Bioethics Outlook

Plunkett Centre for Ethics

Australian Catholic University,
St Vincent's Health Australia (Sydney)
& Calvary Healthcare

Volume 31, No 2 **June 2020**

Allocating healthcare resources in a pandemic: who decides, and how?

Bernadette Tobin

Do the principles upon which medical decisions should be made change dramatically in the context of a pandemic? I do not think so. To begin with, good practice in the care of people nearing the end of their lives has long included asking patients (or their substitute decision-makers) whether they would wish to forgo life-sustaining treatment such as intensive care, cardio-pulmonary resuscitation (CPR) or intubation. Informed refusal of these modes of intervention is, or should be, respected.

In addition

Julian Hughes explains the virtues of good healthcare professionals in the time of a pandemic.

David Albert Jones of the Anscombe Centre explains Catholic principles which inform the proper allocation of resources, in particular ventilators, in a pandemic.

And we publish the Ethical Principles which inform allocation of resources at Georgetown's University Hospital in Washington DC.

In addition, when appropriate circumstances arise, it is good practice, generally in consultation with the patient and family, to withhold CPR in the care of a patient for whom it would therapeutically futile (that is, to a reasonable degree of medical certainty, it would be either ineffective or repeatedly necessary with the patient nonetheless dying in a short time even if it is temporarily successful in restoring a heartbeat).

And one other thing. Life-sustaining treatment may legitimately be withheld or withdrawn for three different kinds of reason.

- First, if it is not genuinely therapeutic (and note that this is neither 'euthanasia' nor 'voluntary assisted suicide').

- Second, if it imposes too great a burden on the patient as an individual (which is a reason for encouraging advance care planning: what is burdensome for one person – say pain, or breathlessness - may be very different from what is burdensome for another – say isolation, or fear of causing inconvenience to the family).

- Third, life-sustaining treatment may be withheld or withdrawn if it is not reasonably available without disproportionate hardship to the carers or others (as well as to the patient).

Generally, the clinical team is a reliable judge of the first, the patient is a reliable judge of the second, and the healthcare team is a reliable judge of the third.

Why be confident that the healthcare team, doctors and nurses, are (or ought to be) a reliable judge of the extent to which life-sustaining treatment for one person creates hardship for others? The answer lies in the promise doctors and nurses made when they entered the profession: to 'care for the sick person'. Built into that Hippocratic commitment is the idea that treatment should be provided on the basis of medical need alone.

So long as doctors and nurses (and administrators) are not distracted by either utilitarianism (the imperative to maximize total 'life-years-saved' or total 'quality-adjusted-life-years-saved') or social prejudice against the elderly or the disabled or those suffering from addictions, so long as they are motivated by medicine's inherent ethic and do not subordinate that ethic to some other social goal like 'maximizing happiness', we can rely on them to allocate resources fairly.

To elaborate: If sick people find themselves, through no fault of their own, competitors for the same resource, doctors and nurses have a reliable ethic - according to which the need for treatment is the central organizing idea.

And so, if allocation becomes necessary, it should be based on patient need, prognosis and the prospect of success for therapy (ie the chances that the patient will recover). By extension, medical needs should be addressed in order of importance and, if a choice between two patients has to be made, preference should be given to the patient in greater need.

True, this ethical principle requires filling out with clinical criteria such as the assessment of known prognostic factors and the patient's pre-morbid and COVID-19 specific health status, aided where possible by objective clinical scores.

Once medical need is accepted as the proper basis on which allocation is to be made, then, in particular circumstances, its application might result (other things being equal) in giving preference to the patient:

- whose need is more urgent;
- who is more likely to benefit therapeutically from the available treatment;
- who is likely to gain the greater or longer therapeutic benefit from the treatment;
- who is likely to suffer the lesser burden from the treatment;
- who is likely to suffer the greater harm without the treatment;
- who is less at risk of various ill-effects from the treatment;
- who is likely to gain the same therapeutic benefit from less of the treatment;
- who is likely to need the treatment for a shorter time or less frequently;
- who has fewer or no alternative avenues of satisfying the need;
- who is more likely to infect others if untreated.

These 'priority criteria' are no more than illustrations of how 'allocate on the basis of medical need' *might* play out in many different circumstances.

