

Ethics and evidence: learning lessons from pandemic triage

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As the Northern Hemisphere winter comes to a close, and many are looking forward to (hopefully) the end of the COVID 19 pandemic, there is a need to look back at the lessons to be learned.

One crucial ethical question has been how to allocate limited resources.¹ In this issue, Supady and colleagues criticise two elements of the triage/rationing guidance offered in the first wave.² They suggest that practical experience should lead to A. rejection of the use of triage committees for allocation decisions, and B. rejection of allocation based purely on 'utilitarian principles'. (They focus on preference for patients predicted to have higher survival, but this is only part of a utilitarian approach).³ The authors argue that triage committees should be involved in policy/guidance for hospitals but not in individual patient decisions about allocation of resources. They further suggest that triage decisions should be based on both utilitarian and egalitarian principles.

It is crucial to look carefully at how we might respond differently to future public health crises. There are two important elements to doing that. First we need to carefully evaluate the *evidence* about what worked and what didn't in this pandemic. Second, we also need careful *ethical reflection* and analysis – weighing up the advantages and disadvantages of different approaches.

From that perspective, Supady and colleagues' conclusions might be premature. At this stage there is little or no published data on how triage decisions were approached in countries that faced overwhelming demand on their hospital systems. In the United States, guidelines emphasised that triage decisions should be made by ethics committees or triage officers rather than treating clinicians,⁴ while this did not feature by and large in European guidelines.^{4,5} Supady et al claim that it would have been impractical to rely on committees because of the dynamic situation with large numbers of simultaneous decisions in different locations. That could well have been the case, though evidence is scant. A working group from New York City, convened in November 2020, reflected on the challenge of rapid decision-making in a crisis and the difficulty of applying a committee model.⁶ However, the alternative – leaving it to clinicians to decide, is potentially associated with psychological burden, as well as risking variability and bias in decision-making.⁴ There is a need to look in greater detail at the experience of triage decision-makers during this pandemic. Before rejecting triage committees, it would be important to consider models that have readily available expert ethical advice with panel/committee review in borderline or difficult cases.

Supady et al also argue that because of difficulty in predicting outcome with sufficient accuracy, as well concern about public outcry, utilitarian triage principles need to be supplemented by egalitarian ones.

There is, as yet, little evidence about how clinicians have prognosticated, or how accurate their triage determinations might have been. One recent paper retrospectively applied two different triage frameworks to 40,000 ICU admissions in a pre-pandemic database.⁷ These triage tools did identify patients with a lower chance of survival (if treated with ICU). On the other hand, they only identified a small proportion of patients presenting to ICU as low priority for admission. However, the outcomes for patients with COVID-19 are likely to be different from (and worse than) a historical cohort of ICU admissions. We need to know

how these and other approaches to triage actually worked in the pandemic. Did utilitarian approaches (in places with overwhelming demand) actually lead to more lives and life years saved? Did egalitarian approaches save fewer lives but offer more equal access to those with prior disadvantage? There will then need to be debate about how to weigh up the merits of different approaches.

What of the public acceptance of different ethical approaches to ventilator allocation in a pandemic? That is likely to vary between countries – depending on the impact of the pandemic in the community, on the approach taken to allocation (as well as the degree of transparency and truthfulness about decisions taken⁴) and on the relevant values in the community. One study, conducted with members of the UK general public in mid 2020 suggests a high degree of support for prioritising patients to maximise survival and life years saved.⁸

At the start of this pandemic, health systems needed to urgently develop ethical guidance because they were not prepared to undertake large scale triage in intensive care. There is no doubt that mistakes were made, and decisions taken that, in retrospect, look questionable. It will be important, looking forward, to have advance plans for the next pandemic. But hopefully there is some time now to reflect in the cool light of day on what worked and what didn't, what needs to change, and what approaches were, broadly, ethical.

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