Is the Life-Cycle Principle Justified as a Tie-Breaker in Triage Decision-Making Within Catholic Health Care?

Part Two

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***Editor's Note**: The text below is the second part of a two-part discussion on the subject of the life-cycle principle in triage protocols. This part will begin to analyze the use of the principle in light of Catholic moral teaching. You may view the first article in the Summer 2020 issue of HCEUSA.*

ANALYSIS

A few questions may help clarify the analysis. These questions derive from the following components undergirding a distinctively Catholic approach to triage decision-making and the question of a life-cycle principle as a tie-breaker. These questions span the following areas: sources of morality, categorical exclusions, age as sole consideration, distinctive roles of age, aging as a universal human experience, intrinsic human dignity, and a rightful suspicion of utilitarian principles.

Sources of morality. Traditional Catholic moral theology recognizes three fonts of morality: intent, object, and circumstances. In some cases, significant circumstances do touch the nature of the object (cf. St. Thomas Aquinas[1]). As applied in the case of the COVID-19 pandemic, *if* a surge occurs that overwhelms capacity *necessitating rationing*, these significant circumstances may alter the object of applying an age-based (e.g., life-cycle) principle as tie-breaker. Outside of these circumstances, it would otherwise be unjust and unethical.

Categorical exclusions. Generally speaking, categorical exclusions — especially for non-medical characteristics — are ethically problematic. Therefore, it is essential to understand properly whether age as a tie-breaker in a life-cycle principle is a categorical exclusion. Upon examination, it may be that situating the life-cycle principle as a tie-breaker is predicated on the idea that all ages are in *principle* eligible for critical care. The life-cycle principle in this context is about stratifying patients, not categorically excluding any. To

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the point, it would only apply when there is true equipoise in prognostic assessment (proportionality of reasonably expected outcomes [benefit : burden] *and* overwhelmed capacity).

Age is not sole consideration. If the life-cycle principle is used in this way, is age then a primary or sole consideration in allocation of scarce resources? It would seem that the primary consideration is given to reasonably expected benefit (aka, likelihood of survival: short-term and long-term), or the relative proportionality of the treatment/care; age is considered secondarily to these other (and earlier) considerations of a triage decision-making process.

Distinctive roles of age. Age in a life-cycle principle as a tie-breaker is distinct from the role disease burden and age may play in prognostication of life-expectancy. In this context, age *qua* prognostic variable and age *qua* life-cycle principle function differently in an allocation scheme primarily based on need (former) and then on equitable access to life's stages (latter). See discussion of "fair innings" versus "pitch count" above.

Aging as a universal human experience. The importance of anthropological considerations in Catholic moral thinking is hard to overestimate. In this context, it is important to note that aging and senescence are a universal human experience. And, aging is, in a way, part of human flourishing (to have the experience of all of life stages) is a *prima facie norm*. This is different from other features of being a human person like the social construct of race.

Inherent dignity of any one at any age remains. A core question in responding to the permissibility of using a life-cycle principle as a tie-breaker in Catholic health care is whether such a mechanism of prioritizing patients offends the inherent dignity of the persons affected. Some may argue that the life-cycle principle as tie-breaker does not, in itself, undermine or necessitate the devaluation of any person at any given age. That is, it need NOT and does NOT call into question the inherent dignity all human persons have irrespective of life-stage/age. To say that it does may commit the fallacy of *affirming the consequent*. Any age of a person has ontic, or premoral, value. A life-cycle principle does not diminish that in any way even if it is used as an evaluative criterion to stratify priority allocation of scarce resources in the context of a surge that overwhelms capacity during a pandemic. Because the life-cycle principle is about equitable opportunity to age/flourish at any age, it is a principle of the common good, and not with respect to an individual human person *per se*. However, it is noteworthy that age having ontic value (a descriptive statement) and that human beings should have equitable access to life stages (a normative statement) presupposes that life cycles and life stages are created and limited values: human persons are mortal, and precisely because of this, aging is not unlimited and eventually comes to an end.[2] In this bodily

existence, on this side of the *eschaton*, we are not immortal (this does not mean to say that our souls are not immortal: just this form of life as embodied spirits).

Rightful suspicion of utilitarian principles. The Pontifical Academy for Life, the United States Conference of Catholic Bishops (USCCB), and others rightfully argue that age should not be the sole criterion for rationing scarce health care resources. Even a "soft utilitarianism" is concerning from a moral perspective.[3] A life-cycle principle as a *tie-breaker* (not as an exclusion criterion) does not mean age is a sole criterion. These perspectives, especially the commentaries offered by the ethicists of the National Catholic Bioethics Center (NCBC), assert that such utilitarian calculus is problematic. However, inferring the immorality of a principle on the mere basis it is "utilitarian" commits the *genetic fallacy*. To further problematize this suspicion is that in practice, maximizing lives saved (let alone maximizing life-years saved) is itself a utilitarian goal, which is operating across the country in a great many scarce resource allocation schema.

