Recommendations for Ethical Allocation of Oncology Medications in Shortage

AUGUST 17, 2026

Disclaimer: This document summarizes recommendations to ethically address critical medication shortages in oncology and relied on collaboration and input from: (1) an expert panel of physicians, pharmacists, ethicists, and Minnesota Department of Health (MDH) staff and (2) the MDH Science Advisory Team.

This document is not legal advice, it does not carry the force or effect of law, and it should not be construed as a statement of legal or regulatory requirements or protections. Health care facilities or systems implementing strategies to manage critical medication shortages and other crisis situations are strongly encouraged to consult with legal counsel, and coordinate their efforts with health system leadership, Health Care Coalition (HCC) partners, and MDH.

Background

Critical shortages of oncology medications affect the ability of health systems in Minnesota to provide these medications consistently and reliably to all patients (adult or pediatric).

This document provides a framework for ethical allocation, care delivery, and organizational response during critical shortages of oncology medications. It also aims to provide a basis for consistent response to these situations among institutions and systems across the State of Minnesota, to promote transparency, fairness, and a whole community approach to the response. It is based on common ethical values endorsed through a public engagement process regarding crisis response, a prior ethical framework for allocation of oncology medications in Minnesota, medical ethics literature, and guidance from national groups.

This guidance incorporates the input of two statewide groups: (1) an expert panel composed of physicians, pharmacists, ethicists, and MDH staff; and (2) the MDH Science Advisory Team. The panel consists of MDH staff and voluntary participants from across the state, convened by the Metro Health & Medical Preparedness Coalition at the request of health professionals involved in managing the shortage. The MDH Science Advisory Team is a multidisciplinary group of subject matter experts organized under a federally funded planning effort to provide evidence-based scientific recommendations to hospitals, health systems, and health care coalitions regarding crisis standards of care.

This document is formatted to ease implementation. For a fuller explanation of recommendations, please see the Appendix.

Ethical values guiding response to shortages

Fundamental ethical commitments

Pursue Minnesotans' common good in ways that:

- Are accountable, transparent, and worthy of trust.
- Promote solidarity and mutual responsibility.
- Respond to needs respectfully, fairly, effectively, and efficiently.

Ethical objectives

Three equally important objectives should be met to honor the fundamental ethical commitments above:

- Protect the population's health
- Respect individuals and groups
- Strive for fairness and protect against systematic unfairness.

Definition of tiers for risk-based adaptations (adapted from ASPR TRACIE CRESTS)

Typical supply to low-risk shortage	Moderate shortage	Critical shortage
Adaptations to manage shortage should pose very low risk for adverse outcomes	Additional adaptations to manage shortage may pose moderate risk of complications/adverse outcomes for some patients, but serious adverse outcomes should not be expected	Given scarcity, cannot avoid additional adaptations that pose significant risk of severe complications/adverse outcomes
Examples of possible adaptations: Strategies to avoid waste (e.g. vial-splitting/aliquoting, pooling patient administrations, rounding doses down, reduce number of pharmacy batch times) Regional coordination to share shortage medication or transfer patient Alternative regimen with basically equivalent outcome	Maintain adaptations from green tier. Examples of additional possible adaptations: Alternative regimen with additional side effects or unclear but expected near-equivalency in terms of outcomes Restrict use to curative intent	Maintain adaptations from green and yellow tiers. Crisis standards of care: Prioritize patients who can most benefit, proportional to supply available

Typical supply to low-risk shortage	Moderate shortage	Critical shortage
Goal: to maintain outcomes consistent with usual standard of care for as long as possible, even though care strategies will alter/adapt to manage shortage. When it is no longer possible to achieve this goal, the ethically appropriate strategy is to implement crisis standards of care. Transition back to usual standards of care as shortage eases.		

Notes:

- ASPR TRACIE CRESTS advises: "All Tier 2 [yellow/moderate] and 3 [red/critical] shortages should involve regional coordination and information sharing to discuss strategies, balance resources, and ensure consistent tiers are being used (i.e., the patient care strategies are as similar as possible within the region…)."
- The ASPR TRACIE CRESTS resources include diagnosis-specific considerations for ifosfamide (e.g., sarcoma, lymphoma, etc.), in addition to the general guidance above which may be generalized to other oncology medications. ASPR TRACIE CRESTS also offers general guidance; the American Society of Health-System Pharmacists (ASHP) offers additional information about medication shortages.

