Equipment shortages have put some front-line physicians in the gut-wrenching position of having to decide which patients with COVID-19 get lifesaving interventions. But it doesn’t have to be this way. Many organizations had policies in place for crisis standards of care years before the outbreak. And even if they hadn’t, decisions about rationing care should be made by triage teams, not by ICU doctors in the heat of the moment.

The AMA has created an ethics resource page, "Crisis standards of care: Guidance from the AMA Code of Medical Ethics," that offers expert guidance on allocating scarce resources during a pandemic. Drawing on numerous opinions from the Code, the page provides a comprehensive guide to help organizations ensure responsibility to patients during pandemics.

The new resource joins a plethora of information and guidance from the AMA on the COVID-19 global pandemic. The AMA and the Centers for Disease Control and Prevention are closely monitoring the COVID-19 pandemic. Learn more at the AMA COVID-19 resource center. Also check out pandemic resources available from the AMA Code of Medical Ethics, JAMA Network™ and AMA Journal of Ethics®, and consult the AMA’s physician guide to COVID-19.

First, establish responsibility

The Code does not define specific clinical protocols for allocating scarce resources, the page notes, but it “does provide foundational guidance for developing ethically sound crisis standards of care guidelines.”

“The goal is to make the decisions that happen at the bedside less ad hoc, so that they’re more consistent, fairer and more objective,” said Elliott Crigger, PhD, director of ethics policy at the AMA. “By having a set of standards, we’re not leaving it to somebody who, say, hasn’t slept in 48 hours or someone with a subtle bias against a patient.”

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Among the opinions collected on the resource page are opinion 10.7, “Ethics Committees in Health Care Institutions,” and opinion 10.7.1, “Ethics Consultation,” which provide guidance for establishing triage teams or triage officers who take responsibility for developing and implementing crisis standards of care guidelines. This relieves treating clinicians of the moral burden of decision-making and minimizes conflict among stakeholders.

“Triage teams should include members with expertise, experience and perspective that are relevant in a public health emergency. Triage officers should similarly have appropriate expertise or training,” the page notes, adding that institutions “should provide appropriate support to enable the triage team or officer to meet the needs of the institution and its patient population.”

**Making difficult decisions less so**

On the subject of making and reassessing specific triage decisions, the resource page cites opinion 11.1.3, “Allocating Limited Health Care Resources,” and opinion 5.3, “Withholding or Withdrawing Life-sustaining Treatment,” and features the following guidance:

- Triage decisions must be based on criteria related to medical need, not on nonmedical criteria such as patients’ social worth.
- When criteria of medical need distinguish among patients, allocate limited resources first based on likelihood of benefit or to avoid premature death, and then to promote the greatest duration of benefit after recovery.
- When criteria of medical need do not substantially distinguish among patients, allocate limited resources by an objective and transparent mechanism, such as random choice or lottery to minimize potential bias, as opposed to “first come, first served,” which may unfairly privilege patients who have the means to seek care promptly.
- Periodically reassess ongoing life-sustaining treatments for all patients. When continued treatment is substantially unlikely to achieve the intended goal of care it may be withdrawn.
- Explain the policies and procedures by which triage decisions that allocate life-sustaining treatments are made and provide a process for appealing decisions when such treatments will be withheld or withdrawn.
- Palliative care must be provided when life-sustaining treatments are withheld or withdrawn.

The resource page also cites numerous *Code* principles relevant to fairness and access, as well as opinions on orders not to attempt resuscitation, physicians’ responsibilities in disaster response and preparedness, defining basic health care and physician health and wellness.


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