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Who Gets the Last ICU bed? A Critical Analysis of Legal and Ethical Accountability in the Allocation of Scarce Medical Resources in India

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Abstract : *Hospitals sometimes face situations where the number of patients who need intensive care is greater than the number of beds available. In such situations, doctors have to decide which patient should receive treatment first. This becomes a serious problem when two or more patients need an ICU bed or ventilator at the same time. The decision is not only a medical issue but also a matter of law, ethics and human rights. In India, the availability of ICU beds, ventilators and trained medical professionals is not equal in all parts of the country. This problem became more visible during the COVID-19 pandemic. However, similar situations can also arise during accidents, disease outbreaks and other medical emergencies. Doctors are expected to save lives, but they may not always have enough resources to treat every patient.*

This article examines the legal and ethical issues involved in the allocation of limited medical resources in India. It studies important legal provisions, Supreme Court judgments, medical ethics regulations and critical care guidelines. It also examines whether doctors should be held personally responsible when patients do not receive treatment because of a shortage of hospital facilities.

The article argues that decisions about the allocation of ICU beds should not be left entirely to individual doctors. Hospitals must follow clear and fair rules while making such decisions. It also suggests that doctors who make genuine decisions according to approved medical guidelines should receive proper legal protection. Finally, the article recommends stronger hospital accountability, transparent decision-making and better use of palliative care.

Keywords: Medical Ethics, ICU Bed Allocation, Medical Negligence, Triage, Patient Rights, Institutional Accountability, Indian Healthcare Law.

I. INTRODUCTION

The main duty of a doctor is to protect the life and health of patients1 (World Medical Association [WMA], 2017). Every patient who approaches a hospital expects proper medical care. In normal situations, doctors try their best to provide the treatment required by each patient. However, the situation becomes difficult when a hospital does not have enough facilities to treat everyone. For example, imagine a hospital where only one ICU bed is available. At the same time, two patients arrive in a serious condition. Both need immediate medical attention. The doctor must decide who should receive the available bed. This is not an easy decision because both patients have equal human value and both need medical help. This problem is known as the allocation of scarce medical resources. It refers to the process of distributing limited medical facilities among patients who need them. These resources may include ICU beds, ventilators, oxygen, medicines, blood and other life-saving facilities.

In India, the shortage of medical facilities is a serious concern. There are differences in healthcare facilities between rural and urban areas and between government and private hospitals (Divatia et al., 2021). Many hospitals also face difficulties because of a shortage of trained doctors, nurses and other medical staff. During the COVID-19 pandemic, the country experienced serious difficulties in providing ICU beds, oxygen and ventilators to patients.2

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The situation creates an important question: When there is only one ICU bed available, who should receive it, and who should be held responsible if another patient dies without receiving treatment? Doctors have a professional duty to treat patients, but they cannot provide facilities that are not available in the hospital. At the same time, hospitals cannot avoid their responsibilities by simply stating that resources are limited. Therefore, it is important to understand the responsibilities of doctors, hospitals and the government in these situations. Indian law recognises the right to life and provides protection against medical negligence. However, there is a need for clearer rules to deal with situations where hospitals have to make difficult decisions because of a shortage of resources. This article studies these issues and suggests ways to make the allocation of medical resources more fair, transparent and legally responsible.3

1. 1 Beauchamp & Childress, 2019
2. 2 Divatia et al., 2021
3. Paschim Banga Khet Mazdoor Samity v. State of West Bengal, 1996; Jacob Mathew v. State of Punjab, 2005

II. RESEARCH METHODOLOGY

This article follows a doctrinal research method. It is based on the study of existing legal provisions, judicial decisions, medical regulations, professional guidelines and published research articles. The study mainly examines Article 21 of the Indian Constitution, the Consumer Protection Act, 2019, the Clinical Establishments (Registration and Regulation) Act, 2010, medical negligence principles and important Supreme Court judgments. It also considers the ethical principles followed in medical practice and the guidelines issued by professional medical organisations. The purpose is to identify the legal and ethical difficulties faced by doctors and hospitals when medical resources are limited.4

III. ETHICAL ISSUES IN THE ALLOCATION OF MEDICAL RESOURCES

Medical ethics helps doctors make decisions while treating patients. It also explains how patients should be treated with fairness and respect. Four important principles are generally followed in medical ethics. They are beneficence, non-maleficence, autonomy and justice (Beauchamp & Childress, 2019). These principles become especially important when hospitals do not have enough resources to treat every patient.