Of course, we all hoped that it would not come to this in Australia: that was the point of the severe measures which were intended to slow down the pace of the spread of this virus. But hospitals were preparing for the worst whilst hoping for the best. And the rest of us might have been called upon to support clinicians in making decisions on our behalf.

Would they have been difficult decisions? No doubt. But doctors and nurses in emergency and intensive care would have been familiar with them. That said, in the circumstances of a pandemic, the involvement of a 2- or 3- person triage team, with clinical and ethical expertise, would be necessary.

In my view, these priority criteria are extensions of the ethical norms of Hippocratic medicine. Patients have the right to refuse any treatment. Trustworthy doctors do not provide (or even recommend) treatments they think would be therapeutically ineffective. In addition, they are sensitive to the possibility that a treatment option would impose hardships not only on the patient or on the family but also on others in the wider society.

At the moment, there is still discussion about how medical resources should be distributed. This is important.

In this context, we should support the women and men who put themselves in harm's way in order to help to save lives.

We should resist that any ethical theory – such as utilitarianism - which would subordinate medicine's inherent ethic to a supposedly 'greater good'.

We should assure the community that, because they know (or ought to know) that all sick people are of equal worth and thus equally worthy of being helped, our doctors and nurses can be relied upon to allocate scarce resources justly. Even in the circumstances of a pandemic. [1]

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[1] Sources include *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*; MedStar Georgetown University Hospital Ethical Principles of Resource Allocation in the Event of an Overwhelming Surge of COVID-19 Patients; Anthony Fisher and Luke Gormally, *Healthcare Allocation: An Ethical Framework for Public Policy*. London: Linacre Centre, 2001. An earlier version of this article was published on ABC Religion and Ethics: https://www.abc.net.au/religion/bernadette-tobin-allocating-heathcare-in-a-pandemic-coronavirus/12124632 6th April 2020

What the virtues have to offer in the midst of COVID-19

Julian C. Hughes

Now more than ever, in the midst of the COVID-19 pandemic, we need the virtues and the insights that virtue ethics afford us. We have all read or heard the dilemma: there is a shortage of intensive care staff or beds so that triage must take place and doctors are placed in a terrible position. The older person with comorbidities, over against the younger previously fit person, is likely to lose out.

The dilemma is described in terms of the tension between the duty to care for patients and the requirement that health care outcomes, at a population level, are maximized. The consequentialist (public health) argument wins rather than the deontological concern about the person in front of you. The upshot is that healthcare workers experience moral distress. This scenario is indeed a deeply distressing one. But is it possible that virtue ethics might be helpful? And, if so, it is interesting that the possibility is scarcely mooted. It is sometimes said that virtue ethics is good at describing matters but not much good at prescribing what should be done. In which case, who wants the virtue ethicist to turn up and start telling people the extent to which they do or do not have the virtues? So, how does virtue ethics help?

Well, it does describe what is going on and this can in itself be helpful. In the dilemma we are considering we can formulate the problem in terms of tension between different inner dispositions or virtues. The doctor or nurse wishes to be compassionate and to show fidelity to the patient right here, but practical wisdom tells her that she has to follow the national guidance and the protocol for treatment decisions. This is simply to restate the dilemma in a different form, except that consideration of the virtues is psychologically more subtle than this. For the virtues are not, in reality, exercised one at a time. They reflect moral character, which is made up of numerous dispositions, not just compassion and fidelity versus practical wisdom, but also honesty, justice, steadfastness, humility, courage, integrity and so on. We face these dilemmas as whole people and, moreover, with others and with the virtue of solidarity. There will be a tension that leads to moral distress, but this is in the context of other inner moral characteristics that will be helpful. At least, they might be helpful once they are named and acknowledged.

