Unilateral Withdrawal of Life-Sustaining Treatment Within Crisis Standards of Care[1]

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The COVID-19 pandemic has prompted an unprecedented need for health care institutions to develop and implement policies for allocating scarce resources if they experience a surge of patients requiring life-sustaining treatment for severe acute respiratory distress.[2] In the absence of definitive guidance from the Church's Magisterium concerning specific requirements of such policies, there is space for moral disagreement concerning triage criteria and allowable practices.

As in all moral matters, however, certain guiding principles ought to be operative. For example, respect for each person's *intrinsic dignity* requires that health care professionals not cause a patient's death by either commission or unjustifiable omission of *ordinary/proportionate* forms of care.[3] Another relevant principle, particularly in the context of scarcity, is the *responsible stewardship* of resources, which includes just allocation of life-sustaining treatments with a preferential option for the poor and vulnerable.[4] One point of disagreement among policies developed by Catholic health care institutions is whether non-futile life-sustaining treatment may be unilaterally[5] withdrawn from one patient, who has a relatively poor expected outcome but is currently benefitting from ventilation, to benefit another predicted to have a better chance of survival to discharge. At least one Catholic hospital explicitly disallows unilateral withdrawal for triage reasons;[6] whereas the National Catholic Bioethics Center's "Triage Protocol Guidelines" state that "'Reallocation' of limited resources from current patients to incoming patients may be morally appropriate" but that *unilateral* withdrawal should not be allowed "unless extreme circumstances warrant."[7]

LIVING IN A "STATE OF EXCEPTION"

Every effort should be made by political and public health authorities to stave off a surge of patients that would constitute "extreme circumstances;" yet, such circumstances have arisen during the COVID-19 pandemic in countries such as Italy and (as of this writing) numerous hospitals throughout the U.S. are nearing surge capacity limits.[8] It may thus be inevitable that some Catholic hospitals will have to implement *crisis standards of care* [CSCs] as they are forced to function within a *state of exception* in which ethical norms are not suspended, but are differentially applied.[9] To understand how the notion of a "state of exception" coheres with the Catholic moral tradition, consider Thomas Aquinas's treatment of theft and "just war" theory. Theft is, of course, condemned by the Seventh Commandment; yet, the possibility of theft

is premised upon the existence of *private property*, the legitimate possession of which is acknowledged by Aquinas and Catholic Social Teaching.[10] The right to private property is not absolute, however, and Aquinas contends that in circumstances of "manifest and urgent" need, "all things become common property."[11] In a state of exception in which all property has become common, appropriating another's surplus wealth to ameliorate one's dire need does not constitute an act of theft. Another state of exception is *war.* While there is a general prohibition on killing other human beings, if the conditions of a "just" war are met, a soldier who kills another either to defend their own life, to safeguard the lives of others, or to advance the war's justified aims is not guilty of murder.[12] In a context in which CSCs must be implemented in order to exercise responsible stewardship of available resources, an act that would otherwise constitute an unjustifiable omission of care — unilaterally withdrawing non-futile life-sustaining treatment — may become a justifiable discontinuation of treatment that is *disproportionate* with respect to the burden placed on the *community*, which is a legitimate criterion in drawing the ordinary/extraordinary care distinction—though not typically utilized in non-crisis situations.[13]

JUSTIFICATION BY DOUBLE EFFECT

Even within a state of exception, it would be unethical to end a patient's life *intentionally*; hence, unilateral withdrawal should adhere to the *rule of double effect* [RDE].[14] RDE arguably justifies unilateral withdrawal for the following reasons. First, the directly intended good is to make a life-sustaining resource available for others and not to kill the patient from whom it is removed, although their death is foreseen. Furthermore, extubation, not the patient's death, is the necessary means for the directly intended reallocation to occur and is itself a morally neutral act. Finally, the death of the extubated patient is proportionate to the life of any subsequently intubated patient.

SOCIAL JUSTICE IMPLICATIONS

In considering the *common good* and the obligation of Catholic hospitals to exercise responsible stewardship of resources, we should note the social justice implications of disallowing unilateral withdrawal insofar as it would entail a default criterion of "first-come, first-serve" — unless a ventilated patient or their surrogate consented to withdrawal or continued ventilation was deemed physiologically futile. Of course, ventilator withdrawal from such patients should be prioritized before any unilateral withdrawal and all possible measures should be taken to avoid a surge that would require implementation of CSCs. Nevertheless, when such a situation is unavoidably forced upon a Catholic health care institution, due consideration should be given to the *health access disparities* that disproportionately burden the poor and vulnerable for whom we should have a "preferential option."[15] Such disparities may result in members of economically and socially disadvantaged groups not being able to access appropriate health care prior to those who are more well-positioned. A first-come, first-serve policy — whether explicit or by default — is also arguably unjust with respect to those who contract COVID-19 later in the pandemic due to preventive behavior or who are more at risk of infection due to their social roles, such as health care and other essential workers.