Ethical approach to allocating oncology medications during critical shortage

Extend supply of scarce medications to maintain outcomes consistent with usual standard of care

CONSERVE SUPPLY	SUBSTITUTE ALTERNATIVES	ADAPT TREATMENT PLANS
• Minimize waste • Reserve supply for curative intent • Pause clinical trial enrollment or seek protocol deviations if possible	• If possible, use the most equivalent alternative based on evidence or expert judgment	• Lowest effective dose at most extended interval possible

Notes:

- *Not all patients being treated with curative intent should receive medications in shortage.* Use alternatives, if possible, without substantially increasing risk of poor outcomes. Consider need for medication in shortage. For example, as Hantel et al suggest, "if a scarce drug used in the adjuvant setting boosts an already high chance of cure only slightly," consider withholding or substituting for it to preserve supply for those with greater need.
- Appropriate alternatives should be considered irrespective of phase of treatment.
- Patients have an ethical right to appropriate palliation; work to address needs for palliation while striving to conserve medications in short supply.

Maximize benefits of scarce medications while minimizing harms and promoting fairness

Clinical prognosis should drive allocation decisions

Substantial differences in prognosis are ethically relevant in differentiating between patients. Small differences should be viewed as morally equivalent and should not be used to allocate resources to or withhold resources from patients.

Use these criteria to prioritize patients

- Likelihood of cure, survival, or substantial prevention of disease progression if they are treated with the medication(s) in shortage
- Availability of appropriate substitutes
- Consideration of whether current supply should be committed to completion of regimens for current patients

Notes:

- Apply these criteria to both primary treatment regimens and salvage use (i.e., treatment used when the patient's cancer does not respond to initial treatment or the disease returns after a period of remission).
- Assessments of likelihood of cure, survival, or substantial prevention of disease should consider quality of evidence
- Appropriate substitutes should be based on evidence or expert judgment.
- If additional supply is likely to become available, consider taking on new patients and relying on additional shipments to provide supply for completion of regimens, to avoid withholding or delaying treatment for patients who should receive priority.
- If additional supply is not likely to become available, then preferentially commit to completion for current patients, while assessing whether there may be reasons to reconsider completion (based on patient difficulties tolerating regimen or indications of lack of effectiveness), thus potentially freeing supply for additional patients.
- Health systems and facilities should determine objective institution-specific thresholds of stock medication levels to determine low, moderate, and severe shortage based on past usage patterns.
- Providers should work in collaboration within health systems and facilities. Likewise, health systems and facilities should work in collaboration with MDH and regional partners to promote situational awareness and strive to ensure that different institutions do not offer different standards of care (e.g., transparently share information; adopt a consistent framework for response; share the shortage medication between systems/facilities, if possible, when some are affected by the shortage more severely than others).

DECISIONS ABOUT ALLOCATION PRIORITIES SHOULD NOT CONSIDER OR BE BASED UPON:

- Race, ethnicity, gender, gender identity, sexual orientation or preference, religion, citizenship or immigration status, or socioeconomic status
- Ability to pay
- Age as a criterion in and of itself (this does not limit consideration of a patient's age in clinical prognostication of likelihood to survive their cancer)
- Disability status as a criterion in and of itself (this does not limit consideration of a patient's physical condition in clinical prognostication of likelihood to survive their cancer)
- Predictions about baseline life expectancy beyond the current episode of care (i.e., life expectancy if the patient were not facing the current crisis, sometimes referred to as life years saved), unless the patient is imminently and irreversibly dying or terminally ill with life expectancy under 6 months (e.g., eligible for admission to hospice)
- First come, first served
- Judgments that some people have greater "quality of life" than others
- Judgments that some people have greater "social value" than others

Notes:

- This list of criteria that should not be considered is meant to be illustrative and not necessarily exhaustive.
- It is ethically permissible to consider prioritizing multiple smaller patients over one larger patient when weight-based dosing is used, if doing so best promotes survival of the most patients currently seeking treatment, given available supply. However, as ASPR TRACIE CRESTS advises, "[p]re-emptive withholding of treatment of larger patients for theoretical benefit of multiple others is unjustified." Doing so would unjustifiably discriminate against larger patients. Any consideration of prioritizing based on size/weight should "involve multidisciplinary discussion including ethics consultation…."
- Residents from other states seeking care in Minnesota should be eligible to receive medications in shortage consistent with the guidance in this framework. Many individuals from other jurisdictions routinely seek care in Minnesota. This practice should be allowed to continue, despite the resource shortage.

