

Universal Do-Not-Resuscitate Orders, Social Worth, and Life-Years: Opposing Discriminatory Approaches to the Allocation of Resources During the COVID-19 Pandemic and Other Health System Catastrophes

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Today's coronavirus pandemic is novel, but the ethical dilemmas it presents are not. In the modern era, physicians have helped patients face the influenza pandemics of 1918, the 1950s, the 1960s, and 2009; HIV/AIDS (1980s and beyond); severe acute respiratory syndrome (2002); and Middle East respiratory syndrome (2015). Physicians cannot do it alone: Institutions must support their efforts (and have a responsibility to provide protection from occupational exposures). Long-standing principles of medical ethics should guide the profession, individual clinicians, health systems, and our society. They must be reaffirmed in the circumstances of health system catastrophes, during which their application—but not the principles themselves—may change. These principles include justice; equity; and, fundamentally, the physician's duty to care for all and not discriminate against a class or category of patients (for example, on the basis of age, race, ethnicity, disability, sex, gender identity, social status, or other personal characteristics) (1).

During a public health catastrophe, although the physician's responsibility remains with the health and welfare of individual patients under his or her care, the well-being of the community must also be considered, including in institutional and other guidelines. Prioritization of resources becomes critical, but prioritization does not mean discrimination against groups.

Fairness does not require that everyone be treated identically, but it does require giving each person his or her due. When crisis triage is necessary, the fairest approach will use clinical criteria applied to individualized patient assessments of likely recovery—not assumptions that disfavor or favor groups. Fairness will not tolerate judgments about worthiness or ask physicians to make quality-of-life assessments.

Some current proposals, including universal do-not-resuscitate orders, social worth, and life-years, contravene fairness and conflict with ethical principles. They risk clinician moral distress and public distrust, further dividing our society.

UNIVERSAL DO-NOT-RESUSCITATE ORDERS

Deciding to not attempt resuscitation for all patients with a particular diagnosis (like coronavirus disease 2019 [COVID-19]) is deeply problematic. The physician's obligations to avoid harm, act in the patient's best interests, and respect the value of each individual require thoughtful balancing of likely burdens and possible benefits of this (and any) intervention. For some patients (with or without COVID-19), the likelihood of

harm is so high and that of benefit so low that resuscitation is not clinically indicated. A blanket approach, however, is not consistent with an individualized, evidence-based, clinical assessment. Clinician health and safety also require attention. Clinicians should not be asked to participate in resuscitation efforts that are not clinically indicated, and policies and procedures should help ensure best practices and availability of personal protective equipment.

SOCIAL WORTH

Recent guidelines from Spain recommend that social worth be considered in rationing decisions (2), recalling the "God squads" that made dialysis determinations in Seattle in the 1960s (3). This is not ethically defensible. It entails judgments in which some categories of persons are deemed less socially worthy than others. Appreciation of the value and dignity of every individual, the humility necessary for making triage decisions, and acknowledgment of social factors that limit opportunity for many persons strongly argue against using social worth or its perception to determine resource allocation.

LIFE-YEARS

Some state guidelines about crisis standards of care and some journal articles promote a "life-years" approach to rationing. Sometimes called a "life-cycle" or "fair innings" approach, it is far from fair, systematically disfavoring older patients, disabled persons, and potentially other groups. Fair approaches evaluate medical need, prognosis, and the effectiveness of treatment for the individual. In a pandemic, the critical question is the ability to survive the acute event, not long-term survival.

One recent article claims concern about discrimination, noting upfront—correctly—that categorical exclusion of large groups from ventilator treatment violates the ethical principle of justice by applying "additional . . . criteria to some patients but not others, without making clear what is ethically different about the patients that would justify doing so" (4). But just because a plan does not set an arbitrary age cutoff or automatically exclude patients with certain disabilities does not mean that it is unbiased.

See also:

Related article

This article's life-years approach proceeds to systematically disadvantage disabled persons and older adults.

The authors support their proposal by asserting that people intuitively prioritize the young (without evidence or recognition that intuitions can be prejudiced; for example, the public once widely supported racial segregation of hospital wards). Moreover, the authors cite an article (5) on organ transplantation that they say provides a precedent for rationing based on life-years, but it is misapplied. That article (5) considered age to determine short-term survival of 1 year (that is, clinical effectiveness of the intervention), not longer survival, life expectancy, or life-years. Also, the contexts are very different. Older patients once were believed to be unlikely to survive the procedure itself; they were not denied a transplant because they had too few life-years to be deserving. In fact, transplants for recipients aged 65 years and older have increased dramatically for lungs—and overall—over the past 30 years (6).

THE RAMIFICATIONS

Crisis triage protocols that contravene ethics are troubling; those doing so while claiming to be ethical and to oppose discrimination against groups are particularly troubling.

The Office for Civil Rights of the U.S. Department of Health and Human Services says that laws about civil rights are still very much in effect during the pandemic, noting that treatment considerations should not include “stereotypes, assessments of quality of life, or judgments about a person's relative ‘worth’ based on the presence or absence of disabilities or age. Decisions by covered entities concerning whether an individual is a candidate for treatment should be based on an individualized assessment of the patient based on the best available objective medical evidence” (7). California's health department has also issued guidance (8).

The aforementioned issues are not theoretical. Everything that can be done must be done to ensure that rationing of resources, such as ventilators and intensive care unit beds, is not necessary during the COVID-19 pandemic. Redistributing ventilators from less affected to shortage areas and using new surge facilities like converted convention centers to increase bed capacity can help. Boosting production of personal protective equipment and ventilators and mobilizing retired health professionals can bridge projected resource gaps. Public health initiatives, including social distancing, hand hygiene, face masks, and self-quarantine, can mitigate spread of the coronavirus.

Resource allocation approaches that advocate disadvantaging older adults, disabled persons, or other groups on the basis of diagnosis, perceived social worth, or predicted life expectancy send a message to all patients that some lives are valued more than others. This will engender distrust in the medical profession—now, when trust is most needed, as well as into the future. The American College of Physicians has said that fairness and ethics require that “allocation deci-

sions [during resource scarcity] should be made based on patient need, prognosis (determined by objective scientific measures and informed clinical judgment) and effectiveness (i.e., the likelihood that the therapy will help the patient recover) . . . [to] maximize the number of patients who will recover” (9).

The challenges and sadness of this pandemic are widespread and deep and include a disproportionate burden for communities that already experience health care disparities. Pitting generation against generation, patient groups against each other, patients against physicians, or physicians against institutions is harmful. We are all in the same boat. When things get tough—especially when things get tough—we must all row in the same direction.

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