

# Ethics and Resource Scarcity: ASCO Recommendations for the Oncology Community During the COVID-19 Pandemic

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## INTRODUCTION

The COVID-19 pandemic will continue to demand more resources than the US medical system has to supply, likely requiring explicit rationing of ventilators, critical and intensive care beds, and medications, including for patients with cancer. ASCO affirms the inherent worth and dignity of each patient affected by cancer and recognizes that cancer is a heterogeneous disease that differs in its prognosis, progression, and treatment among individuals. Therefore, allocation decision processes should not unconditionally deny patients with cancer consideration for access to scarce resources. Oncologists have a vital role to play in caring for and about their patients if resource allocation becomes needed. ASCO makes the following recommendations to guide oncologists.

### Summary of Recommendations:

- Allocation of scarce resources in a pandemic should be based on maximizing health benefits.
- A fair and consistent prioritization and allocation policy should be developed before allocation becomes necessary.
- ASCO recommends The Hastings Center's "Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic"<sup>1</sup> as a model for approaching ethical decision making in the context of COVID-19 and resource shortages.
- Another useful framework, which provides practical guidance for those making difficult decisions under conditions of severe shortage, is the University of Pittsburgh's "Allocation of Scarce Critical Care Resources During a Public Health Emergency"<sup>2,3</sup> with the following clarification regarding multiprinciple scoring systems:
  - If a policy takes preexisting life-limiting diseases into account, it should do so consistently across types of disease and should consider evidence-based information regarding life expectancy.
  - All cancer diagnoses and prognoses should be considered individually, with input from

the treating oncologist. Cancer diagnosis alone should not be considered terminal, even for patients living with advanced or metastatic disease. Consideration of cancer as either a major or severely life-limiting comorbidity should reflect evidence-based factors, including the individual patient's clinical status and prognosis.

- Decisions regarding allocation of scarce resources should be separated from bedside decision making. The oncologist caring for a patient should not make scarce resource allocation decisions about that patient.
- Oncologists should work with their institutions on how best to use scarce resources for care and support of patients with cancer.
- Oncologists should communicate allocation plans and decisions to their patients with compassion and honesty, and health care institutions should offer support to oncologists in these communications.
- Oncologists should engage in advance care planning discussions with their patients and carefully document patient preferences for goals of care, particularly end-of-life care.

ASCO's intentions with this document are: to recommend practical, actionable, and ethically sound policies at the health-system level for allocation of resources, especially critical care resources; to promote the involvement of oncologists in the implementation and, when possible, the development of these policies to account for the needs of patients with cancer and their care teams; and to offer guidance to oncologists for the role that they might play as they develop and adapt to altered standards that affect care for their patients during these challenging situations. This document should supplement and not supersede applicable local, regional, or national allocation plans developed with the appropriate ethical grounding and expertise and is not intended as clinical, legal, or medical advice.

ASCO members are encouraged to share the following policies with their institutions: the University of

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Pittsburgh's "Allocation of Scarce Critical Care Resources During a Public Health Emergency,"<sup>2,3</sup> which has been adopted by hospitals across the United States, and The Hastings Center's "Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic,"<sup>1</sup> which is a general framework that articulates sound core principles. ASCO recommends referring to either or both of these policy models to improve consistency in decision making during the COVID-19 pandemic within and across institutions. Others that have been similarly vetted, informed by consultation with the public, and built on robust ethical frameworks could also be considered.

This document is not intended to be a guide for making individual allocation decisions. Such decisions should be made at the institutional level, ideally adapted from 1 of the 2 policies identified. Here we aim to provide general guidance to the ASCO community about the rationing challenges we are likely to face during the pandemic. Additionally, we recognize that the disruptions caused by the pandemic place additional burdens on oncologists, who must balance their duties to care for patients with their duties to protect their own health and that of their loved ones. It is essential that health care institutions provide their clinicians and staff with the resources necessary to protect their own health and safety. Adequate personal protective equipment should be a fundamental expectation for all frontline health care professionals.<sup>1,4</sup>

Ethical principles at the forefront of pandemic planning differ from patient-centered approaches that may be more familiar to oncologists. We illustrate these public-oriented principles with examples of allocation demands that might affect the oncology community, offering ASCO recommendations and guidance regarding the role of oncologists.

