

**Pellegrino Center for Clinical Bioethics
Georgetown University Medical Center**
**Ethical Principles of Resource Allocation In the Event of an Overwhelming Surge
of COVID-19 Patients**

We are guided at all times by our commitments to clinical excellence, compassionate care, and justice for all, in the spirit of cura personalis. We applaud the professionalism and dedication of our physicians, nurses, and other health care professionals. We applaud the patient-centeredness and teamwork of all our associates. These values and virtues inform our response to the COVID-19 crisis, as specified in the following statement of principles in anticipating the possibility of a surge of patients that might threaten to overwhelm our resources.

1. All patients (or surrogates of patients) with COVID-19, like all other patients, should be asked whether they wish to forgo life-sustaining treatments such as intensive care, CPR, or intubation. Informed refusal of these interventions should be respected.
2. All alternatives should be pursued before engaging in the rationing of ventilators or ICU care. These include therapies that are equivalent or nearly equivalent, sharing of equipment with other institutions, transfer, or even, with consent, therapeutic innovation with a reasonable prospect of success.
3. If rationing becomes necessary, it should be based on patient need, prognosis, and the prospect of success for therapy (i.e., chances that the patient will recover). This should be based on objective clinical criteria such as an assessment of known prognostic factors and the patient's pre-morbid and COVID-19-specific health status, aided, where possible, by an objective clinical score such as SOFA or APACHE II.
4. Rationing decisions should not be based solely upon age or disability. Rationing decisions should not be based on judgments of social worth or on a principle of maximizing total life-years or total quality-adjusted life-years saved. Age and disabling pre-morbid conditions might count among a number of factors in assessing prognosis or prospects of success, but there should be no arbitrary age cut-offs nor any arbitrary exclusions from care based on specific cognitive or motor disabilities. Rationing decisions should be based upon whether the treatment is worthwhile, not on whether the patient is worth treating.
5. Rationing judgments should be made by a two to three-person triage team with both clinical and ethical expertise, independent of the caregivers.

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6. DNR orders should be written with patient or family consent as deemed medically appropriate per usual hospital procedures. Per hospital policy, CPR can be withheld unilaterally from patients in whom it would be biomedically futile (that is, to a reasonable degree of medical certainty it would either be ineffective or repeatedly necessary with the patient dying in a very short period of time even if it is temporarily successful in restoring a heartbeat). There should be no blanket policy of never performing CPR on any and all COVID-19 patients. One can imagine, for example, an otherwise healthy patient with atherosclerotic heart disease for whom the hypoxemia of a COVID-19 pneumonia causes acute ischemia, for whom CPR might be effective and beneficial. All necessary precautions should be undertaken to protect other patients and staff from infection with the SARS-CoV 2 virus during any resuscitative attempt.

7. Ventilator care should not be withdrawn unilaterally based solely on the judgment that another patient has a better chance of recovery. Ventilator care can be withdrawn, per hospital policy, based on a discussion with the patient or surrogate that the burdens of treatment outweigh the benefits. Ventilator care can be unilaterally discontinued if it becomes futile (i.e., if it is judged that, to a reasonable degree of medical certainty, the patient will not survive to hospital discharge even if ventilator care and other life sustaining treatments are continued).

8. All patients deserve our very best care, including attention to their symptoms, psycho-social and spiritual needs, and attention to the needs of their loved ones. Patients who are not expected to survive should receive palliative care consults, recognizing that palliative care resources may also be strained and alternative palliative care models may be needed.

The ethics consult service will be available for advice on any specific cases.