

Management of scarce resources in healthcare in the context of the COVID-19 pandemic

Opinion of the Bioethics Commission

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Context

The COVID-19 pandemic has led the healthcare systems of all countries to question how to best use the existing resources which, under normal conditions, are sufficiently dimensioned. This challenge affects various care institutions (hospitals, doctor's practices, long-term care facilities, mobile care services etc.) and different sorts of resources (number and qualification of staff, medical devices, pharmaceuticals, medical consumables, infrastructure etc.) as well as all cases of medical conditions/diseases which require services of the healthcare systems (not only COVID-19 patients).

The experience in countries which were affected by the COVID-19 pandemic before Austria shows that the usual balance of scarce resources in healthcare provision can suddenly become so acute that the human and material resources are no longer sufficient to try to save the lives of all the people suffering from diseases.¹ As this extreme case presents a dilemma for which there is no ethically or legally satisfactory solution, it is of utmost importance to avoid such a scenario or limit it as much as possible. The following considerations are meant to provide assistance for this situation.

Principles

Despite the emergency situation given the COVID-19 pandemic, the following principles for the ethical assessment remain vital:

1. **Focus of attention:** The specific medical treatment is committed to focusing on the sick person. His or her individual well-being and will are the decisive criteria underlying any decisions. During their specific treatment, collective considerations about the public health can only be considered marginally. In the context of an

1 Rosenbaum L. Facing Covid-19 in Italy — Ethics, Logistics, and Therapeutics on the Epidemic's Front Line. *N Engl J Med*. 2020 DOI [10.1056/NEJMp2005492](https://doi.org/10.1056/NEJMp2005492). Grasselli G, Pesenti A, Cecconi M. Critical Care Utilization for the COVID-19 Outbreak in Lombardy, Italy: Early Experience and Forecast During an Emergency Response. *JAMA*. 2020 Mar 13 DOI [10.1001/jama.2020.4031](https://doi.org/10.1001/jama.2020.4031).

epidemic or a pandemic, the focus shifts towards collective considerations.² The reason behind this is that individuals can only be treated as long as the overall system (health care and other sectors of society) is functioning.

2. **Ethical principles:** Despite this shift towards the responsibility for the collective whole, the specific medical treatment remains committed to its ethical principles and must conform with them as far as possible (optimisation requirement). This implies in particular:
 - a) The duty to explore the will of a sick person as early as possible to determine the extent to which the person would refuse certain treatments anyway (advance care planning).
 - b) The duty to minimise any risks, strain or harm which might arise from the treatment of the person in question and third parties (e.g. staff). This also means assessing to what extent a resuscitation attempt of a person infected by COVID-19 would pose a disproportional risk to the resuscitation team.
 - c) The duty to search for the best possible, even if not optimal, care for the well-being of the sick person, despite the situation of resource scarcity (e.g. extended therapy in non-intensive care, or intermediate care if intensive care is not available; palliative care in absence of a curative goal of care).
 - d) The duty to take decisions in a fair way (e.g. not to decide upon a treatment following subjective criteria, i.e. not to discriminate the person affected).
3. **Binding fundamental rights:** All stakeholders, both in the public sector and in the medical field, are also bound by the values and norms of the constitution and fundamental rights in the context of a pandemic. Regarding the allocation of scarce resources in healthcare, this means in particular the following:
 - a) Equality: Everyone has a right to life (Article 2 ECHR) and other relevant fundamental rights in the medical context, such as in particular the right to respect for private life (Article 8 ECHR). The protection of the individuals and their dignity provided for in these fundamental rights implies the duty to provide healthcare to every person regardless of who they are, in other words, without distinction following non-medical criteria. There is no justification for excluding a person from treatment based on criteria such as their remaining

2 Berlinger N et al. Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19) Guidelines for Institutional Ethics Services Responding to COVID-19: Managing Uncertainty, Safeguarding Communities, Guiding Practice. Garrison, NY: Hastings Center; 2020 [updated 2020 Mar 17; cited 2020 Mar 27]. Available from: <https://www.thehastingscenter.org/ethicalframeworkcovid19/>.
German Ethics Council. Solidarity and Responsibility during the Coronavirus Crisis: Ad hoc recommendation. Berlin: German Ethics Council; 2020 [updated 2020 Mar 27; cited 2020 Mar 27]. Available from: <https://www.ethikrat.org/en/press-releases/2020/solidarity-and-responsibility-during-the-coronavirus-crisis/>.

lifetime or quality of life. At the same time, it needs to be emphasized that there is no right to medical treatment that is not or no longer medically indicated.

- b) Equity: Some people are in need of special support to be able to effectively exercise their fundamental right to life and the access to associated medically indicated treatment, e.g. if they have a physical or mental/cognitive impairment. Such cases require not only the same, but possibly more resources to ensure that they have the same chance as people without such impairments.