Fair processes for allocation within health facilities/systems

Implement fair processes for allocation within facilities/systems

- Assess the needs/prognoses of all affected patients

- Apply the ethical considerations in this framework
- Involve personnel with relevant expertise and preferably no treating relationship to patients under consideration
- Allow time-limited process for real time review of decisions
- Document decisions and implement process for retrospective review

Notes:

- Include ethics personnel in allocation decision-making process as needed.
- Separating allocation decision-making from personnel treating patients avoids bias and allows treating clinicians to maintain their role of advocating for their patients.
- Real time review of allocation decisions may be requested by treating clinicians on limited bases: concern that the allocation decision was based upon misinformation about allocation criteria such as the patient's prognosis; or concern that the decision was based upon a deviation from (1) the ethical considerations specified in this framework, or (2) the system/facility's established decision-making process.
- Retrospective review aims to ensure consistency with this ethical framework, and to assess possible shortcomings that might require adjusting the approach to allocation (e.g. disproportionate impact on some groups of patients).

Take a Whole Community Approach to Allocation

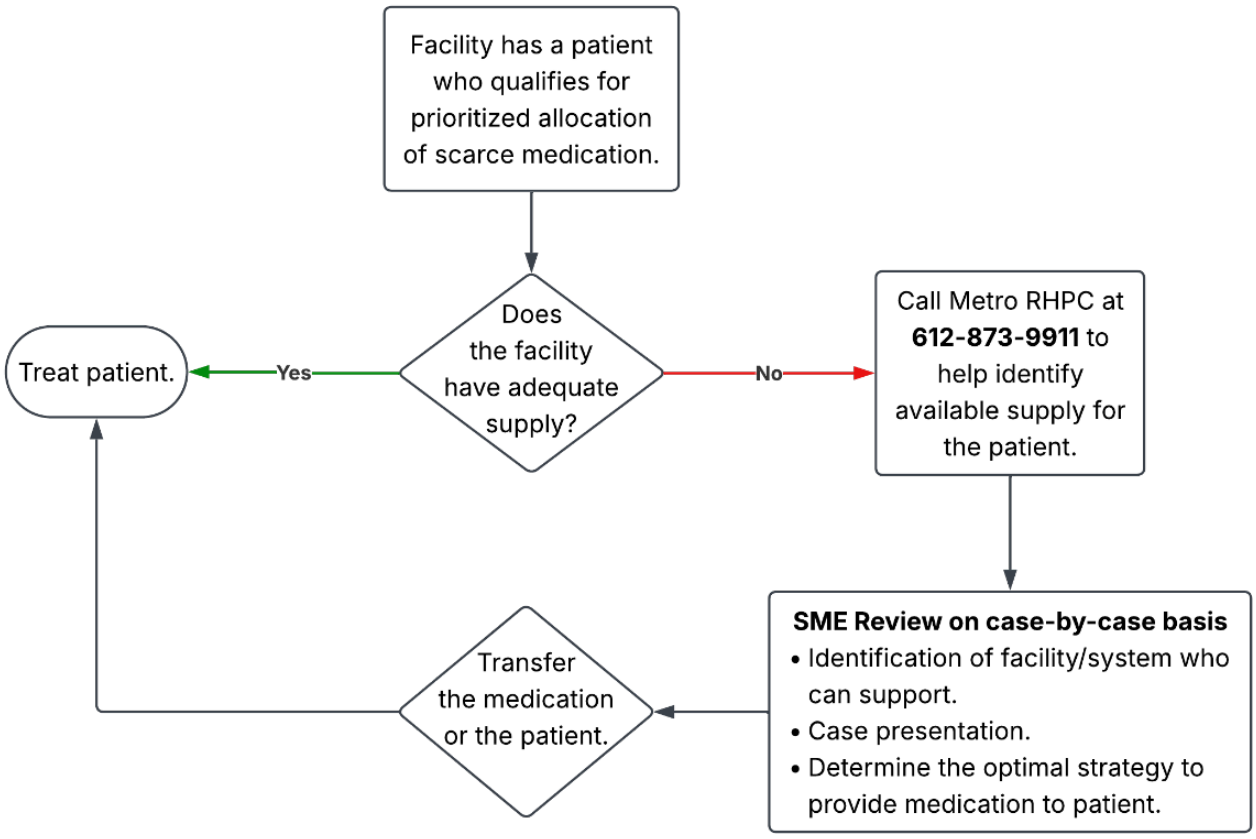
- Promote fair access and outcomes for all
- Implement fair process for allocation between facilities/systems

