

Many thanks for the opportunity to feedback on the NEAC document 'Ethical Framework for Resource Allocation in Times of Scarcity'.

Our thoughts mainly concern the document with respect to ICU triage, though there are some more general ones, and are as follows:

1. An ethical framework which specifically addresses equity in a pandemic is very much needed and welcome, as is the explicit naming of the tensions between this and utility.
2. The document is written with Covid -19 in mind. Would this same framework apply to other pandemics too? If so making the document more generic would be useful so that it could apply to future as well as current threats.
3. The utility principles are not explained in the same detail as the equity ones, and the document would be improved if the same attention and focus to this perspective was outlined and discussed.
4. The document is on the whole more of a high level theoretical document useful to policy makers, and how this might be translated into a local useful, pragmatic workable solution for front line clinicians could be strengthened. A clearer way to translate theoretical ethics into practical ethics would be useful. This would be improved by clinical subject matter experts integrated into the formulation of the document. As this is titled a framework document, is there a way of creating a practical flow diagram to encapsulate the general framework being espoused, as well as particular frameworks for each of the three areas that are focused on?
5. The concept of a 'tipping point' in a pandemic outlined in the Sydney Guidelines is useful to consider. At what point does one recognise that that point has been reached, and what are the underpinning ethical principles that can guide that decision? An ethical discussion based on helping clinicians recognise and address these issues would be useful.
6. Defining more specifically what is meant by equity and ICU triage would be helpful – specifically with respect to equity of access, process, and outcome within ICU.
7. Defining what equity with respect to ICU triage would actually look like in practice would help shed light on the issues discussed.
8. An explicit discussion about whether the opportunities and strengths for an equity and/or utility approach are the same at every point during a pandemic, or whether they change i.e. between vaccination (a public health approach) to ICU (much more a clinical approach) would be helpful.
9. The ethics with respect to equity of not having a national mandated approach to ICU triage would be helpful. If each DHB creates its own system of triaging, then it is likely that someone who would get access in one DHB to ICU, may not get access when presenting in the same way in another. To promote equity, we would propose there should be a core national approach to triage with key components which are the same wherever crisis ICU triage occurs in New Zealand. Local circumstances can then adapt them to make them workable. This has also been strongly endorsed by our external oversight group in CCDHB & HVDHB.
10. Decision making groups (p12) proposed in the document will have different functions at national and local levels. The establishment and specific proposed function of these different groups would benefit from more explanation.
11. The ICU discussion would be improved by recruitment to the writing group of an ICU subject matter expert. For instance the discussion about surge beds is not a useful concept if talking about prioritisation during a period where rationing decisions need to be made because the system's capacity is already overwhelmed by demand.

12. The ethics of reverse triage (when it may not be in the person's best interest) should be explicitly addressed. Specifically, the removal of someone from a resource (e.g. ventilator) during crisis standards of care even though they still might survive, because someone else is likely to benefit from it in a quicker time. In other words, if someone is likely to take up a ventilator for six weeks, should they be taken off this (and therefore likely die) so that three others who might only take up the ventilator for two weeks each take their place, so saving more lives? This is a different scenario to that described in the document about withdrawal of ICU care which focuses on individual benefit, and not the benefit of the greater good. And this scenario is potentially a very real issue for which there is very little written about.

13. Discussion about the ethics of other decision making tools and approaches to triage allocation would be helpful, including the 'reserve' model, the 'life span' argument, and the 'dependent carers' argument.

14. It would be very helpful if the ethical issues of making treatment decisions based on age, frailty and disability were discussed in more detail with respect to ICU and whether or not these should be used in scoring tools to determine triage. This has been a major area of contention overseas.

15. The ethical issues of making treatment decisions in ICU based on comorbidity would benefit from a more detailed discussion, and whether or not these should be used in scoring tools to determine triage. This is especially so, as an argument can be made that because certain groups in society are more likely to have comorbidities, that any prioritisation tool that takes comorbidity into account will unfairly disadvantage that group. The counter argument being that it is comorbidities that are most closely aligned with ICU survival, and therefore absolutely need to be taken into account when triaging to ensure people most likely to survive are picked.

This is especially pertinent to New Zealand, given the higher levels of comorbidity within Maori and Pacific populations compared to Pakeha, and is a current source of intense debate.

16. The ethical issues of making treatment decisions in ICU based on ethnicity should be discussed in detail. Can it be justifiably argued to prioritise based on someone's ethnicity, in order to help address systemic racism and bias over years and within systems, over someone who has a higher chance of survival but is not of that ethnicity? If someone scores equally on an ICU triage scoring tool, is it ethically justifiable to use ethnicity as a tie-breaker? Can it be ethically justified to utilise an ICU triage scoring system that weights favourably based on ethnicity, and what are the arguments for and against?

17. The sentence (p15) 'Patients with the most severe disease who are most likely to die or suffer without treatment should be prioritised for ICU access.' is an argument for palliative care in these circumstances, not ICU. It would be better rephrased as 'Patients with the most severe disease who are most likely to **live** should be prioritised for ICU access.'