During typical patient encounters, ethical principles, including respect for autonomy, beneficence, nonmaleficence, and justice, apply to the clinician-patient relationship.<sup>5</sup> Although clinicians, including oncologists, are accustomed to focusing on individual patients, public health emergencies require them to put into practice principles to protect the health of populations as well.<sup>6-9</sup> Multidisciplinary teams may need to ration critical care resources, as well as develop alternative approaches to standards of care, where operating rooms and resources for infusion and radiation treatment become constrained.<sup>2</sup> Many institutions have developed or are developing resource allocation plans keyed to the particular needs, resources, and circumstances of the local community.<sup>2,3</sup>

## DUTY TO MAXIMIZE HEALTH CARE OUTCOMES

In the setting of a public health crisis, the overarching duty that clinicians and health care administrators face is to maximize the benefits to be achieved with the limited available resources. Benefits might be measured by either

lives or life-years saved (of note, using life-years saved as the key outcome implies giving additional priority to individuals with longer life expectancies in the absence of the current acute illness). Regardless of which measure is chosen, priority should be given to individuals with the greatest likelihood of recovery from the current illness. Rationing policies for lifesaving critical care resources should not use assessments about the perceived quality of a patient's life (although patients may wish to articulate their own judgments about quality of life) or perceptions about a patient's social worth.<sup>2,3,6-9</sup> ASCO recommends that the core principle guiding decisions about allocation of scarce resources in a pandemic be made with the goal of maximizing health benefits to be gained with the limited available resources.

## DUTY TO CARE (CLINICIANS TO PATIENTS)

Clinicians have a duty to provide care in the best interests of their individual patients. However, in the setting of scarcity resulting from an emergency, the duty to care for individual patients must be balanced with the duty to care for the population, steward resources, and protect public safety.<sup>1,6,7</sup> Oncologists should continue to fulfill their duty by providing compassionate care to each patient. ASCO recommends that decisions regarding allocation of scarce resources for patients with cancer not be made by the treating oncologists. The oncologist can therefore maintain his or her fidelity to the patient. Oncologists can support informed allocation decisions by providing accurate, up-to-date information about cancer-related prognoses and oncology treatment options that are relevant to the allocation policy.

### Example

If there is a shortage of available beds in the intensive care unit (ICU), a triage officer or triage committee should be tasked with deciding which patient will be transferred to the ICU via a vetted policy (eg, the policies identified by ASCO here), rather than the clinician caring for these patients at the bedside.

### Application to Cancer Care

Oncologists may not always be able to make final decisions about care of their patients who might benefit from scarce resources, and they may experience moral distress if unable to provide the level of care they ordinarily would.

## DUTY TO STEWARD RESOURCES

In the setting of resource scarcity, the duty (of individual clinicians/staff, institutions, and public health officials) to steward limited resources is urgent to maximally benefit the greatest number of patients.<sup>1-3,6-9</sup> ASCO recommends that oncologists work with their institutions to consider how best to use scarce resources for care and support of patients with cancer during the pandemic. This likely will include examining whether individual care plans (eg,

cancer surgery, chemotherapy or radiotherapy, and clinical trial enrollment) can or should be delayed or altered to best steward scarce resources. The role of the oncologist is to advocate for his or her patients, while understanding that not all will gain access to scarce medical resources in a time of shortage resulting from an emergency.

### Example

In the setting of a severe scarcity of a medication, priority may have to be given to those patients receiving the medication with intent to cure their cancer and/or for US Food and Drug Administration–approved or otherwise strongly evidence-based indication.

### Application to Cancer Care

Oncologists will need to communicate with patients/families about why they do not have access to medications (or other medical resources) that are in short supply.

## FAIRNESS

Resources should be allocated based on ethically relevant differences among individuals, free from unjustified favoritism or discrimination. Whether differences are relevant may depend on clinical criteria and the specific resource that needs allocation because of scarcity (ie, some considerations may be relevant to allocation of 1 scarce resource but not for another). Allocation policies should recognize the duties of fairness and equity in the distribution of benefits and burdens across the population of patients and should not widen cancer disparities.<sup>1-3,6-9</sup> ASCO recommends that whenever possible, an explicit prioritization and allocation policy be developed before a resource requires allocation. A cancer diagnosis alone should not keep a patient from having a fair chance to access scarce and potentially life-saving resources. Oncologists should communicate with those developing plans and making allocation decisions at their institutions about oncology-related considerations (eg, cancer-related factors that affect prognosis and data on COVID-19 outcomes in patients with cancer) that might inform fair allocation plans for oncology patients.

### Example

Only 1 ventilator is available, but 2 patients need mechanical ventilation. The choice of who will receive ventilatory support should be made on the basis of factors relevant to the patient's clinical circumstances, potentially including life-years expected to be saved, and the specific shortage.

### Application to Cancer Care

Clinical factors including diagnosis and prognosis may be relevant in allocation decisions. A diagnosis of cancer alone should not preclude access to scarce medical resources, although certain clinical considerations that are known to significantly affect prognosis (eg, widely metastatic,

treatment-resistant disease) may factor into allocation policies.

