Allocation of Medical Resources

MMID Assignment 2

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The exhaustion of medical resources - ventilators, beds etc - presents itself as a major challenge pertaining to the current global pandemic. Whilst pragmatic decisions are made daily, our actions in this time of crisis imply an ethical stance. Physicians are burdened with the inescapable task of making a value judgement of individual's lives, clearly these actions are not without both practical & psychological consequences.

Scenario

Healthcare systems are under-resourced & many hospitals are faced with insufficient ventilators, beds & other medical resources & as such need to prioritise some individuals over others. The general consensus is that the standard 'first-come-first-serve' allocation process is unjust & medical treatment should be allocated in more thoughtful ways.

Italian physicians have faced this dilemma to the greatest extent thus far. In attempt to best tackle the issue, a number of health officials have released guidelines. Many of the guidelines are structured such:

"The top consideration is maximising benefits in terms of the number of lives saved and the number of life years saved"

Balanced with the likelihood of recovery.
When simplified to this extent most can agree, however operating in this framework implies a value judgement, prioritising some lives over others.

Ethical Questions

Should those with mental retardation or physical impairments have less access to medical care?

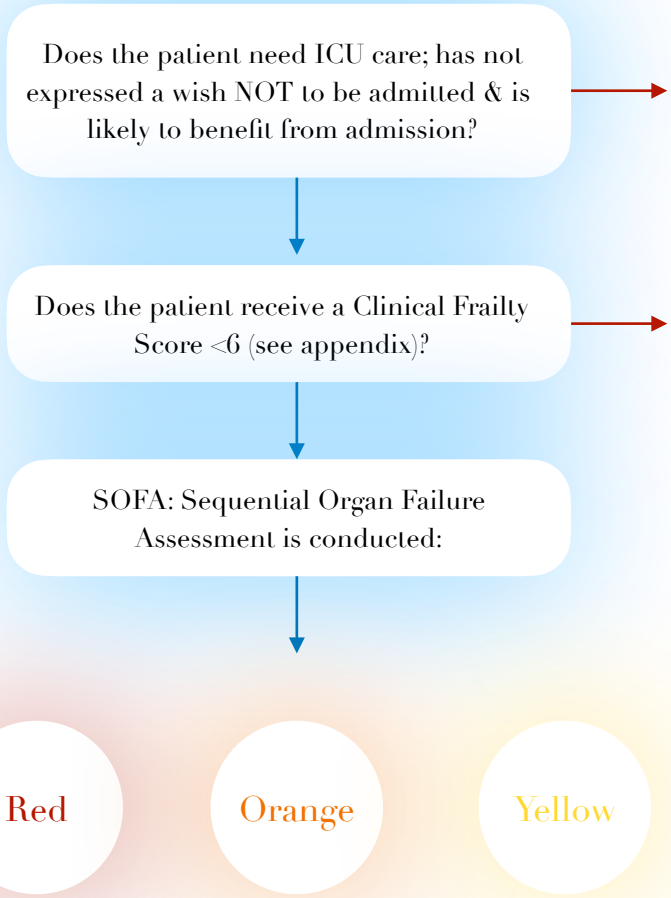
Is it a violation of human rights?

What about the elderly?

Should an individual be removed from ICU on the grounds of a 'fitter' individual needing the bed?

Admission to ICU in SA

As per the CCSSA, decisions of ICU admissions in South Africa are made as follows (for Covid & non-Covid cases):



Resulting in a ranking system that prioritise care given to individuals to maximise the number of life years saved. Further ties are handled in age categories [12-40, 41-60, 61-75, 75+]; Individuals whose work supports provision of acute care to others & lower rank priority score from above

