



Perspective

Covid-19 Crisis Triage — Optimizing Health Outcomes and Disability Rights

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On March 28, 2020, the Office of Civil Rights at the Department of Health and Human Services (HHS) opened investigations into recently released critical care crisis triage protocols.¹

Disability rights advocates are urging Congress to prohibit crisis triage based on “anticipated or demonstrated resource-intensity needs, the relative survival probabilities of patients deemed likely to benefit from medical treatment, and assessments of pre- or post-treatment quality of life.”²

The Americans with Disabilities Act (ADA) proscribes adverse treatment of persons with disabilities, but discrimination is common, including in the health system.³ With surges in Covid-19 cases creating the potential for extreme shortages of critical care resources, health care organizations are planning for crisis-level triage, with guidance provided by professional societies and ethicists that aim to allocate scarce resources

primarily so as to save the most lives.⁴

Crisis triage protocols should seek to optimize health outcomes, but doing so requires explicit protection of core values, such as the equal moral worth of all people. We offer policy recommendations capable of meeting both goals. Allocation of ventilators has become symbolic of the difficult ethical choices we face, but the criteria and processes we recommend apply to any scarce medical resource.

Disability rights advocates recognize that in disasters it may be “appropriate for providers to delay non-essential care [and] not be obligated to provide quantitatively futile care.”² Yet crisis triage arises only in forced-choice scenarios,

when not everyone can receive essential care. Some disability rights advocates assert that in such circumstances, triage based on assessing patients’ likelihood of benefit is fundamentally incompatible with respect for human dignity. Instead, they propose adopting a first-come, first-served process.⁵ But that approach would leave many people with disabilities worse off; in particular, people facing transportation, communication, and other barriers to access could be systematically disadvantaged.

We believe that crisis triage protocols should focus on identifying the patients who are most likely to die without a ventilator yet most likely to survive with one, using the best available clinical survivability scores, not broad categorical exclusions. “Survivability” is sometimes defined as living to hospital discharge or 1 year after discharge (both reasonable) or long term, a criterion that is nei-

ther practical nor ethical. The ability to predict long-term survival is poor and therefore susceptible to bias. Furthermore, many disadvantaged populations have reduced life expectancy, and triage protocols should not exacerbate health inequities.

Near-term survivability, moreover, can be assessed independently from disability. Consider two patients with Down's syndrome, one with adequate cardiac function, the other with cardiovascular disease. Down's syndrome is an inappropriate triage consideration, but worse baseline cardiac function confers lower survivability with Covid-19. Cardiac dysfunction could therefore be integrated into the scoring system, but only if the criterion applied to all patients, not just those with Down's syndrome. Patients with adequate heart function, irrespective of physical or mental disability, would then have the same triage score. Patients with preexisting cardiovascular disease would receive lower scores because they're less likely to derive benefit from the intervention, not because of disability.

Scoring systems using quality-adjusted or disability-adjusted life-years should not be used. They are overtly discriminatory in explicitly counting a year for a person living with a disability as worth less than a year for an able-bodied person. Scoring systems should also be the subject of ongoing research to ensure that they accurately predict near-term mortality and don't unfairly disadvantage people with disabilities unrelated to near-term survival. For example, Colorado recently modified its proposed scoring system (www.colorado.gov/pacific/cdphe/colorado-crisis-standards-care) to

avoid counting congenital hemiplegia as a risk factor, while accounting for the fact that hemiplegia due to ischemic or hemorrhagic stroke confers a higher risk of near-term death.

Although physicians' assessments of current or future quality of life should be impermissible as a triage factor, patients have the right to make medical decisions based on their own quality-of-life assessments. When patients are incapacitated, their designated proxy can make such assessments on their behalf, on the basis of the patient's values and preferences. As during usual care, physicians must be careful to avoid intentionally or unintentionally steering patients or their proxies in any particular direction, given the individualized nature of these decisions, the evidence that clinicians and people with disabilities perceive their quality of life differently, and the mistrust that can be generated when patients or families feel coerced.

Some disability rights advocates have also expressed concern that hospitals might withdraw ventilators from patients on stable long-term ventilation to provide the ventilators to other patients.⁵ Triage protocols should clarify that such involuntary disconnection would violate a primary aim of ethical triage — to promote social cohesion and healing after a crisis.

Whereas a stable disability is an ethically irrelevant consideration for triage, intensity of resource utilization can become a valid consideration in conjunction with the patient's clinical trajectory. In a crisis, it can be ethically acceptable to withdraw a ventilator from one patient to provide it to another if the first patient's condition is deteriorating and he or

she is less likely to survive than the second patient. Still, it's important not to remove critical care resources from patients too soon, since that could result in increased overall mortality, with use of a ventilator cycling through patients none of whom has it long enough to make a difference. Reasonable accommodations for a longer initial ventilator trial are thus justified for patients with conditions that typically improve slowly, including Covid-19. To determine what constitutes "reasonable" accommodation, specialty societies should develop more granular guidance on adequacy of initial therapeutic trials for patients with various conditions necessitating mechanical ventilation.

Most controversial is the aim of maximizing the number of life-years saved, either by prioritizing younger people over older ones or by deprioritizing those with severe life-limiting illnesses. Both kinds of life-year considerations are ethically acceptable, though only as tiebreakers. Privileging younger patients is justifiable because it's based not on stereotyping or bias against older patients but on equal opportunity and minimizing harm: the younger persons have had less opportunity to experience a full life and therefore would suffer greater harm if they were to die. With regard to advanced illness, if two people have the same likelihood of near-term survival but one has advanced cancer and a low predicted likelihood of 5-year survival according to validated measures, it would be ethically acceptable to choose the person with the greater prospect for living longer. It would not be acceptable, however, to assume that all patients with a given disability have shorter life expectan-

cies than other patients and decide that therefore none should receive scarce resources.

A commitment to equal worth requires the application of triage criteria to all patients needing a ventilator, regardless of whether they have a disability or a Covid-19 diagnosis. Because patient characteristics not directly related to clinical outcomes (such as ability to pay, race, disability, or immigration status) should not be used in decision making, where possible there should be a blinded review process, with the triage decision makers unaware of medically and ethically irrelevant patient characteristics.

The ADA requires organizations to make “reasonable accommodations” to ensure that people with disabilities can access services, aiming for all Americans to have equal opportunities to live full lives and to reduce societal prejudices that impair the agency of persons with disabilities. While preparing for the possibility of crisis triage, health care organizations must also be proactive about en-

suring access and mitigating bias in times of scarcity by taking steps recommended by HHS for providing ongoing services for patients who are deaf or blind or have other communication or mobility impairments.

Finally, the science and epidemiology of Covid-19 are rapidly changing, and more will be learned about community acceptance of crisis triage protocols. Health care organizations should consider current triage plans provisional, subject to change based on new learning and actively solicited community input.

To ensure the trustworthiness of the health system, disability rights advocates and health care leaders should work together to finalize crisis triage plans that save the most lives, protect the equal worth of all persons, and enhance communities’ capacity to heal in the wake of a once-in-a-century pandemic.

Disclosure forms provided by the authors are available at NEJM.org.

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This article was published on May 19, 2020, at NEJM.org.

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DOI: 10.1056/NEJMp2008300

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