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EDITORIAL

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COVID19: Why justice and transparency in hospital triage policies are paramount

1 | INTRODUCTION

At the time of writing, countries across the globe are "shutting down" in response to the spread of COVID19. Breathless local reporting of every single newly identified COVID19 case will soon give way to the more important information about epidemiological trends and the economic impact on individuals and societies, as well as our ability to care for those who are infected and need intensive care in our hospitals. Tragically, we have seen a number of countries both in the global north and in the global south run short of the number of ventilators and Intensive Care Unit (ICU) beds that they needed to serve all those patients who were in desperate need of them. Is it too soon to note the hypocrisy of citizens and politicians standing on balconies, applauding health care workers for their hard work and extraordinary risk-taking, while refusing to equip the health care system in such a way that there would not be a lack of personal protective equipment for these same workers? Reportedly, by the end of March 2020, at least 50 doctors lost their lives, in Italy alone, due to infections incurred as a result of the absence of such equipment.

By chance a Select Committee of the UK Parliament is discussing today, as I write this, guidelines that will determine who gets ventilators in case they are unavailable in sufficient numbers in its National Health Service. Locally, where I am, the main hospital might have policies in place on this, but it is not sharing that information with the public.[1] As far as I know, the institution's criteria that would determine triage decision making, or, indeed, whether the hospital even has policies in place that go beyond the initial A&E screening by a triage nurse, have not been communicated to the community. Surprisingly, this is pretty much replicated across the globe. On bioethics listservs clinical ethicists are scrambling to get information from colleagues about their institutions' triage policies. It is plain stunning that these polices were not in place. The occurrence of an agent like SARS-CoV-2, or worse, has long been predicted by global health experts. Clinical ethicists, as they exist in hospitals, and hospital senior management have had many years to draft triage policies that would be responsive to the current crisis. These policies matter not only because the public needs to know what they are, and that they are justifiable. They also matter for the more pragmatic reason that a time of crisis is not the right time for attending individual healthcare professionals to think through the ethical issues of each case they encounter—they will not have time for that. There should have been well-established institutional policies before the pandemic even started in China.

I want to focus here on two issues, namely the need for fairness in hospital triage policies and the need for transparency about those policies.

2 | FAIRNESS

There is no objectively true answer to the question of who should be prioritized if we run low of ICU beds. However, that does not mean triage decision making is a free-for-all of sorts. Depending on what one society values it may legitimately reach different conclusions to another society in terms of the policies that it enacts. For instance, the abovementioned UK Select Committee might decide today that it is primarily concerned with maximizing the number of human life years that it can preserve with its resource allocation policies. That might seem like an obvious thing to do, and to many this is an uncontroversial proposition. What else should a healthcare system do with its limited resources? Maximize health presumably. If this is what a society decides to do, a number of practical policies would follow, which would need spelling out in hospital triage policies. For instance, patients already occupying an ICU bed, who have a bad prognosis and/or who might need to occupy that bed for a long time, might need to be moved to palliative care only, in order to make the ICU bed available to those with a better prognosis and/or who would need to use that scarce ICU bed for a shorter period of time. Not all patients in need of ICU beds will be the same, and the challenge will be to design fair decision making criteria that permit triage personnel in hospitals to decide transparently and fairly about who, among those in dire need, could benefit, will get access.

A health outcomes focused policy option such as this would likely give healthcare professionals that are necessary for sustaining the operations of the healthcare system priority access to clinical care. This is necessary to ensure there is a sufficient number of professionals available to attend to COVID19 patients, as well as to other patients who will present with other illnesses, as they would have prior to COVID19. It would be a disincentive for any healthcare professional considering the provision of professional services to COVID19 patients if they knew that if they got infected they would find themselves in the same queue as other members of the public. Of course, not every healthcare professional is the same, so mere academic medical qualifications are not what should count toward priority access.

[1]Kingston Health Sciences Centre (2020). COVID-19 information for patients and families coming to KHSC. https://kingstonhsc.ca/covid-19 (accessed March 17, 2020).

Other societies might prefer a different kind of approach altogether. In those societies everyone in need, regardless of individual circumstances and outlook, counts the same. Here the maximization of particular health outcomes is not the objective driving policies. Rather, those societies might be concerned about treating everyone equally, as well as removing friction from the decision making process. In the absence of consequentialist criteria that would permit one to fairly discriminate among those who are queuing for access to an ICU bed, how could such an approach address the inevitable decision making? One option would be to grant access based on a first come, first served strategy. Obviously, if you live in such a society, it might be in your best interest to become an "early adopter", be among the first who take their chances with the virus and so end up receiving the best care available at the time, just before the healthcare system becomes overwhelmed with cases and before it has to make allocation decisions, or at least aim to be high up on the waiting list. Other options include lotteries among those in need of access to services.

There are certain things that are no go's. Nobody should be prioritized based on income, sex, ethnicity and the like. And yet, in practice, that may well happen regardless, for instance if resource poor members of society are unable to report to hospitals, and so fail to join the competition for a place in the queue for ICU beds. It is incumbent on government to design policies that take these patients into account too.