Beneficence

Beneficence means doing good for the patient. Doctors must try to provide treatment that benefits the patient's health and improves their chances of recovery. However, when there is only one ICU bed available, the doctor may not be able to provide the same treatment to every patient. This creates a conflict between the duty to help an individual patient and the need to make a decision that may benefit another patient.5

Non-Maleficence

Non-maleficence means avoiding unnecessary harm to patients. Doctors must not take decisions that may cause avoidable injury or suffering. In a situation of medical shortage, refusing an ICU bed may place a patient's life at risk. At the same time, giving the only available bed to a patient who is unlikely to benefit from intensive care may affect another patient who has a better chance of recovery. In view of this, doctors must carefully consider the possible results of their decisions.

4 The Constitution of India, 1950; Consumer Protection Act, 2019; Clinical Establishments (Registration and Regulation) Act, 2010

Beauchamp & Childress, 2019

Autonomy

Autonomy means respecting the patient's right to make decisions about their own medical treatment. Patients should receive proper information and should be allowed to make decisions after understanding the available treatment options. This principle also includes respecting a patient's advance medical directive, where legally applicable. An advance medical directive allows a person to express their wishes regarding medical treatment in certain circumstances when they may no longer be able to communicate.6

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Justice

Justice means treating people fairly and equally. A patient's treatment should not depend on their wealth, caste, religion, gender, social position or personal connections. When medical facilities are limited, hospitals must follow fair rules while deciding who receives treatment. The decision should mainly depend on relevant medical factors and should not be influenced by social or financial status.7

Different Methods of Allocating ICU Beds

There are different methods that can be followed when hospitals have fewer medical resources than patients who need them. Some important methods are explained below.

- **First-Come, First-Served Method**: Under this method, the patient who reaches the hospital first receives treatment first. This method is simple and easy to follow. However, it may not always be fair. Patients living near major hospitals may receive treatment earlier than those coming from distant villages. People with private transport may also reach hospitals faster than others.
- **Sickest-Patient-First Method:** Under this method, priority is given to the patient who is in the most serious condition. The main purpose is to help the person who needs immediate medical attention. However, the most seriously ill patient may sometimes have a very low chance of recovery. Giving the only available ICU bed to that patient may reduce the chance of saving another patient who could benefit more from intensive care.
- **Highest Chance of Recovery Method:** Under this method, priority is given to patients who are medically more likely to survive with intensive treatment. The main aim is to save as many
- lives as possible. However, this method must be used carefully. Age, disability or long-term illness should not automatically become reasons for refusing treatment. Decisions must be based on proper medical assessment.
- **Random Selection Method:** Sometimes two or more patients may have almost the same medical condition and chances of recovery. In such cases, a lottery or random selection method can be considered. This gives patients an equal opportunity and reduces the possibility of personal bias. These methods show that there is no simple answer to the question of who should receive the last ICU bed. Hospitals need clear guidelines that balance medical need, fairness and the possibility of recovery (Emanuel et al., 2020; Persad et al., 2009).8

Ethical codes such as the World Medical Association's Declaration of Geneva and the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 (which continue to govern professional conduct while the 2023 NMC conduct regulations remain kept in abeyance) emphasise patient welfare and non-discrimination, yet they do not provide a step-by-step rule for choosing between patients when beds run out9 (WMA, 2017).

IV. LEGAL RESPONSIBILITY UNDER INDIAN LAW

When a patient dies after failing to receive an ICU bed or ventilator, the family may question the decision taken by the hospital. They may approach a consumer commission, civil court or other legal authority. In India, medical professionals and hospitals can be held responsible when they fail to perform their legal duties. However, a shortage of medical resources creates a difficult situation because the doctor may not always be responsible for the lack of facilities.

