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

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Editor's Note: The question of the use of the life-cycle principle in triage protocols continues to be debated within the clinical ethics community. In light of the conversation and the presence of this principle in many protocols, Nick Kockler has taken the opportunity to thoughtfully analyze the debate. In order to include as much of the conversation, we the editors of HCEUSA have split the text into two parts. The first, which appears in this issue provides the necessary background information and current discussion. The second part, which will appear in the Fall issue, will apply Catholic moral teaching to the question and provide a concluding analysis.

INTRODUCTION

In the early weeks of the coronavirus pandemic, stories coming from the hard-hit areas of northern Italy generated tremendous moral concern about the role age may be playing in the rationing of scarce critical care resources to meet the needs of patients suffering from COVID-19.[1] Indeed, it seemed that professional guidance affirmed the need for and use of age-based cut-offs in the allocation of critical care.[2]

Public health surveillance data on age-stratified prevalence and outcomes underscore the challenges in justly allocating scarce critical care resources.[3] The cumulative rate of laboratory-confirmed COVID-19 heavily skews toward older persons with 286.9 cases per 100,000 for persons 65 and older. When broken down further, we see this same case rate metric is 207.6 for persons 65-74 years of age, 347.5 for persons 75-84 years, and 535.2 for persons 85 years and older. By comparison, this case rate for persons 18-49 years is 56.5 cases per 100,000. In terms of health outcomes, preliminary data suggest fatality rates highest among patients greater than 85 years of age followed by persons aged 65-84 years, and then persons aged 55-64.[4]

At any time, a surge in prevalence and patients presenting to acute care facilities in respiratory distress may overwhelm capacity. Capacity, in this context, means the finite critical care resources in terms of ICU beds, staff, personal

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protective equipment (PPE), mechanical ventilators, other airway management tools, pharmacologic agents, and extracorporeal membrane oxygenation (ECMO) machines. Therefore, there is a need to allocate resources justly according to sound ethical reasoning, clinical judgment, and the social values of public order, professionalism, and justice. Indeed, health care organizations have a duty to plan for and guide decisions in times of contingency and crisis.[5]

To address the confluence of these factors, a model approach to triage decision-making, based on the Oregon Crisis Care Guidance,[6] but adapted for the COVID-19 pandemic, allocates scarce critical care resources IF and ONLY IF a surge overwhelms capacity based on the following criteria:

- Short-term and long-term survival, objectively calculated into a sum/baseline score;
- If necessary: life-cycle-principle if and only if there is prognostic (benefit) equipoise exists; and
- If necessary: randomization.

Health care organizations in the context of the Portland metro area (where the tool was developed) have agreed to approach a surge in a consistent way and share resources to avoid triage decision-making. However, it may still be possible for a surge of patients to overwhelm the entirety of the health care system thereby necessitating the application of a consistent framework for allocating scarce critical care resources.

The Providence Center for Health Care Ethics has had a history of engaging in this work dating at least as far back as the H5N1 (aka, "bird flu") outbreak in 2007[7] and more recently with the Ebola outbreak in 2018. In the COVID-19 pandemic, the Center's ethicists have been engaged internally within the Oregon Region of Providence St. Joseph Health (PSJH), system-wide within PSJH, locally with county public health officials, as well as state-wide with officials in the Oregon Health Authority (OHA).[8]

The community-wide effort within Oregon and especially in the Portland metro area began to mature around the approach to triage decision-making outlined above. As a political endeavor, in the setting of value pluralism, this necessitated tough decisions and questions about the role of Catholic health care in the

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public square as well as the tensions potentially created in upholding social solidarity with other health care organizations (e.g., in avoiding rationing in the setting of a surge) and the community at large as well as remaining faithful to our Catholic identity with our special concern for the poor and vulnerable. This tension was acutely felt around the question of a life-cycle principle as a triage tie-breaker. Thus, we are wrestling with the question: Is using the life-cycle principle as a tie-breaker ethically justifiable in Catholic health care?

BACKGROUND

To begin to answer this question, we have been fortunate to draw upon a rich wisdom within the Catholic moral and social teachings. In surveying these resources, I highlight content from the *Ethical and Religious Directives for Catholic Health Care Services*, a Catholic Health Association (CHA) publication, statements from the Pontifical Academy for Life and the United States Conference of Catholic Bishops (USCCB), and commentary from the National Catholic Bioethics Center (NCBC).

Briefly, several Directives[9] are applicable to triage decision-making and other ethical issues of the pandemic. Though no Directive explicitly and specifically address allocation of scarce resources, three Directives seem to stand out with particular relevance. They are (quoted here verbatim):

> 3. In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.
> 6. A Catholic health care organization should be a responsible steward of the health care resources available to it. Collaboration with other health care providers, in ways that do not compromise Catholic social and moral teaching, can be an effective means of such stewardship.
> 23. The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problem or social status. The respect for human dignity extends to all persons who are served by Catholic health care.

