Triage and the Ethics of Healthcare: An Irish Perspective

Consultative Group on Bioethics and Life Questions
Irish Catholic Bishops' Conference

www.bioethics.org.uk

About the Author

The Irish Catholic Bishops' Conference's Consultative Group on Bioethics and Life Questions is a forum for the exploration of current issues in the ethics of healthcare and of biomedical research. It seeks to develop and promote an understanding of these issues which is consistent with the Gospel, with the teaching of the Magisterium of the Catholic Church, and the best available scientific knowledge.

Triage and the Ethics of Healthcare: An Irish Perspective[*]

Introduction

Healthcare services in recent weeks have come under unprecedented pressure due to the arrival of COVID-19 in Ireland. Healthcare professionals, already overworked and under-resourced, have struggled with a shortage of essential equipment as well as with significant levels of infection. They have also been faced with the painful reality that, even when they use their skill and energy to the very best of their ability, many people may die in the course of a pandemic who, under more normal circumstances, might have been saved.

The common good, while it is the particular responsibility of government, requires the participation of all. One of the remarkable features of the past few months has been the attitude of solidarity which has led to each person playing his or her part and valuing the contribution made by others. In an effort to limit the spread of COVID-19 and to bring it under control, Irish society has invested very significant human and material resources. Alongside this, people all across Ireland, have accepted significant restrictions on daily activity, adopted new work practices and found new ways of serving and caring for one another.

The stated aim of all of this was to manage the pandemic in such a way that all who needed care medical care could receive it and so that the elderly and those with underlying conditions could be protected. Our desire to protect those who are most at risk in our society is demanded by Catholic moral teaching and is entirely appropriate for a society which aspires to the fundamental equality of every person. It must extend to the manner in which clinical decisions are made in healthcare and that is the primary focus of this paper.

There is also a very understandable desire to put the pandemic behind us and to get back to normal. Decisions about relaxing the restrictions and re-starting various sectors of society are not just practical decisions, they are also moral decisions. Human behaviour has been very successful in reducing the level of community contagion. By patiently continuing that responsible behaviour in our own personal lives, we can together rid our communities of the contagion. That is not only what prudence requires, it is what justice requires.

The Role of Ethics in a Time of Pandemic

R. J. Snell makes the case that a pandemic, like a war, does not render ethics irrelevant.

“All voluntary human action is governed by moral law. A pandemic or existential threat does not negate our moral obligations. We may never knowingly and intentionally do wrong, even for good results, even in a crisis situation. In addition to general moral norms, professional codes of ethics continue to apply”. **[1]**

On April 7th, the Irish Government produced its “Ethical Considerations Relating to Critical Care in the context of COVID-19”. This is

published alongside an "Ethical Framework for Decision Making in a Pandemic", which is undated and seems to refer to pandemics in general. **[2]** The latter document wisely points out that "healthcare ethics may not always be able to offer precise answers to every difficult question arising in the context of a pandemic". It can, however, "provide useful tools to help address the issues involved, to weigh up competing interests and to reach appropriate decisions". **[3]**

Other statutory and voluntary groups have also published ethical briefings and guidelines. **[4]** Most of the documents we have reviewed identify similar ethical concerns which need to be considered in responding to the present pandemic.

These include:

- the need to respect the life and dignity of every person
- how decisions regarding the allocation of scarce or limited resources should be made
- how decisions regarding the removal of scarce or limited resources should be made
- whether the placing of "Do Not Resuscitate" orders might be managed differently in the context of a pandemic
- how the general medical services are affected by a pandemic
- the need to provide continuity of care, even when therapy is no longer beneficial or available
- how to ensure the protection of Healthcare Professionals

There are however, some significant differences of emphasis, which appear to reflect different understandings of the common good and of the dignity of the individual person. **[5]**

It would be important that these resource documents, which are specific to the context of a pandemic, should be read and evaluated in the light of the principles and ethical guidance provided in charters, conventions and ethical codes which are more permanent in character. **[6]** This will help to ensure that, in a time of crisis, decisions about treatment and care and the allocation of resources are guided by sound and consistent ethical principles.