Fair access and outcomes:

- The Society of Gynecologic Oncology and their partners note that "…[C]ancer care disparities may emerge or worsen in times of resource scarcity. As treatment recommendations are adjusted during this shortage, identifying patients at risk for experiencing structural barriers to care—and having a plan to mitigate those barriers—must be considered as part of each institution's strategic plan."
- A whole community approach to allocation involves, for example:
    - Sharing shortage medication between facilities/systems to promote access for all patients regardless of where they typically seek care
    - Promoting access for rural and underserved populations, including populations affected by health disparities
    - Removing financial barriers to care wherever possible
    - Providing language interpretation and culturally appropriate communication
    - Conducting retrospective review of allocation decisions to avoid disproportionate impact on some groups of patients

Fair processes for allocation between health facilities/systems

While all health systems/facilities in the state may be affected by the critical shortage of these medications, the severity of shortages may vary across facilities. The Metro Region Regional Healthcare Preparedness Coordinator (RHPC) will coordinate the process outlined below to facilitate sharing resources to meet patient needs. The Metro Region RHPC serves the state in this situation, not only the Metro Region. Please see the Appendix for a fuller explanation of the process.



Note: "SME Review" refers to review by subject matter experts.

Ethical duties of health systems/facilities to provide support

Ethics Support

- To assist with allocation decision making
- To address moral distress of clinical teams

Mental health and spiritual care

- For clinical personnel
- For patients and families

Communications support

- For transparency about response
- Create tools for communication to patients and clinicians about the shortage and what is being done to address it
- To assist patients with special communications needs (e.g., language interpreters)

Notes:

- Given that health professionals have an ethical duty to care in crises, healthcare organizations have a corresponding ethical duty to support those professionals in the discharge of their duty. This includes providing appropriate support for response to resource shortages (e.g., training, guidance, decision-making support), as well as offering assistance for predictable needs such as ethics support and mental health and spiritual care.
- The ethical duty to respect patients entails that healthcare organizations should provide the best care possible under the circumstances of resource shortages. This duty includes not only providing ethically designed treatment plans but also transparent communication as well as mental health and spiritual care.

APPENDIX

Full explanation: recommendations for ethical allocation of oncology medications in shortage

Disclaimer: This document summarizes recommendations to ethically address critical medication shortages in oncology and relied on collaboration and input from: (1) an expert panel of physicians, pharmacists, ethicists, and Minnesota Department of Health (MDH) staff, (2) the MDH Science Advisory Team.

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Background

In recent years, critical shortages of oncology medications, including carboplatin, cisplatin, oxaliplatin, and ifosfamide, among others, have affected the ability of health systems in Minnesota to provide these medications consistently and reliably to all patients (including adult and pediatric patients).

This document provides a framework for the ethical allocation of these medications when they are in short supply; it is intended to guide care delivery and organizational response during periods of critical shortage. It also aims to provide a basis for consistent response to these situations among institutions and systems across the State of Minnesota, to promote transparency, fairness, and a whole community approach to the response. It is based on common ethical values endorsed through a public engagement process regarding crisis response, a prior ethical framework for allocation of oncology medications in Minnesota, medical ethics literature, and guidance from national groups. It incorporates the input of two statewide groups: (1) an expert panel of physicians, pharmacists, ethicists, and MDH staff; and (2) the MDH Science Advisory Team. The panel consists of MDH staff and voluntary participants from across the state, convened by the Metro Health & Medical Preparedness Coalition at the request of health professionals involved in managing the shortage. The MDH Science Advisory Team is a multidisciplinary group of subject matter experts organized under a federally funded planning effort to provide evidence-based scientific recommendations to hospitals, health systems, and health care coalitions regarding crisis standards of care.