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Next, with the Institute of Medicine & Humanities, (CHA) previously published a set of principles that should guide rationing of health care and ought to inform health care policies.[10] These principles are:

> 1. The need for health care rationing must be demonstrable.

2. Health care rationing must be oriented to the common good.
3. A basic level of health care must be available to all.
4. Rationing should apply to all.
5. Rationing must result from an open, participatory process.
6. Health care of disadvantaged persons has an ethical priority.
7. Rationing must be free of wrongful discrimination.
8. Social and economic effects of rationing health care must be monitored.

In addition, two source documents informing this discussion come from the Pontifical Academy for Life (PAL) and the United States Conference of Catholic Bishops (USCCB). The PAL note, "Global Pandemic and Universal Brotherhood: Note on the Covid-19 emergency," states

> This applies as well to all the choices made pursuant to a "care policy," including those more closely connected with clinical practice. The emergency conditions in which many countries are finding themselves can lead to forcing doctors into dramatic and painful decisions, with respect to rationing limited resources not available to everyone at the same time. In such cases, after having done at an organization level everything possible to avoid rationing, **it should always be borne in mind that decisions cannot be based on differences in the value of a human life and the dignity of every person, which are always equal and priceless. The decision concerns rather the use of treatments in the best possible way on the basis of the needs of the patient, that is, the severity of his or her disease and need for care, and the evaluation of the clinical benefits that treatment can produce, based on his or her prognosis.** ***Age cannot be considered the only, and automatic, criterion governing choice.*** **Doing so could lead to a discriminatory attitude toward the elderly and the very weak. In any case, it is necessary to formulate criteria, agreed upon as much as possible and based on solid arguments, to avoid arbitrariness or improvisation in emergency situations, as disaster medicine has taught us.** Of course, it bears repeating: rationing must be the last option. The search for treatments that are equivalent to the extent possible, the sharing of resources, and the transfer of patients, are alternatives that must be carefully considered, within a framework of justice. Under adverse conditions, creativity has also furnished solutions to specific needs, such as the use of the same ventilator for multiple patients. In any case, we must never abandon the sick person, even when there are no more treatments available: palliative care, pain management and personal accompaniment are never to be omitted. (Emphasis added.)[11]

The USCCB statement asserts:

> ... in a time of crisis ***we must not discriminate against persons solely on the basis of disability or age by denying them medical care.*** Good and just stewardship of resources cannot include ignoring those on the periphery of society, but must serve the common good of all, ***without categorically excluding people***

> based on ability, financial resources, age, immigration status, or race. // Foremost in our approach to limited resources is to always keep in mind the dignity of each person and our obligation to care for the sick and dying. Such care, however, will require patients, their families, and medical professionals to work together in weighing the benefits and burdens of care, the needs and safety of everyone, and how to distribute resources in a prudent, just, and unbiased way. (Emphasis added.)[12]

Next, the National Catholic Bioethics Center's (NCBC) ethicists cast doubt on the justification of triage protocols that rely on a utilitarian framework. They write, "the Catholic moral tradition does not accept utilitarian principles as an independent or constitutive source of ethical guidance, because such principles can be used to justify actions that undermine the dignity of the human person."[13] While the NCBC ethicists assert that triage teams may be morally justifiable, they also state,

> 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 criteria. 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.[14]

When taken alone, this statement would align with the triage tool currently developed within the state of Oregon. However, the next section problematizes prognostication for long-term survival (a component of the model triage tool) and the use of age as a tie-breaker. While not overtly objecting to a life-cycle principle as a tie-breaker, the NCBC ethicists state,

> Each protocol we have reviewed states that age is not an exclusionary factor for receiving critical care. However, in some protocols age actually becomes a factor through "tie breaker" determinations. Certain protocols state that in situations involving a priority score "tie" between two (or more) patients, age becomes the deciding factor for which of them receives critical care. The terminology varies in different protocols ("life-cycle principle," "saving the most life-years," "experience life-stages," "cycles of life," or "equal opportunity to pass through the stages of life"), but the operative principle is the same: decisions about who will, and will not, receive critical care are based on age.[15]

This statement, especially the last sentence, is misleading because it gives the appearance that it is based solely on age, which in the model triage tool, it is not. In a subsequent document, the NCBC ethicists assert (without much justification) that using long-term survival should not be a factor in triage priority and they exclude age-based tie-breakers from the list (again without much justification).