Medical Negligence and Duty of Care

Medical negligence occurs when a doctor fails to provide the standard of care expected from a reasonably competent medical professional, and that failure causes harm to the patient. In Jacob Mathew v. State of Punjab (2005), the Supreme Court explained the principles relating to medical negligence and criminal responsibility of doctors. The Court made an important distinction between ordinary negligence and criminal negligence. For criminal responsibility, the negligence must be sufficiently serious and gross. A simple mistake or an error of judgment does not automatically amount to a criminal offence. In cases involving ICU bed allocation, it is important to examine the actual conduct of the doctor. If the doctor follows proper medical guidelines and makes a genuine decision based on the available facilities, the decision should not automatically be treated as negligence.10 Still, if a doctor acts carelessly, ignores the patient's condition or makes an unfair decision without proper medical reasons, legal responsibility may arise.

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Emanuel et al., 2020; Persad et al., 2009
[9] WMA, 2017; Indian Medical Council Regulations, 2002

Consumer Protection Act, 2019

Patients may also seek legal remedies under the Consumer Protection Act, 2019. Medical services can come within the scope of consumer protection law, subject to the applicable legal principles and exceptions. If a hospital provides deficient medical services, the patient or their family may approach the appropriate consumer commission. For example, if a hospital refuses emergency treatment because the patient cannot immediately pay a deposit, the hospital's conduct may be questioned under the relevant legal provisions. Despite this, every case involving the non-availability of an ICU bed cannot automatically be considered deficiency in service. The reason for the denial, the availability of facilities and the conduct of the hospital must be examined.11

Individual Responsibility and System Failure

One of the main problems in resource allocation is deciding whether the doctor or the hospital should be held responsible. A doctor may be willing to treat a patient but may not have an available ICU bed, ventilator or trained staff. In such circumstances, the doctor cannot create facilities that the hospital does not have. For example, suppose all ICU beds in a hospital are occupied by patients who require continuous medical support. Another patient arrives in a critical condition and needs immediate admission. The doctor may have to arrange a transfer to another hospital or provide the best possible treatment with the available facilities. If the doctor has followed proper medical procedures, it would be unfair to hold that doctor personally responsible only because the hospital has no vacant ICU bed. At the same time, hospitals must maintain proper records and fair admission procedures. If the shortage is caused by poor management, unnecessary reservation of beds or improper administrative decisions, the hospital may have to answer for that failure. In view of this, individual medical negligence and institutional failure should be examined separately.12
10 Jacob Mathew v. State of Punjab, 2005
[11]Indian Medical Association v. V.P. Shantha, 1995; Consumer Protection Act, 2019
[12] Jacob Mathew v. State of Punjab, 2005

Article 21 and the Right to Emergency Medical Treatment

Article 21 of the Indian Constitution protects the right to life and personal liberty. The Supreme Court has recognised that the right to life includes access to emergency medical treatment. In Paschim Banga Khet Mazdoor Samity v. State of West Bengal (1996), the Supreme Court considered a case involving the failure of government hospitals to provide proper medical treatment to an injured person. The Court held that the failure of government hospitals to provide timely medical treatment in an emergency violates Article 21. It also explained that the government has a responsibility to develop an adequate healthcare system. This judgment is important because it makes clear that emergency healthcare is not simply a matter of hospital administration. It is also connected with the constitutional responsibility of the State. Although, the judgment does not mean that every hospital must provide an ICU bed even when no bed is available. It highlights the responsibility of the government to maintain a proper healthcare system and ensure access to emergency treatment.13

Clinical Establishments Act, 2010

The Clinical Establishments (Registration and Regulation) Act, 2010 provides rules relating to the registration and functioning of clinical establishments in the States and Union Territories where the Act applies. Section 12(2) requires a clinical establishment to provide medical examination and treatment necessary to stabilise an emergency medical condition within the staff and facilities available.14 This provision is important because hospitals must not ignore emergency patients without considering the treatment that can be provided with their existing facilities. It is important to understand that the Act is not uniformly applicable throughout India. Its application depends on the relevant State or Union Territory. Therefore, it should not be treated as a single nationwide rule applying to every hospital. The provision also recognises the practical limitation of available staff and facilities. This makes it important to distinguish between refusing to provide available emergency treatment and being unable to provide a facility that is genuinely

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unavailable. Even where the Act is not adopted, ethical duties and constitutional standards still discourage ignoring emergency stabilization.

