

Ethical Guidelines for Scarce Resources in a Pandemic

In the midst of the fear, panic and suffering people experience in a pandemic, it may seem as though we need to create new ethical guidelines to address the moral dilemmas that arise as we confront the disease.

People worry about getting access to care and what will happen to them and their families if we run out of essential medical supplies. Will enough caregivers be available and will they have protection they need to care for others?

However, we are not the first, nor, sadly, will we be the last to face such challenges. The Catholic community has, throughout history, sought to accompany the sick in the midst of times like these. The Plague of Cyprian in the 3rd century, the Black Death in the Middle Ages, and, more recently, the Spanish Flu Epidemic of 1918, the H1N1 epidemic, and AIDS were all instances where Catholics brought the healing mission of Christ to those who were afflicted.

Today, our ministry is guided by the same moral principles and commitment to caring for others that inspired and motivated us in the past. The principles of Catholic Social Thought, including dignity of the human person and the common good, have always gone hand-in-hand. We are concerned both about respecting the inherent sacredness of each person and also the needs of the community as a whole. When there are limited resources to be distributed, as happens in a global pandemic, we need to strike a balance between both the person and the community. We are also advocates for the poor and vulnerable, including those who are older, disabled, or immigrants, as they face particularly difficult challenges in these crisis situations.

We hope that the following Frequently Asked Questions (FAQs) will help to clarify how the Catholic ministry responds to particular issues that may arise.

Frequently Asked Questions (FAQs)

In the Catholic ethical framework, what are the criteria for deciding how to allocate scarce resources in a pandemic?

We seek to offer assistance to as many people as possible, and also to use those resources in a responsible way. The best way to achieve that is to use standardized inclusion and exclusion criteria based upon solid, clinical judgment, so that these limited resources will be used to benefit as many people as possible for the welfare of society as a whole. For example, many states, like New York and Minnesota have developed policies that use what is called SOFA (Sequential Organ Failure Assessment) to guide triage decisions about which patients are likely to benefit from treatment based on clinical criteria. These are objective clinical guidelines that are reviewed by medical teams on a case by case basis, rather than being a unilateral decision that excludes whole categories of persons, without regard for the

individual. These decisions need to be applied consistently and fairly to reduce disparities in access to health care.

It is important that decisions about the allocation of scarce resources in a pandemic be transparent and applied consistently to allay fears and maintain people's trust.

Is it ethical for a health care provider to make treatment decisions based upon a person's quality of life?

In making treatment decisions, no individual person or clinician should make judgments concerning another person's "Quality of Life." Such an evaluation is too subjective a criterion for making such decisions, and it would invariably mean imposing one's own view of what a life worth living means on the most vulnerable in our society. Solely using age or disability to limit access to scarce resources is unjust and discriminatory. In the Catholic tradition, we believe everyone has quality of life and inherent human dignity.

Do patients have a right to medical treatment?

Patients have a right to health care, which requires the just distribution of society's resources to assist them to be healthy. The *Catechism of the Catholic Church*, states that "*Concern for the health* of its citizens requires that society help in the attainment of living conditions that allow them to grow and reach maturity: food and clothing, housing, health care, basic education, employment and social assistance" ([CCC 1997](#), no. 2288).

Catholic teaching also emphasizes "*distributive justice*, which regulates what the community owes its citizens in proportion to their contributions and needs" ([CCC 1997](#), no. 2411). Health care, like food, clothing, housing, education, etc., is a need that requires the application of distributive justice. It is a good that we owe each other.

Due to a lack of resources, or because some treatments may be ineffective, it is morally justifiable for a health care professional to refuse to provide a treatment to a patient. Such a decision is never made lightly, and it is not the practice of health care providers to fail to offer whatever treatments they surmise are beneficial and accessible. When medical treatment is offered, it is the patient who should make a personal judgment about whether the benefits of an available treatment are proportionate to its burdens. While an individual can refuse treatments, at the same time, an individual does not have the right to demand every treatment possible. Conversations about treatment plans ought to be a shared conversation based on open and transparent communication about real prognoses based on available resources.

Who makes the decisions about who has access to limited resources? What process is followed?

As this is a decision about medical treatment, physicians would determine the access to limited resources, based upon clear criteria that assess the medical condition of each patient. This would generally be a decision by a multi-disciplinary care team that includes physicians,

nurses, ethicists, social workers and chaplains. It is important that the process supports patients, their families and the clinical staff. Ordinarily, an assessment would be conducted before admission, at time of admission, and reassessed periodically within a specific timeframe based on medical condition and clinical criteria.

Do other hospitals follow the same guidelines as Catholic hospitals?

Each hospital or health care system creates their own policies. However, the broad discussion about the allocation of resources has taken place over many years, and the policies have been developed through the active participation of many different stakeholders. It is important to remember that, after SARS and H1N1 over ten years ago, many states adopted standardized policies and procedures aimed at responding responsibly and ethically to the threat of pandemics. Catholic facilities are as informed by such procedures and guidelines as any other hospital system, even as we are guided by our own tradition and its special commitment to protect and preserve human life. While there are nuances in how principles are applied, there is a broad consensus about best practices.

If I have an advance directive, will it be recognized if I have COVID-19? What about DNRs?

Persons with an advance directive should provide a copy of that document to their physician so that it can be entered into the medical record and honored. It is important to remember that the purpose of an advance directive is to express your wishes to reject or accept medical treatment if you are unable to speak for yourself. It does not mean that one can insist on receiving medical treatment if it is scarce, unavailable, or futile.

With regard to Do Not Resuscitate (DNR) orders, these are medical orders that are written by a physician or a nurse practitioner after consultation with the patient, or their legal representative. Such orders should be followed by the care team.