Ethics Considerations for Bamlanivimab Allocation
Interim Ethical Guidance for Vermont Department of Health

The evidence for effective treatment of COVID-19 has evolved rapidly, with transitions from unproven investigational agents not included in the standard of care to proven therapy sometimes occurring within weeks.

Currently, there are insufficient data to recommend either for or against the use of bamlanivimab for the treatment of outpatients with mild to moderate COVID-19. The NIH Treatment Guidelines state that, despite the FDA's release of an Emergency Use Authorization, "Bamlanivimab should not be considered the standard of care for the treatment of patients with COVID-19."

Since bamlanivimab is not considered standard of care, there is no ethical obligation to provide this investigational treatment to qualifying patients. Aministration of bamlanivimab can therefore be left to the discretion of institutions and individual clinicians as they seek to responsibly balance myriad needs related to the COVID-19 pandemic.

In response to lack of clinician and patient enthusiasm about the use of bamlanivimab and the logistical challenges of safe administration of intravenous bamlanivimab to patients with COVID-19 in the outpatient setting, utilization of existing bamlanivimab supplies has been less than anticipated. There is, therefore, no current scarcity of bamlanivimab and allocation based on a first-come-first-serve system is ethically permissible.

Ethicists in Vermont have differing opinions regarding allocation of bamlanivimab in the event supplies become scarce. This document presents two ethics opinions for approaching allocation decisions should scarcity occur. In the event that scarcity of bamlanivimab emerges, the state may recommend one approach or leave up to individaul institutions and clinicians the ability to determine the approach that best fits their realities and ethical discernment.

The two stances regarding ethical allocation of bamlanivimab should it become scarce are:

(1) There is no ethical obligation to allocate fairly when there is a lack of proven clinical efficacy.
(2) It is ethically obligatory to allocate fairly when there is potential for benefit and no adequate or approved alternatives are available.

The ethical rationales for these stances are briefly summarized below.

1. **There is no ethical obligation to allocate fairly when there is a lack of proven clinical efficacy.** (Tim Lahey, MD, MMSc) Fair allocation of scarce beneficial resources is a core concept in bioethics. It informs battlefield triage, transplant allocation, and beyond. During the COVID-19 pandemic, scarcity of beneficial treatments has driven development of fair allocation systems for ventilators and vaccines.

Such systems for fair and ethical allocation of scarce medical resources are predicated on there being a reasonable expectation that those therapies are beneficial. Treatments that have *not* been proven to be beneficial, on the other hand, need not be allocated systematically. There might be a scarce supply of a drug being tested in a clinical trial, for instance, or scarcity of an herbal remedy being touted on the internet, but without known benefit to patients, these unproven therapies need not be allocated systematically. Clinical trials thus can enroll subjects non-systematically to test scarce experimental therapies and scarce unproven herbal therapies may also be allocated non-systematically.

Non-systematic allocation of investigational agents is ethical even when preliminary data suggest the agent could be beneficial. Nearly all investigational agents in advanced human clinical trials have shown *some* signal of potential benefit in preliminary data, yet higher-quality randomized clinical trials typically find those preliminary data were misleading. This is the case for bamlaniviamb, and thus a first-come-first-served allocation system for bamlanivimab is permissible. Notably, requiring the systematic allocation of investigational agents with some preliminary signs of benefit would represent a substantial change of approach for a wide variety of investigational agents.

2. **It is ethically obligatory to allocate fairly when there is potential for benefit and no adequate or approved alternatives are available.** (Cindy Bruzzese, MPA, MSB, HEC-C) *Justice* (i.e. treating similarly situated individuals similarly; fairness) is a bedrock principle in medical ethics and the primary ethical consideration that should underpin scarce resource allocation decisions during a public health crisis. Previously developed allocation protocols and frameworks to ethically allocate beneficial life-sustaining technologies among patients at risk of death—and who may die whether or not they have access to this technology—are not well suited to resolve allocation questions concerning potentially beneficial therapeutics among patients stable enough to benefit. Preliminary data suggestive of potential for benefit does not mean that a treatment has been proven to be nonbeneficial. Thus, fairness in allocation remains a priority should the resource become scarce.

   Justice also dictates that public health leaders have a duty to safeguard vulnerable and historically marginalized populations from pre-existing health disparities when allocating scarce health care resources like bamlanivimab during the COVID-19 pandemic. A first-come-first-served approach to distribution of bamlanivimab, while ethically permissible when supply is plentiful, becomes ethically problematic when the resource becomes scarce. Maintaing such a process could unjustly privilege those with superior access to health care resources, those who are wealthy or white patients who have lower pre-existing risk of developing severe COVID-19 compared to black patients. To avoid such bias and promote a just process that balances the duty to mitigate the impact of structural inequity while also safeguarding vulnerable populations from potential harms associated with unproven, experimental treatments, is the public health responsibility. Therefore, shifting to a random lottery allocation system should the resource become scarce is the ethical obligation.

In conclusion, given current evidence and the mandate of institutions to prioritize needs and investments to optimally address the COVID-19 pandemic, there is no ethical obligation to offer bamlanivimab treatments. If institutions opt to offer bamlanivimab, they should do so according to the clinical criteria laid out in the FDA's EUA either in a first-come-first-served or random lottery

fashion chosen either by the Vermont Commissioner of Health or the administering institution. New randomized clinical trials indicating clinical efficacy of bamlanivimab, or the absence thereof, should prompt an update of this guidance.

Contributors

Cindy Bruzzese, MPA, MSB, HEC-C
Executive Director & Clinical Ethicist
Vermont Ethics Network
Clinical Ethicist, UVMMC

Tim Lahey, MD, MMSc
Professor of Medicine
UVM Larner College of Medicine
Director of Ethics, UVMMC