Avoiding extreme decision-making dilemmas

Extreme cases involving decision-making dilemmas as a result of scarce healthcare resources can be avoided or the negative effects of these minimised through two approaches that are both necessary in equal measure, i.e. the assumption of clinical responsibility and the assumption of social responsibility.

Assuming clinical responsibility

Clinical responsibility is assumed where established ethical principles in the decision-making process are consistently respected, both for those individuals who have contracted COVID-19 and those patients suffering from another disease.³

3 Bioethics Commission. Dying with dignity. Recommendations on assistance and care for persons in end-of-life situations and related issues. Opinion of the Austrian Bioethics Commission. Vienna: Federal Chancellery; 2015 [updated 2015 Feb 9; cited 2020 Mar 27]. Available from: <https://www.bundestkanzleramt.gv.at/en/topics/bioethics-commission/publications-bioethics.html>
Council of Europe. Guide on the decision-making process regarding medical treatment in end-of-life situations. Strasbourg: Council of Europe; 2014 [updated 2014 May 5; cited 2020 Mar 27]. Available from: <https://rm.coe.int/CoERMPublicCommonSearchServices/Display-DCTMContent?documentId=090000168039e8c5>.

1. **Realistic goal of care:** Any treatment must pursue a goal of care that is feasible under the given circumstances. The circumstances include the patient's medical history, course of treatment so far, the condition and prognosis of the patient and the treatment options that are actually available. The more limited these circumstances are, the more should one consider abstaining from the treatment objective under discussion. Where there has been good reason to pursue a goal of care, a change in this goal, which may also involve purely palliative terminal care, is advisable when the circumstances become restricted.
2. **Careful indication:** Only those medically indicated treatments may be attempted where a goal of care appears realistic in the specific circumstances. This means that the treatment must be both technically feasible and in accordance with the standards of medical science, as well as proportionate in terms of its benefits and disadvantages for the specific individual concerned. This applies e.g. to the use of extracorporeal membrane oxygenation (ECMO = oxygen enrichment of the blood in a circuit outside the body). The scientific evidence in favour of using this extremely resource-consuming and invasive procedure will only be applicable to a few patients. The general rule is that, after this evaluation, any treatment which involves more disadvantages than advantages must be avoided; if this only becomes apparent during the course of the treatment, then it must be withdrawn. Treatment in intensive care is no longer medically indicated if the individual concerned is no longer expected at least to leave the hospital and be integrated into a reasonable living environment.⁴
3. **The will of the individual concerned:** Both the goal of care and the evaluation of the benefits and disadvantages of any treatment must be agreed with the individual concerned. The goal of care or indication must be changed if it transpires that the individual does not support (or no longer supports) a goal of care (even though this may be technically feasible) or considers the disadvantages of a treatment to be more serious than its benefits.

4 Stocker R et al. Intensive-care interventions: Medical-ethical guidelines and recommendations. Berne: Swiss Academy of Medical Sciences (SAMW); 2013 [updated 2013 May 28; cited 2020 Mar 27]. Available from: <https://www.samw.ch/en/Publications/Medical-ethical-Guidelines.html>.

These established ethical principles apply in all healthcare contexts, including outside of the COVID-19 pandemic. The extent to which they are considered in the decision-making process influences whether an individual should be admitted to hospital or transferred from a non-intensive-care unit to an intensive care unit, and therefore also has an impact on the corresponding resource requirements. If a careful examination of the goal of care, indication and will of the individual concerned shows that a specific healthcare procedure is not (or is no longer) justifiable, then this decision is taken based on the individual, and at the same time the burden on the wider collective is relieved, within which another person may require the relevant resource. It is important to stress that this scenario does not involve a triage situation, and is instead based on well-founded ethical decision-making, as should always be the case.

Assuming social responsibility

In order to avoid decision dilemmas in the clinical decision-making process in the context of an epidemic or a pandemic, as is currently the case with COVID-19, while consequently applying the ethical principles, it is crucial that society as a whole is engaged in keeping the infection curve at a level where the healthcare system is not overloaded by a concentrated occurrence of disease (“flatten the curve”). If this social responsibility is not sufficiently recognised, it will sooner or later lead to decision dilemma at least in certain areas of healthcare due to absolutely scarce resources.

Coping with decision-making dilemmas

In a healthcare system, decision-making dilemmas arise when the need for medical resources cannot be met for all those in acute need of them. In the context of the

COVID-19 pandemic, this concerns above all intensive care resources, and specifically the patients requiring mechanical ventilation.⁵ Two scenarios can arise here:⁶

- The treatment hasn't started yet (scenario 1): In this situation, there is a limited number of intensive care resources (intensive care beds, ventilators) available, but there are more people in need of these resources.
- The treatment has already been started (scenario 2): In this situation, the intensive care resources are all occupied and there is at least one more person in need of these resources.

