Ethics

Christian HCPs understand that all human beings are created in the Imago Dei, the image of God (Gen 2:27), and as such possess a sanctity that is not diminished by any humanly imputed mitigating factors. Therefore, all considerations in triage and allocation decisions based on non-medical criteria should be excluded, such as perceived social worth, social class, ethnicity, age, gender, sexual orientation, religious orientation, political affiliation, economic status, nationality, disabilities, or any other trait that does not impact immediate crisis-related prognosis or survivability.

Guiding Ethical Principles

- Instituting and putting into place broad population-based policies that drastically alter the normal patient-physician relationship should be implemented only if: (1) critical care (life-sustaining) capacity has been, or shortly will be, exceeded despite taking all appropriate steps to increase capacity, AND (2) a duly-authorized authority has declared an emergency.
- Triage in times of medical crisis surge conditions and public health emergencies is directed to the saving of as many lives as possible, seeking to maximize good outcomes for the greatest number of people possible.
- During a major health emergency, there is an imposed shift in a HCP’s duty from providing the most definitive and beneficial treatment to individual patients (the standard of care) to the priority of populations or groups of patients who are most at risk and will most likely benefit with an appropriate stewardship of limited resources (termed sufficient care or crisis standard of care).
- Triage and resource allocation decisions should be objective, formalized, open, and transparent to both HCPs and to the public to the extent conditions allow.

Recommendations:

- **Objectivity**: Public health decisions during a crisis should be based on objective factors, rather than on the choice of individual leaders, HCPs, or patients.
- **Impartiality**: To the extent possible, triage and resource allocation decisions that apply to individual patients should be the responsibility of parties other than the treating physician.
- **Care**: All individuals should receive the highest possible level of care required for survival or limitation of long-term disability given the resources available at the time.
- **Non-essential interventions**: Elective, non-essential interventions lack priority in crisis circumstances.
- **Stewardship**: Appropriate stewardship of scarce critical resources requires triage and resource allocation decisions to be prioritized on the basis of medical need and likelihood for survival.
- **“All Things Being Equal”**: When objective medical criteria do not clearly favor a particular patient (all things being equal), then “first come, first served” rules of allocation or a lottery system should apply.
- **Non-Exclusion**: Those making triage and resource allocation should pay particular attention to the needs of at-risk and marginalized persons, including the poor, the aged, and persons with disabilities, and ensure that they are not denied access to the triage process.
- **Palliative Care**: All patients are still to be afforded the maximal care and comfort that is available, and patient-centered principles of medical ethics still apply. If resources are available, they should be deployed as indicated regardless of the prognosis of the individual patient.
• **Reallocation:** During times of medical crisis, it may become necessary to reallocate life-supportive resources from patients who have little prospect for short-term survival to patients who have increased prospects for short-term survival. These decisions should be impartial, based on standard acuity and short-term prognosis scoring systems, and not based on long-term survival prospects, age, or social value. These decisions must be the responsibility of a triage officer or triage committee and not the treating physician, when possible.

• **Euthanasia/PAS:** Withholding or withdrawal of artificial means of life-support in patients who are clearly and irreversibly deteriorating, in whom death appears imminent and beyond reasonable medical hope of recovery is ethically permissible. This is not to be equated with euthanasia which remains prohibited. (see CMDA’s statements on Euthanasia and Physician-Assisted Suicide)

• **Preparedness:** Governments and healthcare institutions have an ethical obligation to have in place a formalized plan for production, supply and allocation of critical scarce resources through a process that is transparent, open, and publicly debated to the extent time permits.

For a full explanation and defense of these recommendations, see Triage and Resource Allocation During Crisis Medical Surge Conditions (Pandemics and Mass Casualty Situations), which will be available mid-April 2020.