Managing Finite Resources

Since early March, one of the concerns that has consistently been expressed by the health authorities has been the possibility that healthcare resources, which of their nature are finite, might be overwhelmed as the impact of COVID-19 increased. As the Irish Dept. of Health points out, this pressure on resources relates not just to the care of those who have COVID-19, but has an impact on the provision of healthcare in general, including the availability of critical care resources for all patients. **[7]** This is why so much emphasis has been placed on "flattening the curve".

Part of the essential response to any pandemic is that every reasonable effort, consistent with fairness to poorer countries, whose healthcare systems are coming under (or are likely to come under) serious pressure from the virus, should be made to ensure that our own healthcare system would have the variety of resources required to deal with the pandemic. One area in which significant concerns have been expressed relates to the availability of adequate supplies of Personal Protective Equipment to protect healthcare workers who have been most exposed to the virus, and also to protect those for whom they care.

Triage: The Fair and Effective Allocation of Resources

In its "Ethical Considerations", the Irish Dept. of Health states that:

"In line with the ethical principle of fairness, there should be processes to guide the distribution of burdens and benefits across members of society so that no individuals or groups shoulder a disproportionate burden or benefit in a disproportionate way, relative to others". **[8]**

Triage is the process by which decisions are made to prioritise certain patients for treatment, while asking others to wait, or perhaps to go without treatment. In the context of COVID-19, this might involve, at one end of the scale, deciding that a patient who has tested SARS-CoV-2 positive but whose symptoms are not severe, should return home and recover with bed-rest. At the other end of the scale, however, it might involve deciding who will have access to ICU and, specifically, to a ventilator. **[9]** The primary moral criteria for good decision-making in relation to triage are the welfare of patients and the achievement of fairness. This is not as easy in practice as it might sound because, as we have been reminded in recent weeks, patients are not statistics; each one is a person with a history and with hopes for the future, with family and friends.

In its COVID-19 guidance, the Dept. of Health states:

"Faced with unprecedented demands, clinicians may need to replace normal standards of care with 'contingency standards of care' until such time as the pandemic is determined to have been brought under control. This creates a tension between a healthcare professional's duty of care for individual patients and the broader public health consideration of maximising the number of lives saved, and overall health gain, of the population as a whole". **[10]**

Most commentators referenced here acknowledge the enormous emotional pressures on healthcare professionals, when it becomes necessary to make decisions which mean that some patients will not have the same level of treatment during a pandemic that they might expect to have under ordinary circumstances. **[11]** As well as raising questions about how healthcare professionals can be supported during the pandemic and afterwards, this also raises important questions about how such decisions are made.

In the event that two or more patients require ICU facilities (including mechanical ventilation) at the same time, and there are not enough resources available for them all, a decision inevitably has to be made. Catholic moral teaching requires that the decision is based on objective clinical indicators, and not on any judgement of the relative value of the lives of the patients. Resources in healthcare must be allocated in accord with distributive justice, meaning that no individual has an absolute right to a limited resource. It is essential, however, that Triage protocols are not based on the false idea that the lives of older people or people with disability are of less value than those of younger of more "able" people.

The UN Convention on the Rights of Persons with Disabilities says: "States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability" and "In particular, States

Parties shall:… Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability". **[12]** The Irish Dept. of Health states that, in making decisions about the allocation of scarce resources: "Categorical exclusion, e.g. on the basis of age should be avoided as this can imply that some groups are worth saving more than others and creates a perception of unfairness". **[13]** As we will explain further on, we would be concerned that this fundamentally positive statement is not reflected in the essentially utilitarian language that is used in the "Ethical Framework".

