Guidelines for Rationing Treatment During the COVID-19 Crisis

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Medical facilities in the United States must ration health care in response to the COVID-19 crisis.[1] There is an acute scarcity of medical resources. Facilities lack both the materials (ICU beds, ventilators, testing kits, personal protective equipment) and the personnel (doctors, nurses, respiratory therapists) required to treat patients suffering from COVID-19. In response to the impending scarcity of resources, some fear that rationing could disadvantage patients with physical and mental disabilities for mechanical ventilation.[2] Some ethicists have suggested that age be a factor in determining which patients are disadvantaged for scarce resources.[3] The scarcity of resources during this pandemic requires ethicists to determine just principles for the rationing of life-sustaining treatment. Should age, life-years expected, or the quality of a patient's life be considered when deciding who receives a ventilator and who does not?

Catholic hospitals must determine how to justly distribute scarce resources so that the hospital can continue the healing ministry of Jesus Christ. The United States Conference of Catholic Bishops and the Catholic Health Association each have published statements regarding the distribution of limited resources during the crisis.[4] Using their insights as points of departure, this article explains the key Catholic values that should inform the rationing of treatment. Further, it articulates specific guidelines for the rationing of scarce medical resources in Catholic health facilities during the COVID-19 crisis. Because Catholic values are always and truly human values, these guidelines can be applied to the provision of treatment in non-Catholic facilities. In addition, Catholic medical ethics can and should draw on secular sources of ethical insight during the pandemic. Considering that it is critically important to engage in dialogue with secular medical ethicists during the pandemic, we begin by articulating the rationing recommendations produced by a group of ethicists led by Ezekiel Emanuel.

SECULAR GUIDELINES FOR RATIONING DURING COVID-19

In an article in the *New England Journal of Medicine*, Emanuel and his colleagues produced guidelines for the allocation of scarce resources during the COVID-19 crisis.[5] The guidelines invite decision-makers to ration treatment ethically and consistently by drawing on four fundamental values: maximizing benefit, treating people equally, promoting and rewarding instrumental value, and giving priority to the worst off.

These values produce six specific recommendations. First, the maximization of benefit requires hospitals to give priority to saving the most lives and the most years of life. Here the priority is given to the sick who are expected to recover. Second, medical facilities should prioritize frontline health workers and those essential

to operating critical infrastructure. These people are not more intrinsically valuable, but they are more instrumentally valuable during a pandemic. Third, equals should be treated equally. Two patients with the same prognosis and life-year expectations should be treated equally. If there is a scarce resource — for example, a ventilator — the resource should be distributed via a lottery for such patients. Fourth, in order to maximize the number of lives saved, each specific intervention should be rationed according to different factors. For example, a vaccine should be distributed to those most susceptible to COVID-19, including those over 60 years of age. Fifth, participants in COVID-19 research should receive priority for some interventions. Finally, the allocation of scarce resources should pertain to all patients, not just patients suffering from COVID-19. This means that a ventilator might be denied a patient with chronic obstructive pulmonary disorder (COPD) so that it can be given to a patient with COVID-19, or vice versa.[6]

Emanuel and his colleagues explicitly employ a utilitarian lens to make their recommendations. So, too, did the Institute of Medicine (now the National Academy of Medicine) in their 2009 report on caring for patients during a large-scale disaster, *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situation: A Letter Report*.[7] This is problematic for Catholic health care ethics, as Catholic ethics has consistently rejected utilitarianism.[8] A Catholic account of rationing during this crisis requires an authentically Catholic ethical lens, with specific recommendations flowing from its fundamental values. As I argue below, Catholic guidelines for the rationing of treatment overlap in certain places with the recommendations offered by Emanuel et al. However, the rationale for these guidelines is distinctively Catholic.

CATHOLIC VALUES, PRINCIPLES AND VIRTUES

A Catholic approach to the rationing of medical resources should draw upon the values, virtues and principles of Catholic health care. The United States Conference of Catholic Bishops offers four guiding values and principles in the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs): human dignity; the preferential option for the poor; the common good; and the stewardship of resources.

