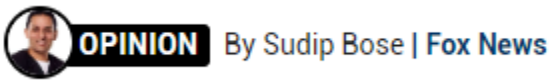
Dr. Sudip Bose: Coronavirus triage — Who gets the ventilator? Who decides?



By Sudip Bose | **Fox News**

As the COVID-19 pandemic began sweeping the U.S. in March, health care institutions and medical personnel were concerned about making excruciatingly difficult decisions about who lives and who dies due to anticipated shortages of ventilators.

U.S. hospitals feared facing the same grim reality that doctors in northern Italy confronted for several weeks – continuing ventilation for patients who are unlikely to survive meant denying ventilators to patients who still had a chance of beating the virus.

I'm an emergency room doctor in Odessa, Texas, a medium-sized city in a metropolitan area of about 250,000 people. Like our counterparts in much larger cities, we prepared for an influx of coronavirus cases and the strong possibility that we would have to remove lifesaving care away from some patients in favor of others.

Faced with the possibility of triaging health care, many hospitals reexamined their ethical guidelines regarding care in the case of pandemic or mass casualty event like a mass shooting or a bombing.

Ethical Choices

As a physician in the Iraq war, I often confronted battlefield situations with multiple casualties. Medical training prescribed my response. First, focus on those who were wounded most severely and required immediate care to survive and, second, treat those who were badly hurt and in great pain, but were not in danger of dying.

The most heartbreaking decisions I had to make was when I encountered unconscious patients who were close to death. With dozens of others who could be saved desperate for medical attention, I had to let go of the dying patients. It was an awful feeling.

On the battlefield, I made these critical triage decisions on my own.

As a civilian doctor in a U.S. hospital, I was shocked to be called upon to confront the possibility of rationing care in the face of COVID-19. Faced with the realities of the pandemic and no better alternative, my colleagues and I determined that these types of triage decisions would be made by teams of doctors who would compare notes on all our patients and create a list of those most

likely to live and those most likely to die. It is a heartbreaking exercise and one I will never grow accustomed to.

Deciding who lives or dies is a complex moral calculation. Medical ethicists look to three philosophical approaches to inform this decision-making process.

Utilitarianism guides us in questioning which actions will produce the greatest good for the greatest number. To a large degree, this principle governed our practice of medicine on the battlefield. Although this approach instructs us to let the dying go and treat the rest, we did everything we could to save every life possible with the resources we had.

There's much we can learn from the COVID-19 pandemic to help us prepare better for future outbreaks or other situations that could potentially overburden our medical resources.

Egalitarianism – When there are many people who stand to receive the same benefit from a particular treatment, how do you prioritize one human life over another? In other words, if you have one ventilator and five people with equal survivability chances, who gets the ventilator? Egalitarianism would suggest you choose randomly – not on the basis of social standing, wealth or even who is the best person.

Social worth – If considering social worth, you would choose who gets the ventilator based on some calculation of the patients' contribution to society, age, family status or other criteria. Obviously, these are subjective decisions and extremely tough to call for all concerned, hence a consultative team approach to this analysis is worth considering here.

What We've Learned So Far

There's much we can learn from the COVID-19 pandemic to help us prepare better for future outbreaks or other situations that could potentially overburden our medical resources.

- Emergency room doctors shouldn't have to face these situations in a rich country. Resources should be inventoried for pandemics and mass tragedies.
- Not all pandemics are alike. Ebola spreads more slowly than COVID-19, but has a much higher fatality rate. We must be prepared for diverse types of disease outbreaks.
- In the current pandemic, we continue to face shortages of personnel protective equipment, like gowns and masks. The United States needs to keep a larger reserve of PPE, and we need to consider increased domestic production of the same.
- COVID-19 should be a catalyst for improving health care access and reducing health care costs.
- Experts need to prepare and plan more effectively. In the current pandemic, it sometimes feels like we're building the plane as we try to fly it.

The last few weeks have resembled war-like conditions in our emergency room. It doesn't have to be that way in the future. We need to learn our lessons well and make sure we're better prepared the next time for a global pandemic.

https://www.foxnews.com/opinion/coronavirus-triage-who-gets-ventilator-who-decides-dr-sudip-bose