## CONSISTENCY

Like patients should be treated alike (and have equal access to the resource in scarcity). This does not mean that all patients should be treated alike but rather that allocation decisions should be made according to standardized, vetted criteria, both within a given institution and, whenever possible, more broadly.<sup>2,3,7,9</sup> Criteria should be applied to all patients who might benefit from the resource being allocated. ASCO recommends that oncologists work with teams at their institutions to promote resource allocation plans that fairly, objectively, and consistently consider patients with cancer. Oncologists can help to communicate allocation decisions clearly to their patients and the public.

### Example

Two patients with acute respiratory distress syndrome (ARDS) resulting from COVID, with the same age and comorbidities and being treated at the same hospital, should receive equal consideration for a bed in the ICU, with a lottery (or other random selection method) used to decide between patients with indistinguishable ethically relevant characteristics.

### Application to Cancer Care

Once considerations such as likelihood of recovery from the current critical illness, prognosis associated with the underlying disease, and perhaps age are taken into account, the mere fact of a diagnosis of cancer should lead to neither higher nor to lower priority for critical care resources as compared with other similarly situated patients. The role of the oncologist is to work with multidisciplinary teams (including oncology, critical care, palliative care, and/or other relevant specialties) toward this purpose.

## TRANSPARENCY

Where time and circumstances allow, plans for allocation of scarce resources should be developed with input of the relevant stakeholder communities, including patients, families, and clinicians, to reflect their values and maintain their trust.<sup>1,6,7</sup> Even if plans for resource allocation cannot be made in advance or with the optimal participation of relevant stakeholders such as oncologists, patients with cancer, and caregivers, plans should be made readily available to the public. ASCO recommends that oncologists become familiar with the allocation plans and policies of their institutions and use best practices for health communication so they can have informed conversations about these with their patients.

### Example

Plans for how the triage officer or triage committee will make allocation decisions should be made publicly

available and, if possible, should have input from members of the community.

### Application to Cancer Care

Information about how allocation policies will be applied to patients with cancer should be made available to communities of patients with cancer and other affected groups.

## COMMUNICATION

Truthfulness, compassion, and honesty in communication remain ethically essential during times of emergency, particularly with patients with chronic or serious illness. Oncologists have a responsibility to communicate directly with patients and their loved ones about patients' values and goals of care at all stages of cancer treatment. These conversations should continue to include appropriateness of cardiopulmonary resuscitation and when the patient may prefer comfort care, should his or her condition deteriorate. Without thoughtful advance discussions and documentation of patient preferences by clinicians with whom they have established relationships, patients may be forced to discuss these sensitive matters with strangers while acutely ill and hospitalized. Engaging in these discussions early and revisiting them periodically are particularly important in the setting of resource scarcity. Early advance care planning may identify patients who prefer noninvasive care and potentially minimize demands for scarce resources such as ICU beds or ventilators. Similarly, prior advance care plans alleviate clinician and family decision-making burdens in the setting of acute, life-threatening complications.<sup>1,10-12</sup> ASCO urges oncologists to engage in advance care planning discussions with their patients early and often and encourages the use of advance directives or other expressions of goals of care, including end-of-life preferences. These conversations should be clearly documented in the medical record.

### Example

Two patients have ARDS resulting from COVID-19, but only 1 ICU bed is available. One patient has a previously documented advance directive stating he prefers to die

naturally, without mechanical ventilation or intensive care. He receives goal-concordant supportive care, and the other patient is admitted to the ICU. No rationing decision is necessary.

### Application to Cancer Care

Oncologists should explore and document patients' values and preferences, including patient-reported perspectives on their quality of life and goals of care, while patients are well. These discussions and their documentation should be repeated periodically to avoid making challenging decisions under the pressure of time.

## ACCOUNTABILITY

All those involved in planning and implementing a plan for allocation should be held accountable for the plan and its results. This includes individuals, institutions, health systems, governments, and public health entities. Commitment to transparency can help to ensure accountability before, during, and after settings of resource scarcity.<sup>1-3,6-9</sup> Furthermore, plans should be made to clearly communicate allocation decisions to patients and families affected by them and develop a system of timely appeals for allocation decisions and review of allocation decisions to ensure these are being made fairly and as intended.<sup>1-3,10-12</sup> ASCO recommends that oncologists communicate allocation plans and decisions to their patients with compassion and honesty and that health care institutions offer support to oncologists in these communications.

### Example

An institution that is making allocation decisions regarding scarce ICU beds should review its allocation plan and how ICU beds have been allocated to ensure that the system is functioning as intended.

### Application to Cancer Care

Oncologists should have the opportunity to review and provide input on how allocation plans are applied to patients with cancer.

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#### AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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