Clinical Considerations

The two key clinical considerations relevant to triage decision-making are:

- the gravity of the patient's condition as a direct result of COVID-19, together with other medical conditions, which have an immediate impact on the likelihood of short-term COVID-19 survival and,
- the extent to which treatment could improve the likelihood of survival. **[14]**

That US National Catholic Bioethics Centre has this to say:

"Patient priority scores for critical care resources allocation should be determined using objective clinical criteria for short-term survival, such as Sequential Organ Failure Assessment (SOFA) or similar. Categorical exclusions based solely on an individual's age, disability, or medical condition (if it does not impact short-term COVID-19 survival) constitute unjust discrimination and are immoral". **[15]**

The greater a patient's need of treatment and the greater the likelihood that the treatment will improve his or her chances of short-term survival, then the greater the moral case for distributing resources to him or her. Where limited resources must be allocated, it is the responsibility of the civil authority to seek the common good, which is not simply the good of society. It is the good of each person and of all and it cannot be achieved if the dignity and fundamental rights of individual persons are not respected.

Some Triage protocols, however, are based on a utilitarian principle, which measures the value of the individual against the needs of society. Such protocols often work against the right of each person to have the unique value of his or her life respected and to be treated as worthy of equal concern. Older and less able people, in particular, risk being unjustly discriminated against under protocols indebted to this sort of utilitarian injunction. The British Medical Association (BMA) Guidance document suggests that "In dangerous pandemics the ethical balance of all doctors and health care workers must shift towards the utilitarian objective of equitable concern for all – while maintaining respect for all as 'ends in themselves'. **[16]** This sounds reasonable but, on the following page the document envisages circumstances in which "demand outstrips the ability to deliver to existing standards" and "more strictly utilitarian considerations will have to be applied, and decisions about how to meet individual need will give way to decisions about how to maximise overall benefit". **[17]**

While the Irish Dept. of Health "Ethical Framework" says that "the starting point for any rationing decision is to consider which patients are most likely to benefit from intervention", it goes on in the following paragraph to say "A multi-principled approach takes into account estimates or projections of: the total number of lives saved; the total

number of life years saved; and long-term functional status should patients survive". **[18]** This is described as "tempering the classical utilitarian approach". We believe, however, that it is really problematic when Triage decision-making seeks to go beyond the question of whether or not the patient, with treatment, is likely to survive COVID-19 and any immediately related health complications. Once the "likelihood of long-term survival" or "long-term functionality" or the "total number of life years saved" or "remaining survival time after discharge", which are at best educated estimates, become deciding factors in who shall have treatment, this very easily leads to a utilitarian calculus which makes a judgement as to the value of the patient's life. A utilitarian approach is explicitly adopted when these factors become the primary or governing decision making principles. The upshot of a utilitarian approach is to deny the equal value of the lives of older people and those with disability.

It may, of course, happen in extreme circumstances that healthcare professionals are faced with a decision as to how to distribute life-saving resources among persons with a roughly equal likelihood of surviving COVID-19 and where there are not enough of the relevant resources for each of the patients. **[19]** Is there a way to make a moral decision in this case without supposing that some lives are intrinsically more valuable than others? One morally legitimate consideration is the extent to which vulnerable persons, e.g., children and the disabled, are dependent on the survival of the various patients. In a situation where not every patient can be provided with life-saving resources it would be fair to make resource-allocation decisions on the basis of the contribution such decisions would make to the welfare of other persons who are dependent on those patients.

On this basis it can also be just to give preference to the treatment of healthcare professionals themselves, upon whom very many vulnerable people depend. Likewise, certain categories of people who would be regarded as more vulnerable to infection or related complications, might be prioritised with anti-viral medication, or for vaccination when vaccines become available. **[20]** The suggestion in the BMA paper, however, that certain groups of people should be prioritised for treatment, or for access to scarce resources, on the basis of their usefulness to society, and that these decisions should be made by Government rather than by doctors, is severely criticised by the Christian Medical Fellowship, on the basis that it conflicts with the "unwritten social contract between the population and the service (NHS)", and that it would do "long-term damage to the public's attitude and trust in the NHS". **[21]**

One other question relating to Triage, is who should be responsible for making the decision about who gets access to scarce critical resources? The preference would be for a Triage team which includes a senior consultant physician, a specialist nurse and an ethicist. **[22]** This avoids conflicts of interest and takes pressure off those immediately responsible for the care of the patient. The care team can then advocate on behalf of their patient and, if necessary, appeal their decision. The BMA document says: "It is essential that, should they be required to, doctors make these decisions in accordance with decision-making protocols rolled out by employing or commissioning organisations". **[23]** This is somewhat worrying, because decisions about treatment should be clinical rather than administrative in nature.

