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An ethical conundrum: Palliative care in the COVID-19 pandemic

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Editorial

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Discussions related to healthcare resource allocation during the COVID-19 pandemic has rapidly emerged in Italy, one of the first severely hit countries in Europe, struggled with the ethical quandary as a result of resource scarcity. As the number of sick people increased sharply and required care all at the same time, decisions relating to who can have access to certain resources, such as intensive care measures, raised serious ethical discussions. There is no right or wrong answer when dealing with ethical quandaries, and such decision is based on systemic priorities which are embedded in the cultural, political, and social contexts within which these decisions are being made.

In view of the exceptional, resource-limited circumstances as a result of the COVID-19 pandemic, the Italian College of Anaesthesia, Analgesia, Resuscitation and Intensive Care (SIAARTI) has raised a number of concerns over the allocation of intensive care treatments. For instance, the increasing demand for intensive care could impede the standard of care being delivered; resources could be diluted as the rapidly increasing demand continues; and care for patients with other non-COVID-19 related illnesses could be compromised as resources are being re-directed to cope with the pandemic (Vergano et al., 2020). These are legitimate concerns regarding resource allocation during the pandemic, and one particularly delicate issue relates to the consideration of setting an age limit for intensive care treatments. The Italian recommendations suggested that the limited resources should be saved for those "who have a much greater probability of survival and life expectancy, in order to maximize the benefits for the largest number of people" (Vergano et al., 2020, p. 5). This guideline also reflects the policy issued by the World Health Organisation (WHO) in that younger populations should have low priority for vaccine since they are at lower risk in the COVID-19 context, but higher priority should be considered if they fall ill and require critical care resources (World Health Organisation, 2020b). In addition to age, comorbidities and functional status of the critically ill patient should also be evaluated; frail elderly patients may be more likely to have a longer and more resource-consuming clinical course than healthier and younger patients, whom would have a relatively shorter clinical trajectory. These criteria are fundamentally advocating the maximization of utility, without compromising impartiality in clinical rationing (Centers for Disease Control and Prevention, 2011; Pan American Health Organisation, 2020). Pertaining to these criteria, a number of frameworks have been further structured and developed in order to facilitate sound ethical decision-making during the pandemic (Dawson et al., 2020; National Ethics Advisory Committee, 2020; Valiani et al., 2020).

However, one cannot overlook that the maximization of collective welfare could potentially compromise the preference or interest of certain individuals; the utilitarian way of decision making accepts that individual compromises may be necessary in order for greater utility to be achieved (Bellefleur and Keeling, 2016). In the COVID-19 pandemic, such idea is translated to the morally justifiable withholding or withdrawal of intensive care measures from some individuals, in the hope of maximizing the number of lives saved under the circumstances of resource scarcity (Centers for Disease Control and Prevention, 2011; Emanuel et al., 2020).

The utilitarian ethical perspective prioritizes collective welfare over individual, and this moral rationalization has been criticized by a number of authors in terms of the lack of value placed on the person. As Rawls (2009) explained, utilitarianism does not draw distinction between persons, implying that each individual is treated as equal unit, replacing individuality by a collective whole (Mack, 2004). While equity and impartiality are seen as the ethical basis, the utilitarian ethical perspectives focus on maximizing utility through the aggregation of collective welfare, which raises question over respect and justice for persons (Mack, 2004; Bellefleur and Keeling, 2016). Such a concern is reflected on the response to the COVID-19 pandemic in which the triage of intensive care resources is prioritized over the person-centered consideration for individuals; the rationing of intensive care treatments in accordance with certain criteria is implemented in order to maximize the number of lives saved (Persad et al., 2009; Biddison et al., 2014), disregarding the individual needs and preferences of those who do not meet the criteria to receive intensive treatments (White and Lo, 2020). Furthermore, resource allocation in a pandemic would simultaneously limit people with other life-threatening conditions to access critical care or other less urgent but essential to sustain their quality of life, compromising the principle of justice and beneficence.

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The medical uncertainties and ethical complexities in the current COVID-19 pandemic added substantial responsibilities on frontline healthcare professionals in making decisions regarding clinical rationing (White and Lo, 2020). However, there has not been much discussions addressing the psychological intricacies for healthcare professionals in making decisions with respect to the allocation and withdrawal of intensive care resources; furthermore, who should be accountable for making such intricate decisions and what are the safeguards?

The purpose of recommendations issued by various agencies, i.e., the SIAARTI, the WHO, the PAHO and the CDC, is to facilitate and support decision making for healthcare professionals (Vergano et al., 2020). However, it is challenging to ensure all institutions across the globe would adopt the same ethical principle when confronted with resource scarcity under the exceptional circumstances of the COVID-19 pandemic. With respect to safeguarding, for patients who do not meet the criteria for life-sustaining treatments, palliative care is recommended by the SIAARTI as well as the CDC as a priority to maximize comfort (Centers for Disease Control and Prevention, 2011; Vergano et al., 2020). However, resources for palliative care services are known to be inadequate (Lancet, 2020), and the outbreak of the COVID-19 pandemic has further amplified resource scarcity in palliative care. This circumstance raises ethical concern over the appropriateness of the utilitarian ethical perspective in maximizing collective welfare in the pandemic, when there is already a known gap of care provision of the alternative care option for those excluded from receiving life-sustaining treatments. How then, can the decision for palliative care as an alternative be ethically justified?

Besides, in the Operational guidance for maintaining essential health services during an outbreak published by the WHO, palliative care was not included in the list of "essential health services of health systems" that should be maintained during the pandemic (World Health Organisation, 2020a); palliative care, as stated by the World Health Assembly, is "an ethical responsibility" (World Health Organisation, 2018), the neglect of palliative care as part of the response strategy to the COVID-19 pandemic by the WHO is not merely an oversight, but a disregard of a fundamental and ethical responsibility as healthcare providers in recognizing the inevitable needs to address human suffering. In comparing with the maximization of collective benefits by allocating resources for those who meet certain criteria (as discussed above), palliative care places value on individual human life and resource allocation is focused on the principle of justice and beneficence (Radbruch et al., 2020).

The pandemic of COVID-19 has undoubtedly placed unprecedented pressure in healthcare systems across the globe, it has, however, further deepened the divide between the practice of medicalization and compassionate care central to palliative care. As policy makers across the globe are primarily focusing on mobilizing resources to maximize the number of lives saved, it is critical for them to consider their ethical and moral responsibility to care for those who the system has deemed not suitable to receive intensive care measures; failure to do so, as reflected from the exclusion of palliative care in the WHO's pandemic response indicated the continuous failure to safeguard those who are dying and suffering, not just physically, but also psychosocially, emotionally, and spiritually.

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