Ethical values guiding response to shortages

Fundamental ethical commitments

Pursue Minnesotan's common good in ways that:

- Are accountable, transparent, and worthy of trust.
- Promote solidarity and mutual responsibility.
- Respond to needs respectfully, fairly, effectively, and efficiently.

These fundamental ethical commitments ground this ethical framework; they constitute the most basic ethical obligations for public health event planning and response.

Ethical objectives

Three equally important objectives should be met to honor the fundamental ethical commitments above:

- Protect the population's health
- Respect individuals and groups
- Strive for fairness and protect against systematic unfairness.

Definition of tiers for risk-based adaptations (adapted from ASPR TRACIE CRESTS)

Typical supply to low-risk shortage	Moderate shortage	Critical shortage
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Examples of possible adaptations: Strategies to avoid waste (e.g. vial-splitting/aliquoting, pooling patient administrations, rounding doses down, reduce number of pharmacy batch times) Regional coordination to share shortage medication or transfer patient Alternative regimen with basically equivalent outcome	Maintain adaptations from green tier. Examples of additional possible adaptations: Alternative regimen with additional side effects or unclear but expected near-equivalency in terms of outcomes Restrict use to curative intent	Maintain adaptations from green and yellow tiers. Crisis standards of care: Prioritize patients who can most benefit, proportional to supply available
Goal: to maintain outcomes consistent with usual standard of care for as long as possible, even though care strategies will alter/adapt to manage shortage. When it is no longer possible to achieve this goal, the ethically appropriate strategy is to implement crisis standards of care. Transition back to usual standards of care as shortage eases.		

Notes:

- ASPR TRACIE CRESTS advises: “All Tier 2 [yellow/moderate] and 3 [red/critical] shortages should involve regional coordination and information sharing to discuss strategies, balance resources, and ensure consistent tiers are being used (i.e., the patient care strategies are as similar as possible within the region...).”
- The ASPR TRACIE CRESTS resources include diagnosis-specific considerations for ifosfamide (e.g., sarcoma, lymphoma, etc.), in addition to the general guidance above which may be generalized to other oncology medications. ASPR TRACIE CRESTS also offers general guidance; the American Society of Health-System Pharmacists (ASHP) offers additional information about medication shortages.

Ethical approach to allocating oncology medications during the critical shortage

Extend supply of scarce medications to maintain outcomes consistent with the usual standard of care

- Use strategies to conserve supply, substitute acceptable alternatives for scarce medications, and adapt treatment plans to preserve supply.
  - Adopt strategies based on evidence or expert judgment
  - Conservation strategies include:
    - Minimizing waste (e.g., by coordinating patient scheduling to fully use vials)
    - Reserving scarce supply for patients with curative treatment intent for whom alternatives are not available or appropriate (i.e., non-acceptable survival trade-off).
      - Note that not all patients being treated with curative intent should receive medications in short supply. For example, as Hantel et al suggest, “if a scarce drug used in the adjuvant setting boosts an already high chance of cure only slightly,” consider withholding or substituting for it to preserve supply for those with greater need.
    - Pausing clinical trial enrollment or seeking protocol deviations if possible.
  - Substitution strategies include switching patients with palliative (or non-curative) intent to alternatives if possible.
    - Patients have an ethical right to appropriate palliation; work to address needs for palliation while striving to conserve medications in short supply.
    - Appropriate alternatives should be considered irrespective of phase of treatment. For patients whose treatment includes a maintenance phase, consider deprioritizing treatment, less frequent administration, lower dose, etc.
  - Adaptations include working to ensure each treatment plan is designed to provide the lowest effective dose of medication(s) in shortage at the most extended interval possible.