It is possible to make an analogy with grief. This is a process, which might make it seem different from moral distress. But coming to terms with moral distress is also a process. Just as in grief it might be helpful to learn that people often feel anger or depression as part of a normal grief reaction, so too in moral distress. It is normal that, if you have the virtue of charity, you will feel a deep sadness when you have to allow someone to die because you also have the virtue of prudence. And it might be helpful to be told that you have been just; and that sticking to the guidelines requires a steadfast spirit, which takes courage. Of course, just as grief can get “stuck” or can become all-consuming, so too moral distress might be overwhelming. In which case, the person needs help. But part of that help might involve discussing the person’s competing inner dispositions. Understanding the virtues, being aware of them, might prove therapeutic. In addition, virtue ethics also allows prescription. It suggests we should look to what the virtuous person would do. So, virtue ethics might well say to the doctor or other healthcare practitioner: show compassion, be brave, exhibit some integrity and the like. But, again, it does not do this in a crass way.

Once we are aware of the virtues and the role they play in our lives we can develop the tendency to ask ourselves questions about the decisions we are making. We can do this gently and in a human fashion. It is not an intellectual exercise, as it might be if I asked myself whether what I had just done was going to maximize welfare, or whether it is what I would choose if behind the veil of ignorance. No, the virtues suggest that I might ask myself, ‘Could I have imparted that news in a better way to the relatives?’; or I might pause to check some further details in the notes before I make a particular decision; or I might take a deep breath and tell myself to be brave as I ring someone up with some bad news, which I know I must impart if I am to be truthful. It is often said that virtue ethics is about what you become by what you do. It is how we develop and become better, more flourishing human beings, even in the face of tragedy. We do not avoid the tragedy or moral distress. We cannot metaphorically pat ourselves on the back for having done the right thing at a population level. The virtuous person will feel the distress but understand it as a natural consequence of the tasks he or she is required to carry out.

Finally, the virtue of solidarity also means that we are all in this together and it reminds us that the virtues are in evidence all around us during this crisis. They are seen in the small kindnesses extended by a neighbour, as well as in the sharing of research data in an open and transparent way between institutions and nations. We cannot and should not ignore the virtues. They are ubiquitous, as they should be, and we should laud them. They tell us how to live well as individuals and societies in the face of distress and hardship. [1]

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[1] https://blogs.bmj.com/medical-ethics/2020/04/19/what-the-virtues-have-to-offer-in-the-midst-of-covid-19/

Resource allocation and ventilators: Catholic principles

David Albert Jones

What does the Catholic tradition say about the allocation of healthcare resources during a pandemic? More specifically, in the context of the current pandemic, what does the Catholic tradition have to say about the provision of ventilation for patients with COVID-19?

The governing principle of medical ethics, as understood within the Catholic tradition, is the intrinsic worth or *dignity of every human being* as made in the image of God.[1] From this it follows that the life of every person is to be respected and protected in accordance with the fundamental requirements of justice.

Within the context of healthcare this principle *excludes intentional killing*, whether death is brought about by action or by deliberate omission.[2] Along with many religious and secular traditions of moral thought, the Catholic Church regards both 'mercy killing' (euthanasia) and medical assistance in suicide as unethical. Treatment or care should never be withdrawn or withheld with the aim or intention of hastening death.

Withholding and withdrawing treatment

The Church is clear, however, that there may be good reasons to withhold or withdraw treatment or care, either because it no longer serves its purpose (is *futile*), or because it is *excessively burdensome* in relation to physical, psychological, social, or economic costs, or because it promises too little benefit relative to the burdens it entails.[3] The Church does not teach, and has never taught, that life must be preserved at all costs. Sometimes the costs or burdens will be a reason not to institute or not to continue treatment.

Another relevant consideration is whether what is offered is medical in character or whether it is part of basic or ordinary care. In 2004, Pope John Paul II made it clear that *clinically assisted nutrition and hydration (CANH) is ordinary care* and is 'in principle obligatory'.[4] The in-principle ethical obligation to provide food and water, with clinically assistance if necessary, may not apply in some dying patients if it would not succeed in prolonging life or in alleviating their symptoms relative to the burdens it entails.[5] Nevertheless, feeding the

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[1] Genesis 1.27, see Vatican II *Gaudium et spes*, 1965: 12; John Paul II *Evangelium vitae*, 1995: 3; CBCEW *Cherishing life*, 2004: 39. Anscombe Bioethics Centre *The ethics of care of the dying person*, 2013: 3.

[2] SCDF *Jura et bona*, 1980: I; John Paul II *Evangelium vitae* 1995: 57.

