

Crisis standards of care: Guidance from the AMA Code of Medical Ethics

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Guidance from the *AMA Code of Medical Ethics* is grounded in core values of respect, compassion, objectivity, transparency and fairness that underly the difficult decisions about allocating scarce resources that arise in a pandemic.

Principle VIII in the *AMA Code* professes that “[a] physician shall, while caring for a patient, regard responsibility to the patient as paramount.” Yet during public health emergencies like pandemics, this commitment of fidelity to the individual patient is counterbalanced by the need to protect the welfare of a population of patients recognized in Principle VII, and to be prudent stewards of limited societal resources entrusted to them, Opinion 11.1.2, “Physician Stewardship of Health Care Resources” in the *AMA Code*.

As a recognized authority for ethics for physicians, the *AMA Code* does not define specific clinical protocols for making allocation decisions under conditions of extreme scarcity and urgent need. However, the *Code* does provide foundational guidance for developing ethically sound crisis standards of care (CSC) guidelines.

Opinion 11.1.3, “Allocating Limited Health Care Resources,” along with Opinion 5.3, “Withholding or Withdrawing Life-sustaining Treatment,” provide guidance on making initial triage decisions about limited critical care resources for individual patients and for periodically reassessing those decisions.

- Triage decisions must be based on criteria related to medical need, *not* on non-medical criteria such as patients’ social worth.
- When criteria of medical need distinguish among patients, allocate limited resources first based on likelihood of benefit or to avoid premature death, and then to promote the greatest duration of benefit after recovery.
- When criteria of medical need do not substantially distinguish among patients, allocate limited resources by an objective and transparent mechanism, such as random choice or lottery to minimize potential bias, as opposed to “first come, first served,” which may unfairly privilege patients who have the means to seek care promptly.
- Periodically reassess ongoing life-sustaining treatments for all patients. When continued treatment is substantially unlikely to achieve the intended goal of care it may be withdrawn.

- | Explain the policies and procedures by which triage decisions that allocate life-sustaining treatments are made and provide a process for appealing decisions when such treatments will be withheld or withdrawn.
- | Palliative care must be provided when life-sustaining treatments are withheld or withdrawn.

Principle IX supports “access to medical care for all people” and Opinion 11.1.1, “Defining Basic Health Care,” states that “health care is a fundamental human good because it affects our opportunity to pursue life goals.”

- | Triage protocols must be applied fairly and consistently for all patients.

Opinion 10.7, “Ethics Committees in Health Care Institutions,” and Opinion 10.7.1, “Ethics Consultation,” provide guidance for establishing “triage teams” or “triage officers” to take responsibility for implementing CSC guidelines for allocating resources, which may help to relieve treating clinicians of the moral burden such decisions impose and minimize conflicts among all relevant parties.

- | Triage teams should include members with expertise, experience, and perspective that are relevant in a public health emergency. Triage officers should similarly have appropriate expertise or training.
- | Institutions should provide appropriate support to enable the triage team or officer to meet the needs of the institution and its patient population.

Opinion 8.3, “Physicians’ Responsibilities in Disaster Response and Preparedness,” recognizes physicians’ obligation to provide care even in the “face of greater than usual risk to [their] own safety, health or life,” and Opinion 9.3.1 “Physician Health and Wellness,” states that when physician health is compromised, “so may the safety and effectiveness of the medical care provided.”

- | Physicians and all workers who risk their health when responding to and caring for others have a strong ethical claim on resources that will preserve or restore their ability to work in the future. Triage protocols may ethically take this into account in directing decisions to allocate limited resources.

Opinion 5.4, “Orders Not to Attempt Resuscitation,” provides that, unless a patient explicitly declines it, cardiopulmonary resuscitation (CPR) should be provided. However, guidance in Opinion 8.3, “Physician Responsibilities in Disaster Response and Preparedness,” indicates that physicians also have a responsibility “to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future.”

- | In public health emergencies, when CPR is unlikely to provide the intended clinical benefit and participating in resuscitation significantly increases already higher than usual risk for health care professionals, it may be ethically justifiable to withhold CPR without the patient’s