

Disclaimer:

The following article has been accepted after peer review for publication in *Journal of Clinical Oncology*. This preliminary version has been posted with author permission and will be replaced with the final published manuscript, after which this preliminary version will be removed. This version, including any author disclosures should be considered preliminary and may contain errors. Suggested citation: Marron JM, Joffe S, Jagsi R, et al: Ethics and Resource Scarcity: ASCO Recommendations for the Oncology Community During the COVID19 Pandemic. *J Clin Oncol* doi: 10.1200/JCO.20.00960

TITLE: Ethics and Resource Scarcity: ASCO Recommendations for the Oncology Community During the COVID19 Pandemic

Authors: Jonathan M. Marron, MD, MPH,^a Steven Joffe, MD, MPH,^b Reshma Jagsi, MD, DPhil,^c Rebecca A. Spence, JD, MPH,^d Fay J. Hlubocky, PhD, MA^e

Author affiliations:

a Dana-Farber/Boston Children's Cancer and Blood Disorders Center, Boston, MA

b University of Pennsylvania Perelman School of Medicine, Philadelphia, PA

c University of Michigan, Ann Arbor, MI

d American Society of Clinical Oncology, Alexandria, VA

e The University of Chicago, Chicago, IL

Acknowledgment: The authors acknowledge the ASCO Ethics Committee and the ASCO Board of Directors for support and feedback on this document. The authors acknowledge the contributions of the following Ethics Committee members who were not authors on this paper, but shared their knowledge and expertise: Abby Rosenberg, MD, MS, MA, and Richard T. Lee, MD.

Corresponding Author: Rebecca Spence, American Society of Clinical Oncology 2318 Mill Road Suite 800, Alexandria, VA 22314 [Rebecca.spence@asco.org], 571-483-1306

Running Head: ETHICS RECOMMENDATIONS DURING THE COVID19 PANDEMIC

No previous presentation

No disclaimers

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

**Approved by the ASCO Ethics Committee April 6, 2020
Approved by the ASCO Board Executive Committee April 7, 2020**

The COVID-19 pandemic will continue to demand more resources than the U.S. 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 heterogenous disease that differs in its prognosis, progression, and treatment for individuals. Allocation decision processes therefore, 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* [1] 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 University of Pittsburgh’s *Allocation of Scarce Critical Care Resources During a Public Health Emergency* [2, 3] with the following clarification regarding multi-principle scoring systems:
 - If a policy takes pre-existing 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 diagnosis and prognosis 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 utilize scarce resources for care and support of cancer patients.
- 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: 1) to recommend practical, actionable, and ethically sound policies at the health system level for allocation of resources, especially critical care resources; 2) 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 3) to offer guidance to oncologists for the role that they might play as they develop and adapt to altered standards that impact 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: 1)

University of Pittsburgh's *Allocation of Scarce Critical Care Resources During a Public Health Emergency* [2, 3] that has been adopted by hospitals across the United States; and 2) The

[Hastings Center Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic \[1\]](#), 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 a robust ethical framework 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 one of the policies identified above. Here we aim to provide general guidance to the ASCO community about the rationing challenges we are very 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 healthcare 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 healthcare professionals [1, 4].

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 for the role of oncologists.

During typical patient encounters, ethical principles, including respect for autonomy, beneficence, non-maleficence, and justice, apply to the clinician-patient relationship [5].

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 [6-9]. 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 [2]. Many institutions have developed or are developing resource allocation plans keyed to the particular needs, resources and circumstances of the local community [2, 3].

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 by the limited available resources. Benefits might be measured either by lives saved or by 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 the patient's life (although patients may wish to articulate their own judgments about quality of life) or perceptions about the patient's social worth [2, 3, 6-9]. **ASCO recommends that the core principle guiding decisions about allocation of scarce resources in a pandemic be maximizing health benefits to be gained by 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 due to an emergency, the duty to care for individual patients must be balanced with duty to care for the population, to steward resources, and to protect public safety [1, 6, 7]. Oncologists should continue to fulfil their duties by providing compassionate care to each patient. **ASCO recommends that decisions regarding allocation of scarce resources for cancer patients not be made by the treating oncologist. The oncologist can therefore maintain their fidelity to the patient. Oncologists can support informed allocation decisions by providing accurate, up-to-date information about cancer-related prognosis 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 (such as the policies identified by ASCO above) 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, public health officials, etc.) to steward limited resources is urgent in order to maximally benefit the greatest number of patients [1-3, 6-9]. **ASCO recommends that oncologists work with their institutions to consider how best to utilize scarce resources for care and support of cancer patients during the pandemic. This likely will include examining whether individual care plans (e.g., cancer surgery, chemo- or radiotherapy, clinical trial enrollment, etc.) can or should be delayed or altered to best steward scarce resources.** The role of the oncologist is to advocate for their patients, while understanding that not all will gain access to scarce medical resources in a time of shortage due to 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 an FDA-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 and discrimination. Whether differences are relevant may depend on clinical criteria and the specific resource that needs allocation due to it being in scarcity (i.e., some considerations may be relevant to allocation of one 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 [1-3, 6-9]. **ASCO recommends that whenever possible, an explicit prioritization and allocation policy be developed before that 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 institution about oncology-related considerations (i.e., cancer-related factors that affect prognosis, data on COVID-19 outcomes in patients with cancer) that might inform fair allocation plans for oncology patients.

