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Ethical Considerations

Care of the Critically Ill and Injured During Pandemics and Disasters: CHEST Consensus Statement

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BACKGROUND: Mass critical care entails time-sensitive decisions and changes in the standard of care that it is possible to deliver. These circumstances increase provider uncertainty as well as patients' vulnerability and may, therefore, jeopardize disciplined, ethical decision-making. Planning for pandemics and disasters should incorporate ethics guidance to support providers who may otherwise make ad hoc patient care decisions that overstep ethical boundaries. This article provides consensus-developed suggestions about ethical challenges in caring for the critically ill or injured during pandemics or disasters. The suggestions in this article are important for all of those involved in any pandemic or disaster with multiple critically ill or injured patients, including front-line clinicians, hospital administrators, and public health or government officials.

METHODS: We adapted the American College of Chest Physicians (CHEST) Guidelines Oversight Committee's methodology to develop suggestions. Twenty-four key questions were developed, and literature searches were conducted to identify evidence for suggestions. The detailed literature reviews produced 144 articles. Based on their expertise within this domain, panel members also supplemented the literature search with governmental publications, interdisciplinary workgroup consensus documents, and other information not retrieved through PubMed. The literature in this field is not suitable to support evidence-based recommendations. Therefore, the panel developed expert opinion-based suggestions using a modified Delphi process.

RESULTS: We report the suggestions that focus on five essential domains: triage and allocation, ethical concerns of patients and families, ethical responsibilities to providers, conduct of research, and international concerns.

CONCLUSIONS: Ethics issues permeate virtually all aspects of pandemic and disaster response. We have addressed some of the most pressing issues, focusing on five essential domains: triage and allocation, ethical concerns of patients and families, ethical responsibilities to providers, conduct of research, and international concerns. Our suggestions reflect the consensus of the Task Force. We recognize, however, that some suggestions, including those related to end-of-life care, may be controversial. We highlight the need for additional research and dialogue in articulating values to guide health-care decisions during disasters.

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ABBREVIATIONS: DNR = do not resuscitate; IRB = Institutional Review Board; MCC = mass critical care

Summary of Suggestions

Triage and Allocation

1. We suggest resources not be held in reserve once a mass disaster protocol is in effect.

2. We suggest disaster and pandemic policies reflect the broad consensus that there is no ethical difference between withholding and withdrawing care and that education regarding such policies be incorporated into training.

3. We suggest triage systems based even on limited evidence are ethically preferable to those based on clinical judgment alone.

4. We suggest critical care resources be allocated based on specific triage criteria, irrespective of whether the need for resources is related to the current disaster/pandemic or an unrelated critical illness or injury.

5. We suggest it may be ethically permissible to use exclusion criteria for critical care resources, since the advantages of objectivity, equity, and transparency generally outweigh potential disadvantages.

6. We suggest protocols permitting the exclusion of patients from critical care during a mass disaster based on a high level of ongoing resource consumption may be ethically permissible.

7. We suggest it is ethically permissible to identify certain resource intensive therapies, procedures or diagnostic tests that should be limited or excluded during crisis standards of care.

8. We suggest policies permitting the withdrawal of critical care treatment to reallocate to someone else based on higher likelihood of benefit may be ethically permissible.

9. We suggest patients who do not qualify under a mass critical care (MCC) protocol for critical care receive do not resuscitate (DNR) orders.

10. We suggest specific groups, eg, health-care workers or first responders, not receive enhanced access to scarce critical care resources when crisis standards of care are in effect.

11. We suggest age of entry for adult critical care units be adjusted down during MCC emergencies that effect substantial numbers of children.

12. We suggest active life-ending procedures are not ethically permissible, even during disasters or pandemics.

Responding to Ethical Concerns of Patients and Families

13. We suggest hospitals communicate the definition of crisis standards of care clearly to patients and families both on admission to the hospital and when triage decisions are communicated.

14. We suggest patients triaged to palliative care be notified of their right to discuss concerns and receive support from hospital personnel, including palliative care, social work, or ethics.

15. We suggest hospitals include ethics resources in planning for MCC and should anticipate a

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