SWOT Analysis

Strengths	Weaknesses
Having such a precise set of guidelines in place alleviates the cognitive burden of decision making from medical staff. Allowing them to focus their attention on performing where needed.	Strict policy implementation fails to assess patients on a patient-by-patient basis. Individualising circumstances is not only more humane, it may result in more life years saved.
The triage structure of removing decision making from those involved in the actual patient interactions alleviates some of the guilt felt by medical staff needing to turn away individuals that do not qualify - an excess, unwarranted stress. Additionally, the removal allows for professional, analytical decision making.	The structure relies heavily on adequate medical staff, in terms of numbers and experience. This can result in staff being spread out too thin and not being able to fully coordinate and treat the complexities of all their patients (in ICU or not). The structure is heavily disadvantaged towards patients with any prior illnesses/conditions as well as patients who are of an older age.
The medical system is allowed the opportunity to run at maximum efficiency - without wasting time on repetitive decision making.	Many communities, particularly the physically disabled & thus dependent, feel this to be a violation of their human rights.
	The primary triage is the foundation of further analysis, trying to complete it in 90 minutes may results in missing key aspects of patients' conditions and needs. Furthermore, the procedure is complex and requires varies inputs to complete the scoring
	The decision maker could be subject to subconscious biases which can have dire consequences for patients. If the the decision making is left to a single entity, there is no supervision of the scoring of patients
	The conditions pertaining to ranking those with equal scores, specifically due to their occupation, is not inclusive of all critical occupations and different levels of occupations should also be considered.

Opportunties	Threats
Many doctors have been attending daily conference calls to cope with the trauma by discussing events with other having similar experiences. Not only does this begin to change the culture within the medical profession, it highlights awareness of the great psychological burdens faced.	The mental health of physicians & medical staff is under great strain. War-like conditions mean that medical staff face great ethical dilemmas daily. A massive psychological burden.
Break-points will be identified in the medical system. Pushing resources to the extremes highlights shortcomings, allowing for a better medical system to evolve overtime.	Members of the public who feel their human rights have been neglected could be left deeply unsatisfied & develop a distrust of the state.
Open a philosophical discussion about the value judgement of human life - revealing insight into the morality, ethical stance & philosophical schools of different individuals	The government could make changes to the structure or laws regarding critical care at any moment. Changes that dampen the success of the structure or increases the burden on the decision maker(s), could result in less lives saved.
Prepare us for future human rights issues faced by the medical establishment	The structure does not fully define every possible scenario and thus relies on experiences staff members, of which there is a limit to nationally and globally.
Through the scoring and documentation process the country expands its database of people living in South Africa (citizens or not). Furthermore, a greater understanding of the country's needs with respect to critical care is gained through continuous documentation.	There is the chance that the current structure is inadequate to handle mass ICU/ventilator needs in the near future due to its timely procedure and intricate scoring system.
	The structure opens itself up to legal implications and problems due to the quick scoring and ranking of patients.
	Due to the seriousness of patients in ICU and on ventilators as well as the great attention that these patients need, the hospital/clinic can be functioning at poor/inadequate levels in its other units and jeopardise the care of other patients.

Philosophical & Ethical Principals

Regardless of whether conscious & explicit or negligent & implicit, resource allocation decision are made. How do the action of those involved comment on the value judgements we make as a society? The classic anecdotal 'trolly-problem' is brought to life when a physician needs to remove a terminally ill patient from ICU to assist a struggling young adult - this is no different from pulling the lever in the trolly case. At what point have we crossed the line of human rights?

By outlining this framework, we have implicitly judged some lives more than others. From a distance these decisions are beautiful as it we are working as a society for the great of the collective - an unprecedented act in the contemporary indulgences of the self. Though close-up these decisions are not beautiful, they are horrific, though some more horrific than others.

Default Exclusion

References

Gopalan, D., Levy, B., Joubert, I. and Paruk, F., 2020. *Allocation Of Scarce Critical Care Resources During The COVID-19 Public Health Emergency In South Africa*. 3rd ed. [ebook] Critical Care Society of Southern Africa. Available at: <https://criticalcare.org.za/wp-content/uploads/2020/06/V3-2020-May-05-Allocation-of-Scarce-Critical-Care-Resources-During-the-COVID-19-Public-Health-Emergency-in-South-Africa-FINAL-.pdf> [Accessed 1 July 2020].

Appendix

Clinical Frailty Scale*

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 Managing Well – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months,** who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.