The Catholic Health Association produced general guidelines for the rationing of treatment in their 1991 document, *With Justice for All? The Ethics of Health Care Rationing*. Their guidelines reflect the core values and principles of the ERDs. CHA identified eight general principles that should guide the rationing of treatment: the need for rationing must be demonstrable; rationing must promote the common good; a basic level of health care should be provided for all; rationing must apply to all; the process of determining principles of rationing should be open and participatory; ethical priority should be given to the unmet needs of the poor and uninsured; rationing should be based on human dignity, free from any wrongful discrimination; the social and economic effects should be monitored by the government.[9]

Let us take a closer look at the core values and principles that should guide the rationing of treatment during the COVID-19 crisis.

Human dignity has two interrelated meanings.[10] Inherent dignity pertains to the God-given, transcendent, immeasurable value of each person. The inherent dignity of each person determines that each person is of equal moral worth. Some are stronger, more intelligent or more virtuous — but none is more valuable than another. Wealth, health and one's profession are irrelevant to inherent human dignity. Normative dignity requires people and groups to treat each person as a transcendently valuable person and not as only instrumentally valuable. Inherent dignity is inviolable, while normative dignity can fail to be respected. Because normative dignity is respected through providing access to health care, medical facilities should distribute treatment according to medical need and not based on other factors, such as wealth.

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The common good emerges in social situations in which each person is given access to the goods he or she needs to live a life befitting a human person. Put differently, the common good exists when a society respects and promotes the normative dignity of all of its members. The common good differs from utilitarianism insofar as the former emerges when a society promotes the good of its all members. In contrast, the latter directs agents to do the action that produces the greatest overall benefit for the individuals affected by the action. While utilitarianism permits certain people and groups to be "left out," the common good does not.

Pope Francis notes that the preferential "option [for the poor] is in fact, an ethical imperative essential for effectively attaining the common good."[11] Gustavo Gutiérrez argues that the preferential option for the poor "implies a universal love that excludes no one, and at the same time a priority for the least ones of history, the oppressed and the insignificant."[12] Directive 3 of the ERDs names those groups of people who count as the "oppressed and insignificant."

> 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 order to promote the common good, society must prioritize the well-being of these groups.

Crucially, for this study, the bishops present responsible stewardship of available health resources as a central value: "Responsible stewardship will be concerned both with promoting the ... right of each person to basic health care ... and with promoting the good health of all in the community." Responsible stewardship "of limited health care resources" should "provide poor and vulnerable persons with more equitable access to basic care." Thus, both the common good and the preferential option for the poor should guide the distribution of scarce health care resources.

There are two specific directives from the ERDs that are pertinent to this topic. Directives 56 and 57 pertain to end-of-life decision making. They direct patients to consider the benefits and burdens of treatment when deciding which treatments are morally obligatory and which are morally optional. Importantly, these directives also guide the patient to consider the burden that a medical treatment may impose "on the family or the community."[13] Here patients are guided to consider the effects of their treatment plan on family members and the larger community.

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In a situation of medical scarcity, the obligation to responsibly steward limited resources commands the medical facility to determine which patients will be offered and which will be denied access to these resources. There is no moral obligation to do what is impossible.[14] In situations of limited ICU beds, ventilators and medical personnel, the medical facility is not obligated to offer care that it cannot provide.

Drawing on directives 56 and 57, Catholic medical facilities should consider the medical benefit that a treatment is expected to provide and weigh that against the burdens that the treatment imposes on the patient and the community. In general, patients who are expected to medically benefit from a treatment should be prioritized, while patients for whom a treatment is expected to be less medically beneficial should be deprioritized for treatment. However, patients who are denied therapeutic, life-sustaining treatment should never be abandoned. Normative dignity requires the provision of basic health care, typically including nutrition, hydration, cleanliness, warmth and palliative care.