Both scenarios only result in a decision-making dilemma when the necessary treatment for the person at risk cannot be arranged at a different place quickly enough to avert the immediate life-threatening situation. Such an impossibility might be for practical reasons (e.g. no transport available) or normative reasons (e.g. no authority). Whatever the case, the clinical decision makers are subject to the principle that they cannot be obliged to do the impossible.

Attempts at mitigation

Both scenarios can in some cases be mitigated by carers using the established ethical principles outlined above to carefully review whether there is an individual among the people concerned

- who does not require intensive care (e.g. because he or she can be stabilised in an intermediate care unit or normal ward) or
- who does not want to go into intensive care (e.g. because he or she rejected it as part of advance care planning) or
- for whom intensive care would be effectively futile (e.g. because the patient has already suffered multiple organ failure) or disproportionate in relation to the individual concerned (because the individual has in any case reached the end of his

5 Truog RD, Mitchell C, Daley GQ. The Toughest Triage — Allocating Ventilators in a Pandemic. *N Engl J Med*. 2020 Mar 23 DOI [10.1056/NEJMp2005689](https://doi.org/10.1056/NEJMp2005689).

6 German Ethics Council. Solidarity and Responsibility during the Coronavirus Crisis: Ad hoc recommendation. Berlin: German Ethics Council; 2020 [updated 2020 Mar 27; cited 2020 Mar 27]. Available from: <https://www.ethikrat.org/en/press-releases/2020/solidarity-and-responsibility-during-the-coronavirus-crisis/>.

or her life due to an advanced underlying disease or health condition and could no longer survive outside of an intensive care unit, if at all).⁷

If this is the case, withholding intensive care treatment that has not yet started (scenario 1) and withdrawing intensive care treatment that has already started (scenario 2) is justified and a justifiable decision can solve the (apparent) dilemma.⁸

Triage

Triage decisions are made when mitigation is not successful: these involve decisions regarding who should receive a particular healthcare service (intensive care bed, ventilator) and who should not receive it even though they may need it, as measured against established ethical benchmarks. At first glance, the triage decisions in scenario 1 may appear less drastic than they do in scenario 2 because resources are “simply not allocated” in the first scenario, whereas in the latter scenario, resources that have already been allocated are “discontinued” – with the risk accepted in all cases that the individual concerned may die due to the disease. Both situations involving withholding and withdrawing treatment do, however, touch upon the limits of ethical arguments within our society, which has not committed itself to a simple utilitarian maximisation of benefits.

7 Bosslet GT et al. An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units. *Am J Respir Crit Care Med.* 2015 Jun; 191(11):1318-1330 DOI [10.1164/rccm.201505-0924ST](https://doi.org/10.1164/rccm.201505-0924ST).

Kon AA et al. Defining Futile and Potentially Inappropriate Interventions: A Policy Statement From the Society of Critical Care Medicine Ethics Committee. *Crit Care Med.* 2016 Sep;44(9):1769-1774 DOI [10.1097/ccm.0000000000001965](https://doi.org/10.1097/ccm.0000000000001965).

8 ÖGARI Ethik. Therapiezieländerungen auf der Intensivstation - Definitionen, Entscheidungsfindung und Dokumentation. *AINS.* 2013;48(4):216-223 DOI [10.1055/s-0033-1343753](https://doi.org/10.1055/s-0033-1343753).
Intensivmedizinische Gesellschaften Österreichs. Konsensuspapier der Intensivmedizinischen Gesellschaften Österreichs: Empfehlungen zum Thema Therapiebegrenzung und -beendigung an Intensivstationen. *Wien Klin Wochenschr.* 2004 Nov;116(21-22):763-767 DOI [10.1007/s00508-004-0267-x](https://doi.org/10.1007/s00508-004-0267-x).

Several (intensive care) professional medical societies in Austria⁹, Switzerland¹⁰ and Germany¹¹ have been discussing this triage situation in view of the COVID-19 pandemic.

- The approach arising from this aims to save as many people as possible with the extremely scarce resources that are available in a triage situation.
- The short-term probability of survival becomes a decisive point of reference in this situation: in terms of starting (or withholding) and continuing (or withdrawing) intensive care treatment, the prognosis should be based as far as possible on whether the individual concerned will be able to survive the intensive care treatment. Of equivalent value to the objective of life support and survival, the issue of avoiding chronic critical illness¹² must also be used to justify the indication. The term “chronic critical illness” describes a state of surviving a life-threatening situation with resulting permanent and irreversible dependence on intensive care measures. Beyond any consideration of the individual’s “life prospects”, this prognosis aspect is of particular importance in view of the major limitation on resources in a catastrophic situation. The prognosis depends among other things on the severity of the current disease (e.g. COVID-19), as well as on the stages of any possible previous diseases (e.g. chronic lung damage) and physical reserves (e.g. the severity of any frailty syndrome).