[3] SCDF *Jura et bona*, 1980: IV; John Paul II *Evangelium vitae* 1995: 65; *Catechism of the Catholic Church* (*CCC*), 1992: 2278; Anscombe Bioethics Centre *The ethics of care of the dying person*, 2013: 6.

[4] John Paul II 'Address on Life-sustaining treatments and the vegetative state', 20 March 2004: 4; See also Anthony Fisher, 'On not starving the unconscious', *New Blackfriars*, 74 (March 1993), 130-145; CBCEW *A practical guide to the spiritual care of the dying person*, 2010: 2.6-2.10.

hungry and giving drink to the thirsty are foremost among the corporal works of mercy.[6] Furthermore, sharing food and water is a fundamental cross-cultural expression of hospitality and human solidarity. In contrast, Pope Pius XII stated that mechanical ventilation and resuscitation '*go beyond the ordinary means* to which one is bound', so that 'it cannot be held that there is an obligation to use them'.[7] They need not be used and should be used only where the likely benefits outweigh the burdens of treatment.

Note that neither in the case of CANH nor in the case of ventilation does the Catholic tradition make an absolute or in-principle *distinction between withholding and withdrawing*. It is in principle obligatory to start and in principle obligatory to continue CANH when these are needed to sustain life. In contrast, it is neither in principle obligatory to start nor in principle obligatory to continue ventilation, even when it could sustain life.

In this way the Catholic tradition differs from some other traditions (such as orthodox Judaism) in which it is not obligatory to start but it may obligatory to maintain continuous life-sustaining therapies. [8] On the other hand, the Catholic moral tradition also differs from other moral approaches which take as an absolute principle the *complete ethical equivalence* of withholding and withdrawing treatment as though the same criteria should always be applied to both.[9]

Most people recognise that the decision whether or not to take something away (for example, whether to call in a loan) is often different to the decision whether or not to give it in the first place. The circumstances are different. What is important here is that doctors should be willing to give treatment on a trial basis to see if it is successful, and they should not withhold treatment that might be beneficial just because they would not wish to face the difficult decision to withdraw it.

Advance decisions to refuse treatment

One good reason not to provide treatment is that the patient or his or her legitimate representative declines consent. The primary responsibility for a competent adult's health lies with that person. It is the person who will bear the suffering of illness and the risks or burdens of treatment. It is an *injustice to impose treatment that has been refused* by the patient, unless sanctioned by legitimate authorities for urgent or overriding reasons, for example, compulsory testing during a pandemic or compulsory treatment for mental illness. The principle of consent, and thus the *prima facie* right to forgo or decline treatment, is accepted by the Catholic Church.[10]

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[5] CBCEW *A practical guide to the spiritual care of the dying person*, 2010: 2.9.

[6] Matthew 25:31-46; *CCC* 2447.

[7] Pius XII 'Address to the International Congress of Anaesthesiologists', 24 November 1957 emphasis added.

[8] See for example, Avraham Steinberg and Charles Sprung 'The Dying Patient Act, 2005: Israeli innovative legislation', *IMAJ* (2007) 9: 550-552.

[9] See for example, GMC *Withholding and Withdrawing Life-Prolonging Treatments*, 2002: 19, but note that this doctrine of moral equivalence is not asserted in the updated guidance, GMC *Treatment and care towards the end of life*, 2010,33. See also CBCEW *A practical guide to the spiritual care of the dying person*, 2010: 2.9.

[10] See for example, USCCB *Ethical and Religious Directives for Catholic Health Care Services*, 2018: 26. Even in the case where the reasons for the refusal are unjust or unethical, for example an overtly suicidal refusal, it seems that lawful authority would be required to intervene in the face of a clear refusal of consent.

As the law may authorise compulsory treatment in exceptional circumstances, for certain purposes and with specific safeguards, so the law may clarify what weight should be given to advance statements or to the decisions of proxy decision makers. As it may sometimes be reasonable for a person to decline a current offer of treatment, it may sometimes be reasonable for someone to decline treatment in advance. The Church is *not opposed in principle to the making of advance decisions*.[11] However, decisions to decline treatment should be made for good reasons on the basis of the burdens and benefits of this treatment for this patient.