The values and principles presented above are not self-applying. In order to implement these values and principles in the rationing of medical treatment, decision-makers also should consider the following virtues. Charity is the virtue by which a person loves God and all those whom

God loves, including all of one's neighbors.[15] During a pandemic, this love of God and neighbor works through three key virtues: prudence, mercy and solidarity. These virtues guide the agent to ration medical treatment rightly. Prudence is the virtue that guides practical reasoning. Through prudence, the agent considers the intended end and then chooses the actions that rightly attain the end. The prudential person necessarily understands the circumstances of a situation and then recommends the action that realizes the intended goal given those circumstances. Mercy orients us to the poor, the vulnerable and the sick. It is the virtue of "being affected with sorrow at the misery of another as though it were his own," and "endeavor[ing] to dispel the misery of this other, as if it were his."[16] The works of mercy, such as caring for the sick, enact the virtue of mercy. Solidarity orients us to the common good. It is the virtue by which a person works with others, especially the vulnerable, to promote the well-being of the vulnerable and, as a result, the common good.[17]

To summarize, a Catholic health care facility should:

1. Respect the inherent and normative dignity of all patients;

2. Provide access to medical care for all in a community;

3. Dedicate itself to advocating for and serving the medical needs of the poor and vulnerable of a community;

4. Responsibly steward limited medical resources by accounting for the medical benefits and burdens to a patient, as well as the burdens imposed on the community.

CATHOLIC GUIDELINES FOR RATIONING DURING COVID-19

Seven specific guidelines for the rationing of limited medical resources during the COVID-19 crisis emerge from the ethical values, principles and virtues presented above. While these guidelines reflect many of the insights of the CHA's 1991 document on rationing, they address the unique challenges that have emerged from the COVID-19 pandemic.

1. Catholic medical facilities should focus on the Christian mission of showing mercy to and providing care for the sick. All patients should receive merciful care. Catholic facilities should recall the words of Pope Francis, that "even if we know that we cannot always guarantee healing or a cure, we can and must always care for the living."[18]

2. The common good directs Catholic medical facilities to prioritize treatments for medical professionals.

3. The preferential option for the poor demands that medical facilities provide special attention and care for poor and vulnerable persons, who often have been excluded from receiving care. This applies to the vulnerable groups mentioned in directive 3 of the ERDs, such as persons who are undocumented, persons suffering from homelessness, members of racial minorities and persons with physical and mental disabilities. These persons will receive a just ration of care and treatment during the COVID-19 crisis only if hospitals intentionally and explicitly follow the bishops' directive to provide special service and advocacy for these people.

4. Scarce resources should be distributed according to the expected medical benefit to the patient. Patients who are most likely to benefit medically from an intervention should be prioritized for that treatment. Non-medical factors, such as age, physical or mental (dis)ability, nationality, race, ethnicity, criminal history and medical insurance status should not be accounted for in the distributional analysis.

5. In situations in which patients are expected to realize the same qualitative benefit from an intervention, the medical facility can consider the expected duration of the benefit. In such cases, the patient with the longest duration of expected benefit from an intervention should receive priority. For example, if patient A is expected to survive for a few weeks on a ventilator, and patient B is expected to survive indefinitely, then the ventila-

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tor should be given to patient B.

6. Medical facilities can withdraw a treatment from a patient in order to reallocate a limited resource to a different patient who is expected to realize a more significant medical benefit from the treatment. This applies even if the cessation of the treatment is expected to result in the death of the patient. In such an instance, Catholic teaching holds that medical facilities that withdraw life-sustaining treatment have allowed the patient to die of her underlying condition; the facility has not killed or euthanized the patient.[19]

7. The rationing of care should be done on a case-by-case basis, accounting for the expected medical benefit of a treatment to individual patients. A case-by-case method is far superior to an abstract or "blanket" method of rationing, which categorizes individuals into groups, such as those over 65 years old.[20] A facility's ethics committee should be engaged in rationing decisions to the degree that this is possible. Due to potential conflicts of interest and the potential for moral distress, physicians and nurses who provide direct treatment and care for patients should not be involved in rationing decisions.