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- 9 ÖGARI Ethik. Allokation intensivmedizinischer Ressourcen aus Anlass der Covid-19-Pandemie: Klinisch-ethische Empfehlungen für Beginn, Durchführung und Beendigung von Intensivtherapie bei Covid-19-PatientInnen. Vienna: ÖGARI (Austrian Society for Anaesthesia, Resuscitation and Intensive Care); 2020 [updated 2020 Mar 17; cited 2020 Mar 27]. Available from: https://www.oegari.at/web_files/cms_daten/covid-19_ressourcenallokation_gari-statement_v1.7_final_2020-03-17.pdf.
- 10 Scheidegger D et al. COVID-19 pandemic: triage for intensive-care treatment under resource scarcity. Guidance on the application of Section 9.3 of the SAMS Guidelines “Intensive-care interventions” (2013). Berne: Swiss Academy of Medical Sciences (SAMW); 2020 [updated 2020 May 23; cited 2020 Mar 27]. Available from: <https://www.samw.ch/en/Ethics/Topics-A-to-Z/Intensive-care-medicine.html>.
- 11 Dutzmann J et al. Entscheidungen über die Zuteilung von Ressourcen in der Notfall- und der Intensivmedizin im Kontext der COVID-19-Pandemie. Berlin: Deutsche Interdisziplinäre Vereinigung für Intensiv- und Notfallmedizin (DIVI); 2020 [updated 2020 Mar 26; cited 2020 Mar 27]. Available from: <https://www.divi.de/empfehlungen/publikationen/covid-19/1540-covid-19-ethik-empfehlung-v2/file>.
- 12 MacIntyre NR et al. Management of Patients Requiring Prolonged Mechanical Ventilation: Report of a NAMDRG Consensus Conference. *Chest*. 2005 Dec;128(6):3937-3954 DOI [10.1378/chest.128.6.3937](https://doi.org/10.1378/chest.128.6.3937).
Madrid RA, McGee W. Value, Chronic Critical Illness, and Choosing Wisely. *J Intensive Care Med*. 2019 Aug;34(8):609-614 DOI [10.1177/0885066618790942](https://doi.org/10.1177/0885066618790942).
Leasa D. Chronic Critical Illness. In: McConachie I, Granton J, Fuller J, editors. *Handbook of ICU Therapy*. 3rd ed. Cambridge: Cambridge University Press; 2014. p. 209-220 DOI [10.1017/CBO9781107323919.020](https://doi.org/10.1017/CBO9781107323919.020).

- Clinical Risk Assessment Scores have been used for this for some time now in (intensive care) medicine that aim to make prognoses of this kind as objectively comprehensible as possible. A person who has a more favourable prognosis (probability of survival) with intensive care treatment should be prioritised in a triage situation according to this consideration.
- On the other hand, it would not be professionally relevant to legitimise the use of sole criteria such as age or an externally attested quality of life, either from an ethical point of view or in terms of fundamental rights. Basing any decision on social status or a personal relationship with the decision-makers is of course completely unacceptable.

The short-term probability of survival can be used as a decisive criterion for scenarios 1 and 2 in triage. The following is assumed for triage under scenario 2, i.e. the withdrawing of (intensive care) treatment of a person for whom it would actually be indicated and who has not rejected it themselves in favour of another person who has a higher short-term probability of survival: this other person must be an actual person who exists and not a hypothetical person who may or may not appear.

In terms of decision making in dilemmatic triage situations, the international recommendation is that all possible support services, such as collegial advice or clinical ethical consultation services, should be used to spread the burden of decision making over several decision-makers in order to relieve the pressure caused by moral stress.¹³

Nevertheless, triage remains a dilemma in each scenario because the decision to withhold or withdraw indicated life-saving treatment in favour of another person cannot be justified in the context of legal-ethical values and legal norms, particularly as one life cannot be weighed up against another life according to its quality. For those doctors who have to make such decisions in a catastrophic situation such as a pandemic (the decision to start or to continue intensive care treatment is also such a decision), the exculpatory circumstance provided by the state of emergency is recognised by society and the legal community in view of this dilemma, as expressed e.g. in section 10 of the Austrian Criminal Code (StGB).

13 Marckmann G et al. Möglichkeiten und Grenzen von Ethikberatung im Rahmen der COVID-19-Pandemie (Stand: 26.03.2020): Ein Diskussionspapier der Akademie für Ethik in der Medizin. Göttingen: German Academy of Ethics in Medicine; 2020 [updated 2020 Mar 26; cited 2020 Mar 28]. Available from: https://www.aem-online.de/index.php?id=90&tx_ttnews%5Btt_news%5D=214&cHash=e9f9274452b89861cac91dcb1c96c808.

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