Maximize benefit of these scarce resources while minimizing harms and promoting fairness:

- Rationing should be avoided if possible. Efforts should be made to extend supplies through conservation, adaptation and substitution before implementing triage or rationing; organizations should triage/ration only as a last resort.
- Clinical prognosis should drive allocation decisions.
    - Substantial differences in prognosis are what is ethically relevant in differentiating between patients; small differences should be viewed as morally equivalent and should not be used to allocate resources to or withhold resources from patients.
- If needed, prioritize patients based on the following criteria:
    - likelihood of cure, survival, or substantial prevention of disease progression if they are treated with the medication(s) in short supply, whether primary treatment regimens or salvage use (i.e., treatment used when the patient's cancer does not respond to initial treatment or the disease returns after a period of remission), these assessments should include consideration of quality of evidence availability of appropriate substitutes, based on evidence or expert judgment
    - consideration of whether current supply should be committed to completion of regimens for current patients
        - If additional supply is likely to become available, consider taking on new patients and relying on additional shipments to provide supply for completion of regimens, to avoid withholding or delaying treatment for patients who should receive priority
        - If additional supply is not likely to become available, then preferentially commit to completion for current patients, while assessing whether there may be reasons to reconsider completion (based on patient difficulties tolerating regimen or indications of lack of effectiveness), thus potentially freeing supply for additional patients.
    - Health systems/facilities should determine thresholds for contracting and expanding allocation of a medication in shortage, based on their patient population and best available information about likely supply. That is, they should determine objective institution-specific thresholds of stock medication levels to determine low, moderate and severe shortage based on past usage patterns.
    - Providers should work in collaboration within health systems/facilities. Likewise, systems/facilities should work in collaboration with MDH and regional partners to promote situational awareness and strive to ensure that different institutions do not offer different standards of care, e.g., by transparently sharing information, adopting a consistent framework for response, and sharing the shortage medication between systems/facilities, if possible, when some are affected by the shortage more severely than others.
- Decisions about allocation priorities ***should not*** consider or be based upon:
    - Race, ethnicity, gender, gender identity, sexual orientation or preference, religion, citizenship or immigration status, or socioeconomic status
    - Ability to pay
    - Age as a criterion in and of itself (this does not limit consideration of a patient's age in clinical prognostication of likelihood to survive their cancer)

    - Disability status as a criterion in and of itself (this does not limit consideration of a patient's physical condition in clinical prognostication of likelihood to survive their cancer)
    - Predictions about baseline life expectancy beyond the current episode of care (i.e., life expectancy if the patient were not facing the current crisis, sometimes referred to as life years saved), unless the patient is imminently and irreversibly dying or terminally ill with life expectancy under 6 months (e.g., eligible for admission to hospice)
    - First come, first served
    - Judgments that some people have greater "quality of life" than others
    - Judgments that some people have greater "social value" than others
        - This list of criteria that should not be considered is meant to be illustrative and not necessarily exhaustive.
- It is ethically permissible to consider prioritizing multiple smaller patients over one larger patient when weight-based dosing is used, if doing so best promotes survival of the most patients currently seeking treatment, given available supply. However, as ASPR TRACIE CRESTS advises, "[p]re-emptive withholding of treatment of larger patients for theoretical benefit of multiple others is unjustified." Doing so would unjustifiably discriminate against larger patients. Any consideration of prioritizing based on size/weight should "involve multidisciplinary discussion including ethics consultation…."
- Residents from other states seeking care in Minnesota should be eligible to receive medications in shortage consistent with the guidance in this framework. Many individuals from other jurisdictions routinely seek care in Minnesota. This practice should be allowed to continue, despite the resource shortage.

Implement fair processes for allocation of these resources within health facilities/systems

- Health systems/facilities should implement a transparent, and fair process to assess the needs of all affected patients, to ensure the ethical allocation of oncology medications during the period of critical shortage.
    - This process should incorporate ethical considerations outlined in this framework.
    - Ideally, the process will be managed by individuals/teams with relevant expertise who have no treating relationship with patients whose plans are under consideration to avoid bias and allow treating clinicians to maintain their advocacy role for their patients.
        - Include ethics personnel as needed
    - Where possible, include a streamlined, time-limited process for review of allocation decisions at provider request. To minimize burden on systems/facilities, these reviews should be limited to cases in which the requestor provides:
        - Objective information that the allocation decision was based upon misinformation about allocation criteria such as the patient's prognosis; or
        - Objective information that the decision was based upon a deviation from (1) the ethical considerations specified in this framework, or (2) the system/facility's established decision-making process.
- Health systems/facilities should document allocation decisions and implement a process for retrospective review of allocation decisions, to ensure consistency with this ethical framework, and to

assess any possible shortcomings that might require adjusting the approach to allocation (e.g., disproportionate impact on some groups of patients).