The Removal of Resources

The withdrawal of life-sustaining treatment from a patient is distinct from the decision not to prioritise life-sustaining treatment for the patient in the first place. It is possible, of course, that a clinical decision may be made that a particular patient now has a good enough prognosis to justify the removal of certain external supports which may previously have been essential to survival.

Otherwise, however, the withdrawal of life-sustaining treatment would normally mean that death comes sooner. Are there circumstances when this might be ethically and morally justifiable? The guidance presented in the Code of Ethical Standards for Healthcare is that there is no moral obligation to accept or to continue treatment if it is "therapeutically futile, overly burdensome to the patient or not reasonably available without disproportionate hardship to the patient, carers or others". **[24]** The principle underlying this sound ethical statement is that there is no moral obligation to choose medical treatment that is disproportionate to its expected benefits (e.g., where the treatment involves a very significant burden on the body's basic functioning and will only delay an inevitable death by a few days). **[25]**

There is a crucial distinction, however, to be made between a judgement that treatment is futile or burdensome and the judgement that the life of the patient is futile or burdensome. It is important to recall that having life is of intrinsic benefit to a person and so it would be immoral to withdraw treatment simply on the basis that the patient's life, in the eyes' of the relevant clinician(s), is of "no benefit" to the patient or to society, and is "not worth living".

It is not consistent with the principle of the sanctity of human life to claim that any patient's life can lack all value, for example, due to illness or disability, or that any human being is morally unimportant and, on that basis, to refuse or withdraw treatment. **[26]**

It would be fundamentally unjust and immoral for example, to take a patient off a ventilator solely on the grounds of his or her age, or because he or she had some disability or health condition not directly connected with COVID-19, even for the purpose of reallocating that resource to a younger or otherwise healthier person, who was in need of it. It would not, however, be immoral for the patient himself or herself to decide to forego the ventilator, in order that someone else might benefit from it. Indeed, a fully free decision (i.e., one not made under duress) in this regard would be an imitation of Christ's self-sacrificial love.

Finally, it is worth underscoring that the removal of resources e.g., a ventilator or an ICU bed, is morally justified if the doctor, or preferably the medical team, treating the patient, reasonably concluded that the treatment was "futile". We accept, of course, that such a judgement may be one of medical probability rather than medical certainty. In a context of limited resources, where another patient is in immediate need of the particular treatment and stands to benefit significantly from it, it is morally permissible for the relevant medics to consider the probability of futility without a presumption in favour of continuance of treatment.

DNR (Do Not Resuscitate) Orders

Cardio-pulmonary resuscitation is an emergency procedure intended to get the lungs and heart working when these basic functions have stopped. For a patient whose general prognosis is good, CPR would nowadays be regarded as normal medical treatment for cardiopulmonary arrest.

If a cardiac arrest is the very-likely or almost inevitable result of a particular condition from which the patient suffers (e.g., terminal cancer or the final stages of motor neurone disease), then CPR is in most cases inappropriate, because it is tantamount to a denial of the clinical indicators and counts as futile (and therefore disproportionate) treatment. A doctor may discuss with the patient the appropriateness of a Do Not Resuscitate order, under such circumstances, so that decisions about resuscitation are not being made in the heat of the moment, and possibly motivated by fear of litigation. Do Not Resuscitate orders, if they are to be made, must be based on objective clinical criteria and they must be recorded in writing and communicated effectively to all who are involved directly in the care of the patient. They should be reviewed on a regular basis.