In approaching this question on whether it is ethically permissible to use a life-cycle principle as a tie-breaker in Catholic health care, the criteria for rationing outlined in the Catholic Health Association (CHA) publication may be a helpful lens. The following analysis connects eight criteria in this document[4] with relevant considerations for the question at hand:

1. **The need for health care rationing must be demonstrable.** As currently drafted, triage decision-making (scarce resource allocation, rationing) occurs *if and only if* surge overwhelms capacity and transfer is unavailable within the geographic footprint wherein the triage protocol applies.
2. **Rationing ought to be oriented toward the common good.** Here, it is important for interlocutors not to collapse the rich understanding of the common good into a utilitarian concept of the greatest good for the greatest number. That said, elements of the common good that are relevant for consideration include: maximizing the number of lives saved, preserving the public order, demonstrating social solidarity, and ensuring equitable opportunity to live a full life.
3. **A basic level of health care should be available to everyone.** Narrowly speaking, triage decision-making here applies to critical care resources due to the nature of COVID-19, and in the circumstances, arguably extraordinary. That said, the principle of proportionality is still undergirding the appeal in the initial stratification of patients based on need and likelihood of benefit.
4. **Rationing should apply to everyone.** Thus, there should be no categorical exclusion, including by age. There ought not to be "automatic cut-offs" for persons at or above (or below) a certain age. As aging and senescence is a universal human experience, and if there is no categorical exclusion by age, such a tie-breaker principle would be applicable to everyone.
5. **Rationing decisions should be the outcome of an open and participatory process.** Regarding this principle, it is important to underscore the political

nature of this work in the public square and in the setting of value pluralism. This reinforces the importance of social solidarity as a primary value in confronting a pandemic in many ways (e.g., masking, physical distancing, etc.). In Oregon, the triage protocol was developed at the convening of a group of subject matter experts and clinical leaders, was vetted with various groups, and was iterative, etc. This was done under the auspices of county public health officials at the encouragement of the region's chief medical officers of the various health systems (some Catholic, most not Catholic). In the iterative process, consensus emerged in this ad hoc political process to ensure consistency and transparency of a common/shared approach. The tool was vetted by public health ethics committees and stakeholders vested in the importance of diversity, equity and inclusion. Dialogue was also sought with disability rights advocates and others.

6. **Those who are disadvantaged have ethical priority in accessing health care.** The young or the young with comparable comorbidities are 'worst off' given the threat — on the basis of a life-cycle principle — to their opportunity to live through life's stages. Of course, this follows from a normative, albeit controversial, reference to a full life. Interestingly, it has been noted by some commentators that persons of color tend to have higher prevalence of major comorbidities at younger ages than white persons with same comorbidities. CDC data also suggest that African American and Hispanic patients tend to be younger than white patients. A life-cycle principle or use of age as a prognostic variable may mitigate such disparities and represent the preferential option. Though, this is not without its problems, to be sure.[5]
7. **Rationing may not result from wrongful discrimination.** This criterion is challenging because in order to ration, arguably, one has to discriminate. This is the nature of stratifying patients and the act of prioritization. Therefore, the moral question is whether any given prioritization, or tie-breaking mechanism, is *wrongful* and why. The life-cycle principle may not be wrongful discrimination: some may argue that everyone ages, it is a value to promote opportunity to live through life's stages, etc. Conversely, it may be wrongful: such a mechanism may not meaningfully separate patients. For example, it is not likely to be applied as a tie-breaker between a 20 year old and an 80 year old but rather between a 44 year old and a 50 year old: Is that a meaningful difference in age? In addition, could it reinforce cultural biases against the elderly?
8. **The effects of rationing should be monitored.** Like the iterative process in developing the triage protocol, there have been calls amongst its participants, clinical and administrative leaders, and advocacy groups, for continuous monitoring and transparency in the process. Stakeholders, both internal

and external to our ministries, should strive to ensure sufficient debriefs, accountability and follow-up.

RESPONSE

The following six arguments and wonderments explore whether the life-cycle principle as tie-breaker is NOT wrongful discrimination and whether it may be compatible with Catholic moral and social teaching.

Argument from justice. If the use of a life-cycle principle is justifiable as a tie-breaker, it must (1) support equitable access to life stages/ages; (2) maximize life-years within a community; (3) help mitigate adverse effects of health disparities as a corrective mechanism; (4) not be the sole criterion; (5) not be the primary criterion; (6) not represent a categorical exclusion (should be framed as a secondary stratification mechanism); (7) be based on the premise that young are worst off as they have had the least chance to live through life's stages; and (8) recognize that in some circumstances (e.g., pandemic when surge overwhelms capacity), individual interests may become subordinate to the common good.