Let us assume that in a given hospital, clinical ethics staff and decision makers got their acts together and have a policy in place. Let us assume my local hospital had a policy in place that was applicable to the current situation: there is still a need for transparency.

3 | TRANSPARENCY AND TRUST

In crisis situations, even more so than under normal circumstances, we want to know what the rules are that affect us. We clamour for security. It helps our mental well-being a great deal to know when our next salary will be arriving, where we will receive our healthcare, and that things are in order, as it were. When that order is challenged and new regulations and policies affecting us emerge, it is vitally important that these policies are communicated clearly, and that they are justified to us. Currently we are in a situation where COVID19 related policies are handed down to us by governments and enforced. In a democracy that can go on only for so long, given that it is unclear what degree of physical distancing is really necessary, and for whom, for instance, in order to achieve exactly what endpoint. It is not uncontroversially obvious that all of the current limitations of our civil liberties are truly necessary to achieve the outcomes that are declared desirable by public health officials.[2] Vast numbers of people depend on surviving in the gig economy, where gigs have all but dried up: just ask your artist friends, the server at your local pub, or your hairdresser. Perhaps governments justifiably err on the side of caution, but there is already a huge price paid by many whose livelihoods and security have evaporated in front of their eyes, based on these policies. Experts in the UK suggest that these kinds of measures would need to be maintained for "potentially 18 months or more … given that we predict that transmission will quickly rebound if interventions are relaxed".[3] This seems unrealistic in the current world economic order. Politicians announce measures every other day in press conferences, looking all crestfallen, but then are more often than not unable to answer basic questions about the rationales for the draconian measures they just introduced. The lack of transparency that led to particular decisions with wide-ranging harmful impacts on workers and their families will, I predict, inevitably lead to a deepening of distrust as far as government is concerned, especially given that it is unclear what the endgame of this is, and how long current restrictions are going to last. This much is at least acknowledged by the lead author of the UK report. He is quoted in the *New York Times* thus: "'We don't have a clear exit strategy', Dr. Ferguson said of the recommended measures. 'We're going to have to suppress this virus—frankly, indefinitely—until we have a vaccine'".[4]

Given predicted—and quite likely—shortages of ICU beds, ventilators and the like, it is of paramount importance to maintain the public's trust in healthcare institutions and the healthcare delivery system that they are part of. That means, we need to be able to trust that decisions about who will gain access to those ICU beds were arrived at in a fair and transparent manner. We need to be able to trust that the team that drafted those guidelines did not design them in such a way that it gives them and their friends and families a fast track to ICU beds, should they need them. Rawls' veil of ignorance and the impartial observers of impartialist ethics are prime candidates for how our guidelines drafters ought to operate. We *are* truly all "in the same boat". This requires of whoever is in charge of designing resource allocation policies currently, to communicate and justify these policies in a transparent manner. In a time where many might reach a state of panic it is necessary to publicize such policies widely, and so, yes, it is unacceptable that these policies are unavailable at the time of writing on my local hospital's COVID19 website, or on that of far too many other hospitals. Hospitals ought to display these policies prominently not only on their websites, but also at their entrances, offer them proactively to patients and their loved ones on admission, etc. Nobody should be under any illusion about the criteria that drive admission decisions and about the normative and empirical rationales that these criteria are based on. Patients and their families have a right to know on what basis the triage nurse and/or attending clinicians decide whether they are admitted to the ICU,

[2]Harmon, A. (2020). Some ask a taboo question: Is America overreacting to the coronavirus? *New York Times*, March 16. https://www.nytimes.com/2020/03/16/us/coronavirus-hype-overreaction-social-distancing.html (accessed March 17, 2020). Osterholm, M.T., & Olshaker, M. (2020). Facing COVID-19 reality: A national lockdown is no cure. *Washington Post*, March 21. https://www.washingtonpost.com/opinions/2020/03/21/facing-covid-19-reality-national-lockdown-is-no-cure (accessed March 28, 2020). Broadhead, A., & Smart, B.T.H. (2020). Why a one-size-fits-all approach to COVID19 could have lethal consequences. *The Conversation*, March 23. https://theconversation.com/why-a-one-size-fits-all-approach-to-covid-19-could-have-lethal-consequences-134252 (accessed March 28).

[3]Ferguson, N., Laydon, D., Nedjati-Gilani, G., Imai, N., Ainslie, K., et al. (2020). Impact of non-pharmaceutical interventions to reduce COVID-19 mortality and healthcare demand. March 16. https://doi.org/10.25561/77482 https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf (accessed March 17, 2020).

[4]Fink, S. (2020). White House takes new line after dire report on death toll. *New York Times*, March 16. https://www.nytimes.com/2020/03/16/us/coronavirus-fatality-rate-white-house.html (accessed March 17, 2020).

or provided with palliative care only, or are refused access to the hospital facilities altogether. They also have a right to know under what circumstances life-preserving care might be ended in favour of palliative care only.

It is one thing that not everyone who could benefit from life-preserving care will be able to access it; it is quite another not to explain how rationing will be undertaken in a given healthcare delivery facility, and how that rationing decision is arrived at. Hospitals in particular, if they have not yet done so, must move fast to set up their decision making frameworks, and they must move fast to transparently communicate those frameworks to the communities which they are tasked to serve.

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