In contrast, the use of an advanced refusal of treatment as a means to hasten death, for example by the blanket refusal of all life-sustaining treatment or care if the person contracts a certain illness and is unable to make a contemporaneous decision, is a form of conditional suicide. Those who promote this form of advance refusal of treatment are effectively *promoting suicide by omission*. The blanket refusal of all life-sustaining treatment and care without consideration of potential benefits or burdens is not compatible with a Catholic understanding of the dignity of human life.

Allocating scarce resources

Where resources are limited it may not be possible to provide a treatment to everyone who could benefit from that treatment. In this case treatment may have to be rationed. The alternative to rationing is that the available resources go to groups or individuals who are wealthy or powerful, and those who are disadvantaged in society face a further disadvantage in accessing healthcare. This need for rationing is more overt in emergency situations, such as the present pandemic, but even outside emergency situations *rationing already exists* in all modern healthcare systems. The Church accepts the need to ration healthcare resources but requires that it is done in accordance with the norms of distributive justice and encourages it to be done transparently.

The key principle of justice in healthcare allocation is that *healthcare should be distributed in accordance to need*. However, there are different possible criteria for healthcare need. Archbishop Anthony Fisher and Professor Luke Gormally give ten measures of healthcare need: (1) greater urgency, (2) greater likelihood to benefit, (3) likelihood of greater benefit, (4) likelihood of lesser burden from treatment, (5) lesser likelihood of harm from treatment, (6) likelihood of greater harm without treatment, (7) likelihood to gain the same benefit from less treatment, (8) likelihood to need less treatment, (9) lack of alternative methods to satisfy need, and (10) greater likelihood to infect others if untreated.[12] It is evident that these measures may pull in different directions: for example, someone who is very ill may have more urgent needs but may be less likely to benefit.

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[11] CBCEW *The Mental Capacity Act and 'living wills': a practical guide for Catholics*, 2008: 4.2.

[12] Anthony Fisher and Luke Gormally, *Healthcare Allocation: An Ethical Framework for Public Policy*. London: Linacre Centre, 2001: 129 see also. Paul Gately, Ashley Beck and David Albert Jones *Healthcare Allocation and Justice: Applying Catholic Social Teaching*. London: CTS, 2010.

Usually, and reasonably, greater urgency is taken as the primary criterion for emergency treatment. However, if there are not enough resources to treat all urgent cases then it is also reasonable, and need not be unjust, to *favour a patient who is more likely to benefit*. On the other hand, there is no ethical requirement always to use this criterion. The treatment is not wasted if given to a patient who has urgent need and who has some prospect of benefit even if someone else might have benefited more. Nor need it be an injustice to save one person even if more could have been saved had you acted differently.[13] There is also a virtue in attending to the person in front of you and, even more, in continuing to treat someone whom you have started to treat. The beginning of treatment constitutes a human relationship and this changes the circumstances of the decision.

It is therefore reasonable for hospitals to have a system of queuing ('first come first served') combined with the priority of more urgent cases and, among these, priority for those most likely to benefit. Similarly, those receiving treatment should be reviewed regularly to assess whether the treatment is effective in relation to its goals. Healthcare professionals will often use tools to help with these assessments but these tools should reflect the actual health condition of the person. Policies that institute age limits or that exclude people on the basis of specific diseases or of specific disabilities do not necessarily reflect the condition of the person. Such approaches are both inaccurate (and hence contrary to prudence) and discriminatory (and hence unjust) and in many jurisdictions they would be unlawful.

There are no perfect solutions here. Decisions require the virtue of prudence and, even when the right decision is made, it will often be painful because it is hard not to be able to save everyone. It also takes courage to make the hard decisions that need to be made even though this involves the possibility of making a mistake. It is important that healthcare professionals who have to make these decisions are supported emotionally and that they are not judged too harshly in retrospect (nor judge themselves too harshly) where they have acted in good faith on limited knowledge.

There are reasonable disagreements about how to apportion resources justly when not everyone can have everything. Nevertheless, there also some truths that can be affirmed unequivocally. Decisions must never be made on the basis of negative value judgements about the worthwhileness of someone's life. People should not be excluded purely on the basis of age or disability. There are no lives unworthy of life. If a decision is made about who is next allocated a ventilator, this may be done on the basis of whether the ventilator is more or less likely to save this or that patient, but must not be done on the basis that this or that patient is more or less worth saving.