Catholic facilities must reject the "quality of life" of a patient as a criterion for the allocation of scarce medical resources. Because of their equal inherent dignity, the physically and mentally disabled should have equal access to scarce medical resources as do the non-disabled. Facilities should employ the same analysis for this patient population as with all other patient populations. In practice, patients with comorbidities will be deprioritized in the rationing of certain interventions, such as ventilators, because such patients typically will not be expected to receive substantial and lasting benefit from such interventions. However, this deprioritization would result from the patient's inability to derive benefit from the intervention and not from the fact that the patient suffers from an alleged low "quality of life" or has a physical or mental disability.

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As noted above, Catholic facilities should not disadvantage patients for treatment based on age. Such blanket exclusions violate normative dignity. Catholic hospitals should ration scarce resources based on expected medical benefit, not non-medical factors, such as age.

Guideline #5 above recognizes that medical facilities may rightly account for the expected duration of a benefit in the distribution of a scarce resource. In situations in which two patients are expected to benefit from an intervention and are expected to be discharged from the hospital post-intervention, the scarce resource should be offered to the patient who is expected to enjoy the benefit for the longer duration. If all other health factors are equal between the patients, medical facilities should offer the resource to the younger patient. This decision responsibly stewards the resource because the younger patient is expected to enjoy the benefit of the intervention for the longer duration.

For example, imagine a case in which two patients, one 40 years old, and the other 80 years old, are expected to be discharged from the hospital after mechanical ventilation. Neither patient has a comorbidity. In such an instance, the ventilator should be offered to the 40-year-old, because the duration of the medical benefit to the 40-year-old is expected to be longer than the benefit to the 80-year-old. In this case, age indirectly guides the distribution of a scarce resource. An alternative scenario demonstrates that age is not the determining factor. Imagine a scenario in which two patients, an 80-year-old patient with no comorbidities and a 40-year-old patient with COPD, require a ventilator. The medical team determines that the ventilator provides the 80-year-old with a reasonable hope of survival and eventual discharge from the hospital. The medical team is doubtful that, given his lung condition and the acuity of his COVID-19, the 40-year-old can be weaned from the ventilator. In this case, the ventilator should be offered to the 80-year-old, as he is expected to realize a more significant medical benefit from the ventilator than the 40-year-old.

CONCLUSION

The above analysis supports the general principle that Catholic facilities should prioritize life-sustaining treatment for those patients for whom the treatment provides the most significant medical

benefit. In a time of scarcity, this principle enables Catholic facilities to withhold, withdraw and reallocate life-sustaining treatment as needed. However, as this analysis has demonstrated, Catholic health care is about more than medical treatment: it is a continuation of the ministry of healing and mercy of Jesus Christ. During the COVID-19 crisis, Catholic health care should continue to provide care for all, because all are God-loved.[21]

