



It's Not About the Vent: Reflections on Resource Allocation in a Time of Crisis

By Mary E. Homan, DrPH

For those who remember Oprah on daytime television, she often surprised her audience members with a set of car keys under their chairs and pointed at individual attendees and shouted, "You get a car! And you get a car! Everybody gets a car!" Right now, there is a [meme](#) going around with a picture of Oprah yelling, "You get a vent, you get a vent! Everybody gets a vent!" Although it is a humorous – albeit macabre – sentiment, the actual concern over who will receive (and remain on) a ventilator differs depending on how you perceive equity in the health care system.

This week, ProPublica released a [report](#) regarding the mortality disparities of COVID-19 between black and non-black persons. Milwaukee County [reported](#) that as of 11:00 a.m. on Tuesday, April 7, of the 1,324 confirmed cases of COVID-19, 609 cases were persons who are black or African-American. Thirty-five COVID-19 deaths out of 49 were of persons who were black or African-American. To put this in perspective, black or African-Americans make up 27% of Milwaukee County's [population](#), but they represent 46% of COVID-19 cases and 71% of the deaths. Unfortunately, Milwaukee's experience is not unique.

Early in my career, I participated in an [ethics consult](#) where the family was fearful of the medical system, and didn't trust the "white coats." If this family couldn't trust their loved one's care team when it was apparent the patient was in her last moments of life, how will families, who are kept physically distant from their COVID-19-positive loved ones, trust caregivers to make fair decisions about allocating resources?

Bioethicists have been struggling for weeks (some for years!) to help clinical decision makers, state emergency response teams, and health departments justly allocate resources. There are classifications, tiers, and even tie-breakers for hospitals when they are down to the last pint of blood, last dose of morphine, last isolation gown, or last ventilator. Even if the team making triage decisions is blinded to a patient's disability status, payor source, race, or gender, the fact remains that societal inequities do not provide a level playing field. Not everyone has the same access to adequate insurance coverage. Social determinants of health are associated with lower access to

health maintenance, higher rates of uncontrolled diabetes, more frequent environmental exposures, and higher rates of both heart and lung disease. The people allocating scarce resources are not blinded to these health outcomes. The most vulnerable among us will suffer.

When I developed the Ebola ethics guidelines for my previous health system, I wrote that we must strive to ensure burdens are not borne disproportionately by any patient, patient group, care site, or community. I called for a protection from discrimination for those whose social or medical condition places them in the so-called margins of society. Sharing the burdens equally and protection from discrimination are two examples of character in action.

Triage officers will be forced to make tough decisions and those at the bedside will struggle with the consequences. We must continue to care even when we can't cure. We must trust our patients' distrust of the system and partner with their loved ones in this time of fear and anxiety.

Sadly, we are not Oprah. Not all resources will be available. We can, however, work to assure that everyone has an equal chance of being treated with justice, care, and compassion.

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