Medical professionalism is an evolving concept that reflects the myriad changes occurring in our health care system. In 2002, the American Board of Internal Medicine Foundation defined this concept in its physician charter, stating that medical professionalism “supports physicians’ efforts to ensure that the health care systems and physicians working within them remain committed both to patient welfare and to the basic tenets of social justice” (Ann Intern Med 2002;136:243-6). ASA endorsed this physician charter, which includes a commitment to a just distribution of finite resources: “physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources” (Ann Intern Med 2003;138:839-41). ASA’s Guidelines for the Ethical Practice of Anesthesiology further endorse and promote professionalism as they describe ethical behavior of anesthesiologists with respect to patients, colleagues, themselves, institutions, and society (asamonitor.pub/3G3hvbe). During the COVID-19 pandemic, the challenges of professionalism for anesthesiologists became manifest as they served as ethical stewards for the appropriate distribution of limited medical resources, including drugs and equipment. In fact, as with other physicians, anesthesiologists themselves became a limited resource.

The 21st century has witnessed a bevy of anesthesiology shortfalls, the product of a mixture of technical, organizational, socioeconomic, and ethical challenges (asamonitor.pub/3G3hvbe; Ethical Issues in Anesthesiology and Surgery. 1st Edition, 2015). Limited anesthetic drug supplies have necessitated changes in anesthetic and intensive care plans that could potentially adversely affect patient outcomes, thus introducing ethical implications. Medications in limited supply are to be utilized for approved indications, while off-label use is to be restricted, and alternative treatment options should be explored. Alternative treatments should be comparable in efficacy without causing patients undue harm, and patients should be informed of the risks and benefits to enable them to make informed decisions about the care they are to receive. In fact, patients have expressed interest in knowing about drug shortages that may affect their care, and a shared decision-making model incorporating patients’ input can ensure that patients receive optimal treatment when the standard of care may not be available (Anesth Analg 2015;121:502-6; Anesth Analg 2020;130:265-70).

Delivering elective surgeries is a prudent way to counter drug shortages and maximize availability for urgent needs. Guidelines published by ASA and the American Society of Health-System Pharmacists state that postponement of elective surgeries should be considered if drug supplies are limited or alternative treatments are not comparable to standard treatment (asamonitor.pub/3D9uc2d; asamonitor.pub/3Edh4H4).

During the COVID-19 pandemic, medication and equipment shortages often forced difficult decisions regarding which patients would receive life-saving treatments such as ventilators and ECMO circuits. As a result, it became necessary to develop institutional guidelines for the ethical distribution of these resources, although the guidelines varied greatly between institutions (JAMA Netw Open 2020;3:e2012606). Guidelines not only addressed prognosis for hospital survival, but also adjusted for factors such as structural inequities that disadvantage specific populations, and whether a patient is a frontline essential worker. Whether age may be taken into consideration in circumstances when there are not enough resources for needy patients with similar prospects for survival is a matter of debate. Some guidelines gave preference according to the so-called “life-cycle” principle that, admittedly, favors younger patients, enabling as many people as possible to live an as-full-as-possible human lifespan (Am J Respir Crit Care Med 2021;203:287-95). The process of obtaining informed consent from the patient or surrogate decision-maker for the initiation, management, and discontinuance (when indicated) of ventilator or ECMO support was particularly challenging (JAMA 2020;323:1773-4).

One common approach to limited resource allocation during a pandemic incorporates a utilitarian philosophy in which limited community resources are allocated to minimize harm (nonmaleficence) and maximize benefit (beneficence) for the greatest number of patients. Distributive justice generally requires prioritizing 1) saving those most likely to survive in order to save as many lives as possible while also 2) enabling the continued functioning of society (social stability). These two goals are usually, but not inevitably, mutually supportive of each other. Importantly, the goal of attaining societal benefit can override the accepted ethical traditional weight placed on respecting individual patient autonomy.

This utilitarian approach also endorses identifying alternative ways to effectively treat patients without adversely affecting societal health outcomes (HEC Forum 2021;33:45-60). The off-label and non-evidence-based use of hydroxychloroquine for COVID-19 patients created a largely misinformed yet overwhelming “therapeutic” demand. This situation highlighted the fact that not all supplies should preferentially have been allocated for COVID-19 purposes because patients receiving hydroxychloroquine for evidence-based reasons, such as rheumatoid arthritis, must continue to have access to this medication. Similarly, patients already on long-term ventilatory support for chronic disease or disability, regardless of their diagnosis, would not have their ventilators removed from them to provide benefit for COVID-19 patients in critical need of such.

Given that continued societal function is a key utilitarian goal, two supportive arguments have been offered for prioritizing medical care for health care workers (HCWs). One focuses on the community’s essential need for HCWs in providing patient care. This represents a social function argument that should be distinguished from one based on social worth. HCWs are not inherently more worthy of treatment than non-HCWs, but treatment of HCWs potentially benefits societal function in that these HCWs may again become available (Proc Natl Acad Sci U S A 2021;118:210783118).

Considerations of professionalism and its aspiration for ethical behavior emphasize an anesthesiologist’s obligation and responsibility for the management and distribution of limited clinical resources in a manner that preserves a just, effective, and sustainable health care system for the society in which we reside.