Triage and Resource Allocation Statement - Executive Summary

Health care systems and health care professionals (HCPs) should be prepared for mass casualty incidents (MCI), including disasters, epidemics, and pandemics, as have occurred throughout history and will certainly occur in the future. During an MCI, 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 image of God (Gen 1:27) 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 conviction, political affiliation, economic status, nationality, disability, 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 MCIs is directed to the saving of as many lives as possible, seeking to maximize good outcomes for the greatest number of people possible, but this is not an absolute goal and must not be sought at the expense of higher values held by HCPs who recognize the intrinsic value of all human beings as bearers of the divine image.
- During an MCI, there is an imposed shift in an 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 treatment required for survival or limitation of long-term disability given the resources available at the time. Despite limitations in treatments, all patients should receive humane, compassionate care.
- **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. Either approach recognizes the inherent equality of all human beings.
• **Non-Exclusion**: Those making triage and resource allocation decisions 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 comfort care resources are available, they should be deployed as indicated regardless of the prognosis of the individual patient.

• **Reallocation**:
  - During an MCI, reallocation is defined as the non-consensual withdrawal of life-supportive treatment (in the absence of a properly executed advance directive or decision of a properly authorized surrogate) with the direct intent of transferring that same life-supportive treatment to another patient who is considered a more worthy candidate for such treatment (by any criteria or bias) when the same or equivalent treatment is currently not available.
  - CMDA rejects any form of reallocation as defined above, whether by individual HCPs or by triage officers/committees. Withdrawal of life-supportive resources from a vulnerable patient should never be used as a means to another’s end.

• **Alternative to Reallocation: Optimal Stewardship and Care in a Time of Absolute Scarcity**
  - The difference between reallocation and optimal stewardship is that the former is based on a utilitarian calculus comparing the “worth” or “benefit received” between patients where life-supportive treatment is unilaterally removed from one patient, based on their prognosis at the time, and given to another. The latter is based on the beneficent/non-maleficent treatment and care of each individual patient irrespective of the immediate needs of other patients. Even in an MCI, the good of the individual patient remains paramount.
  - Even when life-supportive treatments are readily available, many patients on life-supportive treatment may become terminally and irreversibly ill with little or no reasonable hope of recovery, from a medical standpoint. All fifty states and the District of Columbia recognize advance directives that permit direct withdrawal of life-supportive treatment under these circumstances. Withholding or withdrawal of life-support in patients is also ethically permissible when:
    - The medical treatment becomes detrimental or no longer is contributing to the patient’s expected goals and outcomes; and
    - The suffering and burdens of a treatment outweigh the intended and foreseeable benefits. (The intention is to avoid those sufferings and burdens, and even if death is foreseen, it is not intended as a means or an end, but is accepted as the natural course of the underlying illness.) See CMDA’s statements on Double Effect and Euthanasia.
  - During worst-case extremes of crisis surge conditions, optimal stewardship of scarce life-supportive resources, such as mechanical ventilation, may require that a more stringent standard (more so than what would occur under normal circumstances of perceived unlimited resources) apply for what constitutes optimal beneficent and sufficient treatment. The ethical appropriateness of continuing or discontinuing treatment is equally applied to all patients. The relative stringency of these clinical standards (e.g., length of a trial of ventilation before a patient improves, percentage estimate of short-term survivability, level of acuity, SOFA or APACHE II score, and similar markers of survivability and benefit from treatment) will vary depending on the severity and magnitude of the MCI or crisis surge condition.
  - Further allocation of available life-supportive resources should be offered only within the bounds of well-communicated time-limited trials appropriate for the patient’s medical condition and the severity and magnitude of the current MCI or crisis surge condition.
  - Any decision to apply more stringent standards for what constitutes optimal beneficent and sufficient treatment should be impartial, based only on standard objective medical acuity including short-term prognosis scoring systems (such as SOFA and APACHE II scores) and not based on long-term survival prospects, age, disability, or social value. These decisions must be
the responsibility of an appointed triage officer or triage committee and not the treating HCP to the extent possible.

- **Persons With Disabilities**: During an MCI or crisis surge condition, persons with disabilities possess the same dignity and worth as others and should not be denied treatments based on stereotypes, assessments of quality of life, or judgments about their relative worth. Treatment decisions should be based on individualized assessments based on the best available medical evidence. For instance, patients with certain spinal cord injuries who are otherwise stable but require long-term use of ventilators should not have their ventilators removed for the purpose of reallocation. Preexisting terminal diagnoses, such as metastatic cancer, end-organ failure (lung, liver, kidneys), or severe dementia, are not considered a disability, but rather a medical condition.

- These situational standards of beneficence should apply to all patients equally. Withdrawal of treatment for any patient should be based solely on those objective medical criteria appropriate to the situation and without deference to another patient who may benefit from subsequent resources that would be made available. Unless continued treatment is determined to be medically non-beneficial with no objective hope of short-term survival, decisions to withdraw treatment should never be unilateral or against the patient’s, or their family’s, wishes but remain a shared decision. Unlike many utilitarian reallocation schemes, these standards and criteria are not to be used to stratify or rank one patient against another, but to optimize the stewardship of limited resources by providing the best possible treatment to each and every patient, constrained by the contingencies of an MCI.

- **Conscience Objections**
  - During worst-case extremes of crisis surge conditions, when an officially declared emergency exists and population-based ethics dominate, non-consensual withdrawal and reallocation of life-supporting resources and/or unilateral decisions not to resuscitate (based on either patient condition or health care provider safety) may be dictated by government public health authorities, by designated triage officers/teams, or by published protocols. CMDA rejects any form of reallocation.
  - Some HCPs may experience moral distress based on their professional commitment to be patient advocates. Treating HCPs should be provided a formal means to appeal and advocate for their patient and/or to conscientiously object to complying with a triage order. At a minimum, HCPs should be provided with the option to step aside and allow another HCP to comply with the order when such appeals are denied. For further information and reflections, see CMDA’s statement Duties of Christian Health Care Professionals in the Face of Pandemics.

- **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. Institutions and governmental authorities also have an ethical obligation for the development, publication, education of HCPs, and practice of triage methods and plans for MCIs.

- **Christian Unity**: Jesus calls us to love one another, so if differences of opinion about ethical issues arise during these challenging times, Christian HCPs should work hard to maintain the unity of the Spirit through the bond of peace.

For a full explanation and defense of these recommendations, see Triage and Resource Allocation During Crisis Medical Surge Conditions (Pandemics and Mass Casualty Situations).