While society has an obligation to take all possible measures to prevent a state of exception

in which CSCs must be implemented, and unilateral withdrawal of non-futile life-sustaining treatment should always be a "last resort," ruling out the possible justification of such an act unwarrantedly constrains Catholic health care institutions' moral responsibility to exercise responsible stewardship over available resources and to consider in the development and implementation of their triage policies not only the intrinsic dignity of each individual patient, but also the needs of the common good and those of socially disadvantaged persons.

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ENDNOTES

1. This paper includes material developed more extensively in Jason T. Eberl and G. Kevin Donovan, "Is it Ethical to Unilaterally Withdraw Life-Sustaining Treatment in Triage Circumstances?" *Health Progress* (2020): https://www.chausa.org/publications/health-progress/article/pandemic-coverage/is-it-ethical-to-unilaterally-withdraw-life-sustaining-treatment-in-triage-circumstances; Jason T. Eberl, "Ethics as Usual? Unilateral Withdrawal of Treatment in a State of Exception" *American Journal of Bioethics* 20:7 (2020): 210-11; and Jeffrey P. Bishop and Jason T. Eberl, "Is It Ethically Permissible to Unilaterally Withdraw Life-Sustaining Treatments during Crisis Standards of Care? Yes" *CHEST* (forthcoming).
2. See Armand H. Matheny Antommaria et al., "Ventilator Triage Policies During the COVID-19 Pandemic at U.S. Hospitals Associated With Members of the Association of Bioethics Program Directors" *Annals of Internal Medicine,* April 24, 2020: https://doi.org/10.7326/M20-1738.
3. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services [ERDs]*, 6th ed. (Washington, D.C.: USCCB, 2018), nn. 23, 56, and 70.
4. *ERDs*, nn. 3 and 6.
5. By "unilaterally," I mean that such treatment is withdrawn without, and perhaps against, the explicit consent of the patient or an appropriate surrogate.
6. MedStar Georgetown University Hospital, "Ethical Principles of Resource Allocation In the Event of an Overwhelming Surge of COVID-19 Patients": https://kennedyinstitute.georgetown.edu/wordpress/wp-content/uploads/2020/03/CovidEthics-MGUH.pdf.
7. National Catholic Bioethics Center, "Triage Protocol Guidelines," [TPG] April 16, 2020: https://www.ncbcenter.org/resources-and-statements-cms/triage-protocol-guidelines?rq=triage, n. 5.a.
8. National Public Radio, "COVID-19 Hospitalizations Hit Record Highs. Where Are Hospitals Reaching Capacity?" November 10, 2020: https://www.npr.org/sections/health-shots/2020/11/10/933253317/covid-19-hospitalizations-are-surging-where-are-hospitals-reaching-capacity.
9. See Giorgio Agamben, *State of Exception*, trans. Kevin Attell (Chicago: University of Chicago Press, 2005).
10. See Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church [CSDC]* (Vatican City: Libreria Editrice Vaticana, 2004), n. 176.
11. Thomas Aquinas, *Summa theologiae,* trans. English Dominican Fathers (New York: Benziger, 1948), IIa-IIae, q. 66, a. 7; cf. *CDSDC*, n. 177.
12. See Michael Walzer, *Just and Unjust Wars: A Moral Argument with Historical Illustrations,* 5th ed. (New York: Basic Books, 2015).
13. See TPG, n. 5.b.ii.
14. For historical and contemporary formulations and discussions of double-effect, see Joseph Mangan, "An Historical Analysis of the Principle of Double Effect" *Theological Studies* 10 (1949): 41-61; Joseph Boyle, "Toward Understanding the Principle of Double Effect" Ethics 90 (1980): 527-38; P. A. Woodward, ed., *The Doctrine of Double Effect: Philosophers Debate a Controversial Principle* (Notre Dame: University of Notre Dame Press, 2001); and T. A. Cavanaugh, *Double-Effect Reasoning: Doing Good and Avoiding Evil* (New York: Oxford University Press, 2006).
15. Centers for Disease Control and Prevention, "COVID-19 Racial and Ethnic Health Disparities," December 10, 2020: https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html.