To round out background material, this is also an issue in secular circles. An oft-cited article in this current debate is the article published in *JAMA* by Doug White and Bernard Lo.[16] In their supplemental material (the model policy for the University of Pittsburgh), they incorporate the principle "save life-years" in the primary stratification of priority. Moreover, they write,

> We suggest that life-cycle considerations should be used as a tiebreaker if there are not enough resources to provide to all patients within a priority group, with priority going to younger patients. We recommend the following categories: age 12-40, age 41-60; age 61-75; older than age 75. The ethical justification for incorporating the life-cycle principle is that it is a valuable goal to give individuals equal opportunity to pass through the stages of life — childhood, young adulthood, middle age, and old age. The justification for this principle does not rely on considerations of one's intrinsic worth or social utility. Rather, younger individuals receive priority because they have had the least opportunity to live through life's stages. Evidence suggests that, when individuals are asked to consider situations of absolute scarcity of life-sustaining resources, most believe younger patients should be prioritized over older ones. Public engagement about allocation of critical care resources during an emergency also supported the use of the life cycle principle for allocation decisions. Harris summarizes the moral argument in favor of life-cycle–based allocation as follows: "It is always a misfortune to die; it is both a misfortune and a tragedy [for life] to be cut off prematurely."[17]

Interestingly, the NCBC resources link to an article by the same researchers cited by White and Lo regarding public engagement.

To help with conceptual clarification for the narrow question addressed here, a life-cycle principle is defined as a normative rule prioritizing patients based on stratifying patients who have lived fewer of life's stages. In other words, those who have not had a chance to live more of life's stages should be afforded that opportunity. There is a conceptual connection to a traditional goal of medicine: that physicians should help prevent untimely deaths. (To be sure, these are crude constructs and in any given case warrant caution and nuance.) In a baseball (or cricket) metaphor, commentators appeal to a "fair innings" construct: that patients are prioritized who have NOT had a chance to 'play' a fair number of innings. This is in contrast to prognostication and likelihood of longer-term survival. To continue the baseball metaphor, age in a prognostic rubric is more akin to the pitch-count of a starting pitcher: it serves as a rough metric for how much reserve is left in a person to continue to play. This is a different criterion than whether or not enough innings have been played to count as an official game. In summary, a life-cycle principle would prioritize younger patients over older patients, which opens it up to the charge of ageism and a wrongful discriminatory principle. ✣

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ENDNOTES

[1] Lisa Rosenbaum, "Facing Covid-19 in Italy – Ethics, Logistics, and Therapeutics on the Epidemic's Front Line," *New England Journal of Medicine*, May 14, 2020, 382 (20): 1873-1875.
[2] Ibid. 1874-1875.
[3] Centers for Disease Control and Prevention (CDC), "COVIDView: A Weekly Surveillance Summary of U.S. COVID-19 Activity," cdc.gov/coronavirus, updated June 19, 2020, accessed June 24, 2020.
[4] CDC COVID-19 Response Team, "Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) – United States, February 12 – March 16, 2020," *Morbidity and Mortality Weekly Report*, March 18, 2020, 3-4.
[5] Nancy Berlinger, et al., "Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic: Managing Uncertainty, Safeguarding Communities, Guiding Practice," thehastingscenter.org/ethicalframeworkcovid19/, March 16, 2020, accessed June 24, 2020.
[6] Oregon Crisis Care Guidance Workgroup, "Oregon Crisis Care Guidance," theoma.org/crisiscare, updated June 2018, accessed June 24, 2020.
[7] John F. Tuohey, "A Matrix for Ethical Decision Making in a Pandemic," *Health Progress*, November-December 2007, 20-25; also available at chausa.org, accessed June 24, 2020.
[8] For a discussion of our work in the current pandemic, please watch the webinar hosted by Catholic Health Association: see Julie Minda, "Pandemic laid bare emerging and ongoing ethical dilemmas, say Providence ethicists," *Catholic Health World*, April – May 2020, chausa.org, accessed June 24, 2020.
[9] United States Conference of Catholic Bishops (USCCB), *Ethical and Religious Directives for Catholic Health Care Services*, 6th edition, (Washington, DC: USCCB, 2018).
[10] Institute of Medicine & Humanities, *With Justice for All? The Ethics of Healthcare Rationing* (St. Louis, MO: Catholic Health Association, 1991).
[11] Pontifical Academy for Life, "Global Pandemic and Universal Brotherhood: Note on the Covid-19 emergency," academyforlife.va, March 30, 2020, accessed June 24, 2020.
[12] USCCB, "Bishop Chairmen Issue Statement on Rationing Protocols by Health Care Professionals in Response to Covid-19," usccb.org, April 3, 2020, accessed June 24, 2020.
[13] National Catholic Bioethics Center Ethicists, "Ethical Concerns with COVID-19 Triage Protocols," ncbcenter.org, April 3, 2020, accessed June 24, 2020.
[14] Ibid.
[15] Ibid.
[16] Douglas White and Bernard Lo, "A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic," *JAMA*, March 27, 2020, 323 (18): 1773-1774.
[17] Ibid. See also: jamanetwork.com, accessed June 24, 2020.