[13] The Constitution of India, 1950, Article 21; Paschim Banga Khet Mazdoor Samity v. State of West Bengal, 1996

[14] Clinical Establishments (Registration and Regulation) Act, 2010, Section 12(2)

V. MAJOR GAPS IN THE INDIAN HEALTHCARE SYSTEM

Although India has several laws and medical guidelines relating to patient care, there are still many difficulties in dealing with the shortage of medical resources. These difficulties affect both patients and doctors.15

Lack of Common Triage Guidelines

One major problem is the absence of a single, clear and legally binding national framework for allocating ICU beds during situations of serious medical shortage. Different hospitals may follow different methods while deciding which patient should receive an ICU bed. In some hospitals, the decision may be taken by the senior doctor. In others, it may be taken by the hospital administration. This difference can create confusion and unfair treatment. Doctors may also face legal problems because there is no common standard to explain whether their decision was correct. India needs clear guidelines that hospitals can follow during medical emergencies. These guidelines should explain how patients must be assessed, who should take the final decision and how the reasons for refusing or delaying ICU admission should be recorded.16

Difference Between Government and Private Hospitals

Another important problem is the difference between government and private healthcare facilities. Government hospitals often face a shortage of beds, equipment and medical staff because of the large number of patients. Private hospitals may have better facilities, but the cost of treatment can be very high. As a result, a patient's ability to pay may indirectly affect their access to critical care. For example, a patient may find an available ICU bed in a private hospital but may not be able to afford the treatment.17 This creates a situation where access to life-saving treatment depends not only on medical need but also on financial capacity. Emergency treatment should not be refused simply because a patient cannot immediately make a payment. Hospitals must follow the applicable emergency treatment requirements and must not allow financial considerations to replace proper medical assessment.

Problems in Advance Medical Directives and End-of-Life Care

Another important issue is the continued use of life-support treatment in patients who may not benefit from further intensive treatment. In some cases, patients with serious and irreversible

[15] Divatia et al., 2021

[16] Emanuel et al., 2020; Persad et al., 2009

[17] Divatia et al., 2021; Paschim Banga Khet Mazdoor Samity v. State of West Bengal, 1996

medical conditions remain in ICUs for long periods. Doctors and family members may find it difficult to decide whether life-support treatment should continue or be withdrawn. Fear of legal action, lack of awareness and family disagreement can make these decisions even more difficult. In Common Cause v. Union of India (2018), the Supreme Court recognised the right to die with dignity and accepted the validity of advance medical directives. The Court also recognised the importance of decisions relating to withholding or withdrawing medical treatment in certain circumstances. In January 2023, the Supreme Court simplified the procedure for implementing advance medical directives by modifying some of the earlier requirements. Despite these developments, hospitals still face practical difficulties in implementing end-of-life decisions. Many patients and family members are also not fully aware of advance medical directives. The 2024 joint position statement of the Indian Society of Critical Care Medicine and the Indian Association of Palliative Care provides important guidance on end-of-life care and decision-making in ICUs. Hospitals should give more attention to palliative care and proper communication with families. This can help patients receive care that respects their wishes and medical condition. It can also support better use of limited ICU facilities (Mani et al., 2024; Rajagopalan & Kapadia, 2024).

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Fear of Legal Action Among Doctors

Doctors work under great pressure, especially in emergency departments and ICUs. They must make decisions quickly, sometimes without having enough time or resources. If a patient dies after being denied an ICU bed, the family may question the doctor's decision. In some cases, doctors may face police complaints, court cases or public criticism. Because of this fear, doctors may avoid making difficult decisions. They may admit patients to the ICU even when intensive treatment may provide very little benefit. They may also continue treatments because they are worried about possible legal action. This situation can affect other patients who genuinely need critical care. Doctors should be held responsible when they commit negligence or act dishonestly. However, they should not be punished merely for making a genuine medical decision during a shortage of resources.18

[18] Jacob Mathew v. State of Punjab, 2005

VI. RECOMMENDATIONS FOR IMPROVING FAIR ALLOCATION OF MEDICAL RESOURCES

The shortage of ICU beds and other medical facilities cannot be solved only by placing responsibility on individual doctors. The government, hospitals and medical professionals must work together to develop a fair system. The following measures may help improve the present situation.19

Introduce Clear Triage Guidelines

Hospitals should prepare written guidelines for allocating ICU beds, ventilators and other critical medical facilities. These guidelines should explain how patients should be assessed and how priority should be decided. Medical factors such as the seriousness of the illness and the possibility of benefiting from intensive treatment should be considered. The rules should also prevent discrimination based on caste, religion, gender, disability or financial status. A common framework would help doctors make decisions with greater confidence and reduce confusion during emergencies.20

Establish Hospital Triage Committees

The decision about who receives the last available ICU bed should not always depend on one doctor. Hospitals should establish a committee consisting of senior doctors, intensivists and other suitable medical professionals. Where necessary, medical ethics experts may also be included. The committee should examine the medical condition of patients and make decisions according to approved guidelines. This method can reduce personal bias and ensure that decisions are properly recorded. It can also protect doctors from carrying the entire burden of difficult decisions alone.