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NOTES

1. The rationing of care in the United States is not a creation of the COVID-19 crisis. Medical care is always rationed, with the poor typically denied access to the full complement of care and treatment. The issue of rationing has emerged as an important topic in 2020 because, due to the COVID-19 crisis, rationing will apply to those persons — the non-poor — who typically have had easy and ready access to the health care they need.
2. At the time of the writing of this article, disability-rights groups have filed lawsuits against the rationing guidelines of Alabama and Washington state. The state of Alabama's "Criteria for Mechanical Ventilator Triage Following Proclamation of Mass-Casualty Respiratory Emergency," published in 2010, maintains that "persons with severe mental retardation, advanced dementia or severe traumatic brain injury may be poor candidates for a ventilator. See page 8, http://www.adph.org/CEP/assets/VENTTRIAGE.pdf. The Washington State Department Health's "Scarce Resource Management & Crisis Standards of Care," published in 2020, directs providers to consider the baseline functional status of patients, including "energy levels, physical ability, cognition, and general health" in determining who should receive scarce resources. Patients with a loss of one of these capacities should be considered for transfer to "outpatient or palliative care." See page 3, https://nwhrn.org/wp-content/uploads/2020/03/Scarce_Resource_Management_and_Crisis_Standards_of_Care_Overview_and_Materials-2020-3-16.pdf.
3. See Lisa Rosenbaum, "Facing COVID-19 in Italy—Ethics, Logistics, and Therapeutics on the Epidemic's Front Line," *New England Journal of Medicine*, March 18, 2020, DOI: 10.1056/NEJMp2005492. Rosenbaum also cites the guidelines produced by the Italian College of Anesthesia, Analgesia, Resuscitation, and Intensive Care. Rosenbaum notes that while "the guidelines did not suggest that age should be the only factor determining resource allocation, the committee acknowledged that an age limit for ICU admission may ultimately need to be set."
4. Kevin C. Rhodes, Joseph F. Naumann and Paul S. Coakley, "Bishop Chairmen Issue Statement on Rationing Protocols by Health Care Professionals in Response to Covid-19," April 3, 2020, http://www.usccb.org/news/2020/20-54.cfm. Catholic Health Association, "Ethical Guidelines for Resources in a Pandemic," CHA website, March 30, 2020, https://www.chausa.org/docs/default-source/ethics/ethical-guidelines-for-scarce-resources-in-a-pandemic.pdf?sfvrsn=2.
5. Ezekiel J. Emanuel et al., "Fair Allocation of Scarce Medical Resources in the Time of Covid-19," *New England Journal of Medicine*, March 23, 2020, DOI: 10.1056/NEJMsb2005114. See also an article by Robert Truong, Christine Mitchell and George Q. Daley, "The Toughest Triage — Allocating Ventilators in a Pandemic," *New England Journal of Medicine*, March 23, 2020, DOI: 10.1056/NEJMp2005689.
6. Chronic obstructive pulmonary disease (COPD) is a chronic inflammation of the lungs that obstructs the flow of air in the lungs.
7. Institute of Medicine, *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situation: A Letter Report*, https://www.ncbi.nlm.nih.gov/books/NBK219958/.
8. John Paul II, *Veritatis splendor*, nos. 75-77, http://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor.html.
9. Catholic Health Association, *With Justice for All? The Ethics of Health Care Rationing*, as referenced in Mary J. McDonough, *Can a Health Care Market be Moral?: A Catholic Vision* (Washington D.C.: Georgetown University Press, 2007), 226-27.
10. Darlene Fozard Weaver, "Christian Anthropology and Health Care," *Health Care Ethics USA*, Fall (2018): 1-6.
11. Pope Francis *Laudato sí*, no. 158, www.vatican.va/content/francesco/en/encyclicals/documents/papa-francesco_20150524_enciclica-laudato-si.html.
12. Gustavo Gutiérrez, "The Option for the Poor Arises from Faith in Christ," *Theological Studies* 70, no. 2 (2009): 317-26.
13. United States Catholic Conference of Bishops, *Ethical and Religious Directives for Catholic Health Services*, 6th ed., www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf.
14. Thomas Aquinas, *Summa theologiae*, 5 vols. trans. Fathers of the English Dominican Province, reprint (Allen: Christian Classics, 1981), I-II 13.5.

15. Aquinas, *Summa theologiae*, II-II 23.1.
16. Aquinas, *Summa theologiae*, I 21.3.
17. John Paul II, *Sollicitudo rei socialis*, nos. 37-40, http://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_30121987_sollicitudo-rei-socialis.html.
18. Francis,"Message to the Participants in the European Regional Meeting of the World Medical Association," November 7, 2017, http://www.vatican.va/content/francesco/en/messages/pont-messages/2017/documents/papa-francesco_20171107_messaggio-monspaglia.html.
19. Congregation for the Doctrine of the Faith, *The Declaration on Euthanasia*, May 5, 1980, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html. In paragraph 4, the *Declaration* maintains that physicians "may in particular judge that the investment in instruments and personnel is disproportionate to the results foreseen; they may also judge that the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques. It is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community."
20. Catholic Health Association of the United States, "Ethical Guidelines for Scarce Resources in a Pandemic," March 2020.
21. I extend my gratitude to Brian Kane, James Keenan, SJ, Nathaniel Blanton Hibner and Andrea Vicini, SJ, for reviewing this article and for their helpful suggestions. I am also grateful for the copy-editing work of Christian Lingner, my research assistant.

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