Argument from moral intuition. If the use of a life-cycle principle is justifiable as a tie-breaker, it must (1) avoid undermining trust in health care and in health care professions; (2) reinforce the objective, professional ethos of health care workers; and (3) demonstrate coherence with the social sense of tragedy of life lost early in the life cycle.

Argument from social solidarity. If the use of a life-cycle principle is justifiable as a tie-breaker, it must (1) be preferable to preserve social fabric within a community than to have

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differing rationing criteria; (2) help protect the public order in a pandemic (e.g., avoid evoking a sense of panic and worry in the public when being brought to one hospital over another portends to dramatically different decision-making approaches and possible outcomes); (3) be justifiable through the prism of probabilism and scandal (i.e., a clear explanation in response to doubt about its "wrongfulness" as a tie-breaker and a plan to manage pharisaic scandal); (4) reinforce trust in health care when different organizations use the same criteria to allocate scarce resources; and (5) have a low likelihood of actually being used.

Argument from avoiding abdication of responsibility. If the use of a life-cycle principle is justifiable as a tie-breaker, it must (1) support or remain consistent with the overall public health goals of saving the most lives (i.e., that is it is favorable to the public health goal versus a lottery system or other forms of randomization); and (2) be preferable to a non-choice choice of lottery or other form of randomization.

Argument from moral authority. If the use of a life-cycle principle is justifiable as a tie-breaker, it must (1) be [at least] consistent with existing precedent in present-functioning age-

related allocation principles (e.g., in solid organ allocation decisions); and (2) be consistent with rationale appealed to in popular models such as the University of Pittsburgh (cf. White and Lo above) as well as the principles articulated by Emanuel et al. in the *New England Journal of Medicine*.[6]

Argument from harm reduction. If the use of a life-cycle principle is justifiable as a tie-breaker, it must (1) be better for leaders in Catholic health care to control and contain its use (in public policy) through iterative and on-going engagement with stakeholders and peers across systems. This approach to reducing the harms of public policy appeals to a passage in *Evangelium Vitae* and abortion policies.[7] As applied here, it is permissible to support a generally problematic policy that permits some wrong if by participating and engaging in its formation the Catholic representative has helped reduce its likelihood or impact. Thus, in this sense, Catholic health care would tolerate the use of a sub-optimal, problematic principle in a narrow sense (as outlined above) *qua* tie-breaker. Furthermore, it must (2) preserve transparency, many have indicated that age would likely be used in any case and so making it explicit avoids an occult or implicit use of such criteria; and (3) protect the public order and solidarity with other health care systems in the extraordinary times of a pandemic.

In the end, adoption of a triage protocol for scarce critical care resources when a surge overwhelms capacity in a pandemic can pose significant challenges to Catholic health care. One particular example explored here is the use of the age-based, life-cycle principle as a tie-breaker in prioritizing patients for critical care resources. It is incumbent upon clinical, mission, and ethics leaders within Catholic health care ministries to wrestle with these issues, engage in public discourse about them, and actively participate in forming just allocation protocols that support human dignity and the common good. ✣

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ENDNOTES

1. Cf. St. Thomas Aquinas, *Summa Theologiae*, II-I, Question 18, especially Article 10.
2. For this part of the analysis, I am indebted to James Walter who illuminated the relevance of these aspects in the debates around the roles of "quality of life" and "sanctity of life" in decision-making when persons face life-limiting illnesses. See James Walter, "The Meaning and Validity of Quality of Life Judgments in Contemporary Roman Catholic Medical Ethics," in *Quality of Life: The New Medical Dilemma*, eds. James Walter and Thomas Shannon, (Mahwah, NJ: Paulist Press, 1990), 78-88, esp. 84-85.
3. See Rosenbaum and the Italian professional society guidance. Rosenbaum, 1875.
4. Institute for Medicine & Humanities, 19-26.
5. Darshali A. Vyas, et al., "Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms," *New England Journal of Medicine*, June 17, 2020, nejm.org, accessed June 24, 2020.
6. See Ezekiel Emanuel, et al., "Fair Allocation of Scarce Medical Resources in the Time of Covid-19," *New England Journal of Medicine*, March 23, 2020, 382:2049-2055.
7. Cf. No. 73.

Discussion Questions

1. Have you researched your state's pandemic plan? Many have been updated since the start of the outbreak. Be sure that you have the most recent plan.
2. Has your organization discussed whether the state plan conflicts with your own strategy regarding crisis standards and rationing? Does the state plan require actions that might be contrary to Catholic moral teaching? How would your organization resolve any conflicts in plans?
3. Do you agree with the author's conclusion? Is there a give and take when existing in a pluralistic society, especially when a community effort is needed to overcome a grave threat?