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Who Gets a Ventilator?

We don't want doctors playing God. Here's how we avoid that.

Imagine that you're a physician at a hospital overwhelmed by the coronavirus. Three new patients have just arrived in your I.C.U., each gasping for air— a 75-year-old grandfather who was in perfect health just a week ago, a 30-year-old woman who has diabetes and asthma, and a 50-year-old I.C.U. nurse who, like you, has been treating coronavirus patients for weeks. Without ventilators, they will likely die, though you can't know that for sure. What you do know is that in your maxed-out hospital, there's only one free ventilator. Is it up to you to choose who gets the chance to live, to play god? "That is the worst possible situation— that individual doctors would be faced with making this tragic choice on their own, based on their own sense of moral values and own judgment." That's what's happening in parts of Italy, where distressed doctors have been seen weeping in the hallways because of the choices they've had to make. Across the US, states are rushing to make sure that no doctor is left to make these painful moral decisions alone and on the fly. They're writing or revising their existing pandemic triage plans, which are meant to guide health care workers in crises like this. But here's the problem. In the United States, there's no agreement on how to make these potentially life and death judgment calls. Instead, the US takes a patchwork approach with different states offering different ethical formulas and some not offering detailed plans at all. As one doctor recently wrote, 'We've taken an every hospital system for themselves approach.' It may be a political problem as much as a medical one that is keeping us from having a national framework. "I think the politics of that would be sensational. I mean, I can't even

begin to tell you what it would feel like to know that the White House issued a model for how to do this, that Americans would then have to point to and say, 'Your model killed my grandmother.' They want it to be state-driven." But in the face of coronavirus, isn't this patchwork inadequate? We need unified thinking on this— a national triage strategy that we can all see and understand. "You can not have triage decision-making that is not transparent. That would be a terrible mistake to have triage decision-making taking place and for the public to be unaware or not to have available what the criteria are that are being used." Any federal plan will have to wrestle with some profoundly philosophical questions. How do we do the greatest good? Does that mean saving the greatest number of lives or the most years of life? Does it mean prioritizing people with the best chances of surviving and leaving the sickest behind? Soon, we're in a labyrinth of complex moral trade-offs. Let's take a few examples, starting with age. Should young people get priority access to ventilators? Some ethicists have advocated for cutoff ages, often around 80, above which nobody qualifies for one. But how old is too old? Some state plans do consider age as a factor. Others don't. Or they use it as a tie-breaker between patients. But isn't that ageist? "It reeks of age discrimination, which is why I said I would make that a second-tier consideration. I would say in the first instance, you're going to make this decision based on who has the better likelihood of survival." Now what about doctors and nurses? Should they get preferential treatment? Again, states are divided. On the one hand, health care workers are essential to fight the pandemic. But on the other hand, it's starting to look like the sickest coronavirus patients may need weeks, if not months to get better. Even if they survive, they may not be able to return to work quickly. "There are other arguments. So one is you are asking people to show up to work and take risks not just for themselves, but for their families. So if you really want people to

take that risk, you need to let them know you have their back, that you will honor their risk-taking. That's always a bitterly disputed topic and should be. I don't want to end up with an intensive care unit that is full of doctors and nurses and the local people are shut out. That is terrible, and that's wrong." What about pre-existing conditions, everything from obesity to cancer? Should doctors try to estimate how many years a patient might live after they've survived the virus and what their quality of life might be? Should doctors take social factors into account, like whether a patient has dependent children? Maybe the most excruciating choice is when doctors should remove ventilators from patients who already have them but don't seem to be improving. There's even an argument that the fairest thing to do would be to assign ventilators randomly through a lottery. A lottery, at least, would treat everyone the same. And wherever we choose, will patients and their families have the right to appeal decisions before some kind of ethics jury? Only a few state pandemic plans even mention an appeals process. There is one thing that almost everyone agrees on. These choices should not be left to exhausted doctors in overflowing I.C.U.'s. The results would be inefficient, chaotic, and maybe unfair. The pressure could also traumatize doctors and lead to a kind of moral burnout. To be clear, hospitals do have ethics committees to help doctors with difficult cases. But in a pandemic, they also need fast-acting response teams making decisions and communicating with neighboring hospitals. A coronavirus plan could offer guidance on how to do that best. It could also encourage cooperation across state lines, something that's not happening much now. "We live in an age of pandemics, and we are not ready. It is now our worst nightmare. We missed a lot of opportunities along the way to prepare not just the health system for this kind of dialogue that we're having now, but also the public writ large." Many bioethicists have been thinking about this for years and have even

proposed specific guidelines for how to deal with a pandemic like this, but no single formula has been formally endorsed at the national level by a government agency like the Department of Health and Human Services or the Centers for Disease Control. Even the American Medical Association, the country's largest association of physicians, offers only the loosest ethical instructions. To be sure, no national plan will be foolproof or binding or can guarantee that doctors won't face tough choices at the bedside. And it would need to be flexible as we learn more about coronavirus. Still, a national strategy would at least encourage a consistent moral approach to this pandemic and prevent the nightmare scenario that worries some experts— people moving sick family members from state to state in hopes of qualifying for a ventilator in a state with different rules. Some experts think national guidelines could come together quickly enough to make a difference. "Our group, the groups in New York, the groups from Seattle and elsewhere— get us all together for a few hours, and I'm pretty sure we could resolve any differences between our plans. We can come up with a plan we would recommend for the country. There's no technical reason that couldn't happen." A federal agency such as the CDC or the Department of Health and Human Services can bring states together to create a unified national triage strategy for coronavirus— one that sets out how America will respond to this crisis not just logistically or economically but morally. We need to know that if the worst comes to pass, our lives are all subject to the same arithmetic.

Link to video:

Who Gets a Ventilator?

By Katie Engelhart and Dominic Smith

We don't want doctors playing God. Here's how we avoid that.

At some American hospitals, ventilators are already in short supply, as a result of the coronavirus pandemic. But what happens when there aren't enough to go around? How

do we decide who gets a chance to live and who dies? The video above argues that the United States needs a national rationing plan. Individual doctors and hospitals can't be left to make these agonizing choices on their own, and the question of who lives and who dies should not depend on what state a patient lives in.

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