Adopt a whole community approach to allocation

- **Promote fair access and outcomes for all**
    - The Society of Gynecologic Oncology and their partners note that "…[C]ancer care disparities may emerge or worsen in times of resource scarcity. As treatment recommendations are adjusted during this shortage, identifying patients at risk for experiencing structural barriers to care—and having a plan to mitigate those barriers—must be considered as part of each institution's strategic plan.
    - A whole community approach to allocation involves, for example:
        - Sharing shortage medication between facilities/systems to promote access for all patients regardless of where they typically seek care
        - Promoting access for rural and underserved populations, including populations affected by health disparities
        - Removing financial barriers to care wherever possible
        - Providing language interpretation and culturally appropriate communication
        - Conducting retrospective review of allocation decisions to avoid disproportionate impact on some groups of patients
- **Implement fair processes for allocation of these resources between health facilities/systems, to promote a whole community approach to treatment**
    - While all health systems/facilities in the state may be affected by the critical shortage of these medications, the severity of shortages may vary across facilities. If a facility is caring for a patient who qualifies for prioritized allocation of scarce medication, but lacks supply to provide treatment, that facility may reach out to the Regional Healthcare Preparedness Coordinator (RHPC) for the Metro Region at 612-873-9911 to help identify available supply for that patient. The Metro Region RHPC serves the state in this situation, not only the Metro Region. All systems/facilities throughout the state are encouraged to call this number when seeking assistance with locating supply.
    - The Metro RHPC will coordinate the following decision-making process:
        - Identify whether another system and facility may be able to support the patient's needs.
        - Rapidly convene a group of subject experts (SMEs) to review the case to determine the optimal strategy, either transferring the medication across system/facilities, or transferring the patient's care to the accepting system/facility.
        - If both options are possible, it would be more ethically preferable to transfer medication doses between systems/facilities, since this will avoid unduly disadvantaging the patient by requiring travel, additional expense, or other burdens to access the medication(s). In some cases, there may be barriers to transferring medications, however. MDH and other state agencies may be able to assist with addressing barriers to transferring medications, if any. If it is not possible to resolve the barriers, the only available option may be to transfer the patient to the system or facility with available supply of the medication.

        - The group of SMEs will include ethicists as well as providers with relevant expertise/roles from facilities across the state.
    - The facility seeking treatment options for their patient will present a brief, de-identified case summary including the patient's diagnosis, comorbidities, whether treatment intent is curative or not, and other relevant information (for example, the patient's ability to travel to another system to seek care, whether the patient's insurance would permit transfer to another system).
    - The group of SMEs will discuss requests to access treatment on a case-by-case basis, consistent with the recommendations provided in this ethical framework, to promote fairness and a whole community approach to management of the shortage.
    - New patients—including both newly diagnosed patients already affiliated with the health system, and unaffiliated patients who cannot access medication at their usual point of care—should be triaged using these same principles.

Ethical duties to provide support

- Given that health professionals have an ethical duty to care in crises, healthcare organizations have a corresponding ethical duty to support those professionals in the discharge of their duty. This includes providing appropriate support for response to resource shortages, including
    - training, guidance, and decision-making support
    - ethics support for allocation decision-making and addressing moral distress
    - mental health and spiritual care.
- The ethical duty to respect patients entails that healthcare organizations should provide the best care possible under the circumstances of resource shortages. This duty includes providing
    - ethically designed treatment plans
    - transparent communication
        - Health systems/facilities should create tools for communicating to patients and clinicians about the shortage and what is being done to address it.
        - These institutions should also assist patients with special communications needs, such as interpreters.
    - mental health and spiritual care, given the distressing nature of the challenges posed by this crisis.

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