The National Catholic Bioethics Centre (Philadelphia) states: "Physicians should be able to place DNR orders under a Triage protocol, when the clinical facts offer no reasonable expectation of recovery from resuscitation". **[27]** The Irish Dept. of Health points out that, in a pandemic situation, the pressure on resources could have a direct impact on how decisions about CPR are made for all patients, whether or not they have COVID-19. "If, due to his/her condition and prognosis, a patient would not meet criteria to access intensive care during the pandemic, it may not be appropriate to provide that patient with cardiopulmonary resuscitation (should s/he collapse) since the required follow up care in the intensive care unit would not be available". **[28]**

It seems clear that mortality rates from COVID-19 are significantly higher among very elderly patients and patients with certain co-morbidities (often described as "underlying conditions"). Of itself, however, COVID-19 is not, in the vast majority of cases, a terminal illness. While clinical decisions may have to be made on a case-by-case basis, depending on the short-term prognosis of each individual patient, it would be unethical to automatically apply a DNR order to certain categories of patients with COVID-19 (e.g., the elderly, or those with disability, or with other underlying health conditions), or that they should be asked to agree to a DNR status. That would be tantamount to making a false judgement as to the lesser value of the life of a patient, based on his or her age, disability or other medical condition.

Older People and Increased Risk

It is impossible to ignore the fact that, as the pandemic approached its peak in Ireland, the numbers of older people who died in communal settings was disproportionately high. While people living in their own homes could be told to cocoon, this is significantly more difficult in communal settings, especially where people are dependent on higher levels of personal care. Allowing for the fact that older people would inevitably be more vulnerable to an infection once contracted, the question arises – against the background of a

generally highly professional management of the pandemic – as to whether more could or should have been done to protect vulnerable people living in communal settings. This is not just a question about what happened to date, but about what must happen now and in the future.

A Vision Inspired by Faith

In all of this, Christians, while remaining tireless advocates for life, accept the reality of death as part of the human condition. We seek to save life while it can be saved, and when it becomes clear that therapy is of no further benefit, we continue to offer the best possible nursing and pastoral care, until death naturally comes. "For a Christian, death is not a hopeless adventure; it is the door of life that opens to eternity; it is the experience of participation in the mystery of Christ's death and resurrection". **[29]**

Endnotes

[*] This paper was prepared by the Consultative Group on Bioethics and Life Questions of the Irish Catholic Bishops' Conference as a briefing for bishops on 21 April 2020 under the title *Triage and the Ethics of Healthcare*, and is reproduced as part of the Anscombe Bioethics Centre COVID-19 Briefing Papers series with permission.

[1] Snell, R.J., "The Coronavirus Pandemic and the Ethics of Triage". https://www.cultureoflife.org/2020/03/26/thecoronavirus-pandemic-and-the-ethics-of-triage/ Posted: March 26, 2020.

[2] An Roinn Sláinte. *Ethical Considerations Relating to Critical Care in the Context of COVID 19*. https://www.gov.ie/en/publication/13ead5-ethical-considerations-relating-to-critical-care-in-the-context-of-c/, 7th April 2020. (Henceforth: "Ethical Considerations"). This document is published alongside an *Ethical Framework for Decision Making in a Pandemic*, which is undated: https://www.gov.ie/en/publication/a02c5a-what-ishappening/#ethical-framework-for-decision-making-in-a-pandemic (Henceforth, 'Ethical Framework'.)

[3] An Roinn Sláinte. "Ethical Framework", 5.

[4] These include: British Medical Association. *COVID-19 – ethical issues. A guidance note*: https://www.bma.org.uk/media/2226/bma-COVID-19-ethics-guidance.pdf (undated; accessed 14th April 2020; henceforth: BMA, *COVID-19 – ethical issues*); National Catholic Bioethics Centre. *Ethical Concerns with COVID-19 Triage Protocols*: https://ncbcstore.org/ncbc-resources-for-COVID19/ethical-concerns-with-COVID-19-triage-protocols; 3 April 2020; (Henceforth: "NCCB Ethical Concerns"); Redman, Melody & Haslam, James. *When Demand Outstrips Supply: A Christian View of the Ethics of Healthcare Allocation during the COVID-19 Pandemic*. Christian Medical Fellowship. 3 April 2020. http://admin.cmf.org.uk/pdf/When_demand_outstrips_supply-COVID19_briefing_paper.pdf (Henceforth: Redman & Haslam); Jones, David A. "Resource allocation and ventilators: A statement of Catholic Principles". Oxford: Anscombe Bioethics Centre, 8th April 2020. https://bioethics.org.uk/research/covid-19-briefing-papers/resource-allocation-and-ventilators-a-statement-of-catholic-principles-prof-david-albert-jones/ (Henceforth, "Jones".)