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[13] As argued by Elizabeth Anscombe in "Who was wronged? Philippa Foot and 'Double Effect'", Mary Geach and Luke Gormally (eds.) *Human Life, Action and Ethics,* Exeter: Imprint Academic, 2005: 249-252

MedStar Georgetown University Hospital Ethical Principles of Resource Allocation in the Event of an Overwhelming Surge of COVID-19 Patients

As a MedStar facility with a Catholic and Jesuit identity, we are guided at all times by our commitments to clinical excellence, compassionate care, and justice for all, in the spirit of *cura personalis.* We applaud the professionalism and dedication of our physicians, nurses, and other health care professionals. We applaud the patient-centeredness and teamwork of all our associates. These values and virtues inform our response to the COVID-19 crisis, as specified in the following statement of principles in anticipating the possibility of a surge of patients that might threaten to overwhelm our resources.

1. All patients (or surrogates of patients) with COVID-19, like all other patients, should be asked whether they wish to forgo life-sustaining treatments such as intensive care, CPR, or intubation. Informed refusal of these interventions should be respected.

2. All alternatives should be pursued before engaging in the rationing of ventilators or ICU care. These include therapies that are equivalent or nearly equivalent, sharing of equipment with other institutions, transfer, or even, with consent, therapeutic innovation with a reasonable prospect of success.

3. If rationing becomes necessary, it should be based on patient need, prognosis, and the prospect of success for therapy (i.e., chances that the patient will recover). This should be based on objective clinical criteria such as an assessment of known prognostic factors and the patient's pre-morbid and COVID-19- specific health status, aided, where possible, by an objective clinical score such as SOFA or APACHE II.

4. Rationing decisions should not be based solely upon age or disability. Rationing decisions should not be based on judgments of social worth or on a principle of maximizing total life-years or total quality-adjusted life-years saved. Age and disabling pre-morbid conditions might count among a number of factors in assessing prognosis or prospects of success, but there should be no arbitrary age cut-offs nor any arbitrary exclusions from care based on specific cognitive or motor disabilities.

Rationing decisions should be based upon whether the treatment is worthwhile, not on whether the patient is worth treating.

5. Rationing judgments should be made by a two to three-person triage team with both clinical and ethical expertise, independent of the caregivers.

6. DNR orders should be written with patient or family consent as deemed medically appropriate per usual hospital procedures. Per hospital policy, CPR can be withheld unilaterally from patients in whom it would be biomedically futile (that is, to a reasonable degree of medical certainty it would either be ineffective or repeatedly necessary with the patient dying in a very short period of time even if it is temporarily successful in restoring a heartbeat). There should be no blanket policy of never performing CPR on any and all COVID-19 patients. One can imagine, for example, an otherwise healthy patient with atherosclerotic heart disease for whom the hypoxemia of a COVID-19 pneumonia causes acute ischemia, for whom CPR might be effective and beneficial. All necessary precautions should be undertaken to protect other patients and staff from infection with the SARS-CoV 2 virus during any resuscitative attempt.

7. Ventilator care should not be withdrawn unilaterally based solely on the judgment that another patient has a better chance of recovery. Ventilator care can be withdrawn, per hospital policy, based on a discussion with the patient or surrogate that the burdens of treatment outweigh the benefits. Ventilator care can be unilaterally discontinued if it becomes futile (i.e., if it is judged that, to a reasonable degree of medical certainty, the patient will not survive to hospital discharge even if ventilator care and other life sustaining treatments are continued).

8. All patients deserve our very best care, including attention to their symptoms, psycho-social and spiritual needs, and attention to the needs of their loved ones. Patients who are not expected to survive should receive palliative care consults, recognizing that palliative care resources may also be strained and alternative palliative care models may be needed. The ethics consult service will be available for advice on any specific cases.

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A quarterly publication of the Plunkett Centre for Ethics
The Plunkett Centre is a joint centre of Australian Catholic University,
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Individuals: $55 Institutions: $99 Pensioners and Students: $27.50

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