Example: Only one ventilator is available, but two patients need mechanical ventilation.

The choice of who will receive ventilatory support should be made based on factors relevant to their 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, though certain clinical considerations that are known to significantly affect prognosis (e.g., 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 [2, 3, 7, 9]. Criteria should be applied to all patients who might benefit from the resource(s) 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 ARDS due to COVID, with the same age and comorbidities and being treated at the same hospital, should receive equal consideration for a bed in the intensive care unit, 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 neither lead to 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 multi-disciplinary 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 [1, 6, 7]. Even if plans for resource allocation cannot be made in advance or with the optimal participation of relevant stakeholders such as oncologists, cancer patients, and caregivers, plans should be made readily available to the public. **ASCO recommends that oncologists become familiar with their institution’s allocation plans and policies 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 member(s) of the community.

Application to Cancer Care: Information about how allocation policies will be applied to cancer patients should be made available to cancer patient communities 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 the patient’s 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 the patient’s 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 non-invasive 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 [1, 10-12]. **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 due to COVID but only one ICU bed is available. One has a previously documented advance directive stating they prefer to “die naturally” without mechanical ventilation and/or intensive care. They receive goal-concordant supportive care while 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 plans 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 (see above)

can help to ensure accountability before, during, and after settings of resource scarcity [1-3, 6-9]. Further, plans should be made to clearly communicate allocation decisions to patients/families affected by them and to develop both a system of timely appeals for allocation decisions and review of allocation decisions to ensure these are being made fairly and as intended [1-3, 10-12]. **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.

References

1. Berlinger N, W.M., Powell T, et al. *Ethical framework for health care institutions & guidelines for institutional ethics services responding to the coronavirus pandemic: Managing uncertainty, safeguarding communities, guiding practice*. [Web] 2020 [cited 2020 April 7]; Available from: <https://www.thehastingscenter.org/ethicalframeworkcovid19/>.
2. White DB, L.B., *A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic*. JAMA, Published online March 27 2020.
3. White DB, H.S., in *A model hospital policy for allocating scarce critical care resources*. 2020, University of Pittsburgh: Department of Critical Care Medicine, School of Medicine.
4. (CMSS), C.o.M.S.S. *CMSS Issues Statement on Personal Protective Equipment*. 2020 [cited 2020 April 7]; Available from: <https://cmss.org/cmss-statement-ppe/>.
5. Beauchamp TL, C.J., *Principles of biomedical ethics*. 6 ed. 2009, New York, NY: Oxford University Press.

6. Control., C.f.D., *Ethical Considerations for Decision Making Regarding Allocation of Mechanical Ventilators during a Severe Influenza Pandemic or Other Public Health Emergency*. 2011.
7. Hick, J.L., D. Hanfling, M. K. Wynia, and A. T. Pavia. *Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2*. . NAM Perspectives. 2020 [cited 2020 April 7]; Available from: <https://doi.org/10.31478/202003b>.
8. Persad G, W.A., Emanuel EJ., *Principles for allocation of scarce medical interventions*. Lancet, 2009; 373(9661):423-431.
9. Emanuel EJ, P.G., Upshur R, et al., *Fair Allocation of Scarce Medical Resources in the Time of Covid-19*. The New England Journal of Medicine, 2020.
10. VitalTalk. *COVID Ready Communication Playbook*. [cited 2020 April 7]; Available from: <https://www.vitaltalk.org/guides/covid-19-communication-skills/>.
11. Center, M.M.R.C. *Oncology Language for the COVID-19 Pandemic*. [cited 2020 April 7]; Available from: <https://www.rogelcancercenter.org/cancer-patients-and-covid>.
12. Truog RD, M.C., Daley GQ, *The Toughest Triage — Allocating Ventilators in a Pandemic*. The New England Journal of Medicine, 2020.