[5] The "Ethical Framework" identifies seven ethical principles which, it says, should guide decision making, namely: Minimising Harm, Proportionality, Solidarity, Fairness, Duty to Provide Care, Reciprocity and Privacy. The "BMA" document also lists seven guiding principles, but only three of them are the same, namely Minimising Harm, Fairness, and Reciprocity. The others are: Equal Respect, Respect (which is different to "equal respect"), Working Together (which is similar to "solidarity"), Flexibility and Open and Transparent Decision-Making.

[6] Cf. United Nations: Convention on the Rights of Persons with Disabilities. New York, December 2006. https://treaties.un.org//doc/source/docs/A_RES_61_106-E.pdf, (Henceforth: UN Convention); Pontifical Council for Assistance to Healthcare Workers. New Charter for Healthcare". Philadelphia. National Catholic Bioethics Centre, 2017 (Henceforth: New Charter); & Irish Catholic Bishops Consultative Group on Bioethics. Code of Ethical Standards for Healthcare.

Dublin: Veritas 2018. (Henceforth: Code of Ethical Standards).

[7] *Op. cit.*, An Roinn Sláinte. *Ethical Considerations*, 1.

[8] *Ibid.*, 2.

[9] Cf. *Ibid.*, 2. An important consideration is that: "In emergency and non-emergency situations, it is not ethically appropriate to offer intensive care to every patient, since intensive care will not provide benefit to some patients who are seriously ill or dying.

[10] *Op. cit.*, An Roinn Sláinte. *Ethical Considerations*, 2.

[11] Cf. *Op. cit.*, BMA, *COVID-19 – ethical issues*, 3: also *Ibid.*, An Roinn Sláinte. *Ethical Considerations*, 6

[12] *UN Convention*, Art 25.

[13] *Op. cit.*, An Roinn Sláinte. *Ethical Framework*, 17.

[14] Cf. *Op. cit.*, Jones. Dr. Jones notes that: "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".

[15] NCBC, *Ethical Concerns*.

[16] *Op. cit.*, BMA, *COVID-19 – ethical issues*, 2.

[17] *Op. cit.*, BMA, *COVID-19 – ethical issues*, 3.

[18] *Op. cit.*, An Roinn Sláinte. *Ethical Considerations*, 17.

[19] Cf. Snell, R.J. Snell comments in #7: "The absence or shortage of medicine, resources, or treatment may mean that care is unavailable and cannot be provided to a patient. This is not equivalent to withholding care, which is always impermissible".

[20] *Op. cit.*, An Roinn Sláinte. *Ethical Considerations*, 17 & 18.

[21] Redman & Haslam, 5. Also cf. BMA, *COVID-19 – ethical issues*, 6 & 7.

[22] The Irish Dept. of Health suggests that such decisions should be made by at least two senior clinicians, but makes no reference to specialist nurses or other professionals. Cf. *Ethical Considerations*, 5.

[23] *Op. cit.*, BMA, *COVID-19 – ethical issues*, 3.

[24] *Op. cit.*, *Code of Ethical Standards*. #1.4 & #5.9; (cf. also *Evangelium vitae*, # 65; *Declaration on Euthanasia*, section IV.

[25] Decisions about withdrawal should, where possible, involve the communication of clinical information to the patient, or otherwise to the family. For further discussion on this question see: *Code of Ethical Standards*, #1.20 & 1.21. Also *New Charter*, pp 108-109. Also *Ethical Considerations*, 4.

[26] *Code of Ethical Standards*, #1.16.

[27] NCBC, *Ethical Concerns*.

[28] *Op. cit.*, An Roinn Sláinte. *Ethical Considerations*, 5.

[29] *Op. cit.*, *New Charter*, 107.

The Anscombe Bioethics Centre
82-83 St Aldate's, Oxford, OX1 1RA, United Kingdom
Tel: 07734 964 620
Email: admin@bioethics.org.uk
Reg. Charity No. 274327