Strengthen Hospital and Government Responsibility

Hospitals must maintain proper records of ICU admissions, bed availability and emergency treatment decisions. The government should also take steps to improve critical care facilities, especially in rural and economically weaker areas. Hospitals must not use a shortage of beds as an excuse for poor administration or unfair treatment. If the problem is caused by improper management, the institution should be held responsible. Legal authorities should carefully distinguish between genuine shortages and failures caused by negligence or administrative misconduct.21

[19] Emanuel et al., 2020

[20] Emanuel et al., 2020; Persad et al., 2009

Provide Legal Protection for Good-Faith Triage Decisions

Doctors need reasonable legal protection when they make genuine decisions during serious medical shortages. The government should consider introducing specific legal provisions to protect doctors who follow approved triage guidelines and act honestly in the interest of patients. Such protection should apply only when doctors follow proper procedures, record their reasons and act without discrimination or personal benefit. However, this protection should not cover gross negligence, intentional wrongdoing, corruption or deliberate denial of treatment. This would help doctors perform their duties without unnecessary fear while maintaining accountability towards patients.

Improve Advance Medical Directives and Palliative Care

Hospitals should create awareness about advance medical directives and the right of patients to make decisions about their treatment. Doctors should discuss the available treatment options with patients and their families, especially when a patient has a serious and irreversible medical condition. Palliative care services should also be strengthened in

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government and private hospitals. The guidelines issued by ISCCM and IAPC in 2024 can help hospitals improve end-of-life care and make appropriate medical decisions (Mani et al., 2024). These steps can protect patient dignity and reduce unnecessary medical treatment where further intensive care is not beneficial.22

Increase Investment in Critical Care Facilities

The long-term solution is to improve the healthcare system itself. The government should increase investment in ICU beds, ventilators, oxygen facilities, trained nurses and critical care doctors. Special attention should be given to rural hospitals and government medical institutions. Hospitals should also develop proper emergency referral systems so that patients can be transferred to another suitable hospital when the required facilities are not available. Improving the availability of medical facilities will reduce the number of situations where doctors have to choose between two critically ill patients.

VI. CONCLUSION

The question of who should receive the last available ICU bed is one of the most difficult issues in medical ethics. When hospitals do not have enough facilities, doctors must make decisions that may affect the lives of patients. Such decisions cannot be treated as ordinary medical decisions because they involve human rights, fairness and legal responsibility. In India, doctors have a duty to provide proper medical care, but they cannot be expected to provide facilities that are not available. At the same time, hospitals and the government have a responsibility to improve healthcare facilities and ensure that emergency patients are treated fairly. The existing legal framework provides protection against medical negligence and recognises the importance of emergency medical treatment. However, there is a need for clearer guidelines on the allocation of limited medical resources. This article argues that the responsibility for resource allocation should not be placed entirely on individual doctors. Hospitals should establish proper triage committees and follow transparent medical guidelines. Doctors who make honest decisions according to approved procedures should also receive reasonable legal protection. More importantly, the government must take steps to improve critical care facilities and reduce the difference between public and private healthcare services. The allocation of an ICU bed should never depend on a person's wealth, social position or personal influence. Every patient deserves fair consideration and respect. A proper legal and ethical system must protect both patients who need treatment and doctors who are required to make difficult decisions. In conclusion, the aim of healthcare law should not be only to identify who is responsible after a patient dies. It should also ensure that hospitals have a fair system to protect lives before such tragedies occur.23

[21] Paschim Banga Khet Mazdoor Samity v. State of West Bengal, 1996; Divatia et al., 2021

[22] Mani et al., 2024; Common Cause v. Union of India, 2018; Rajagopalan & Kapadia, 2024

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