The Anscombe Bioethics Centre

COVID-19 Briefing Paper 1

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Resource allocation and ventilators: A statement of Catholic principles

What does the Catholic tradition say about the allocation of healthcare resources during a pandemic? More specifically, in the context of the current pandemic, what does the Catholic tradition have to say about the provision of ventilation for patients with COVID-19?

The governing principle of medical ethics, as understood within the Catholic tradition, is the intrinsic worth or *dignity of every human being* as made in the image of God.[1] From this it follows that the life of every person is to be respected and protected in accordance with the fundamental requirements of justice.

Within the context of healthcare this principle *excludes intentional killing*, whether death is brought about by action or by deliberate omission.[2] Along with many religious and secular traditions of moral thought, the Catholic Church regards both 'mercy killing' (euthanasia) and medical assistance in suicide as unethical. Treatment or care should never be withdrawn or withheld with the aim or intention of hastening death.

Withholding and withdrawing treatment

The Church is clear, however, that there may be good reasons to withhold or withdraw treatment or care, either because it no longer serves its purpose (is *futile*), or because it is *excessively burdensome* in relation to physical, psychological, social, or economic costs, or because it promises too little benefit relative to the burdens it entails.[3] The Church does not teach, and has never taught, that life must be preserved at all costs. Sometimes the costs or burdens will be a reason not to institute or not to continue treatment.

Another relevant consideration is whether what is offered is medical in character or whether it is part of basic or ordinary care. In 2004, Pope John Paul II made it clear that *clinically assisted nutrition and hydration (CANH) is ordinary care* and is 'in principle obligatory'.[4] The in-principle ethical obligation to provide food and water, with clinically assistance if necessary, may not apply in some dying patients if it would not succeed in prolonging life or in alleviating their

[1] Genesis 1.27, see Vatican II *Gaudium et spes*, 1965: 12; John Paul II *Evangelium vitae*, 1995: 3; CBCEW *Cherishing life*, 2004: 39. Anscombe Bioethics Centre *The ethics of care of the dying person*, 2013: 3.

[2] SCDF *Jura et bona*, 1980: I; John Paul II *Evangelium vitae* 1995: 57.

[3] SCDF *Jura et bona*, 1980: IV; John Paul II *Evangelium vitae* 1995: 65; *Catechism of the Catholic Church* (CCC), 1992: 2278; Anscombe Bioethics Centre *The ethics of care of the dying person*, 2013: 6.

[4] John Paul II 'Address on Life-sustaining treatments and the vegetative state', 20 March 2004: 4; See also Anthony Fisher, 'on not starving the unconscious', *New Blackfriars*, 74 (March 1993), 130-145; CBCEW *A practical guide to the spiritual care of the dying person*, 2010: 2.6-2.10.

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symptoms relative to the burdens it entails.[5] Nevertheless, feeding the hungry and giving drink to the thirsty are foremost among the corporal works of mercy.[6] Furthermore, sharing food and water is a fundamental cross-cultural expression of hospitality and human solidarity. In contrast, Pope Pius XII stated that mechanical ventilation and resuscitation '*go beyond the ordinary means* to which one is bound', so that 'it cannot be held that there is an obligation to use them'.[7] They need not be used and should be used only where the likely benefits outweigh the burdens of treatment.

Note that neither in the case of CANH nor in the case of ventilation does the Catholic tradition make an absolute or in-principle *distinction between withholding and withdrawing*. It is in principle obligatory to start and in principle obligatory to continue CANH when these are needed to sustain life. In contrast, it is neither in principle obligatory to start nor in principle obligatory to continue ventilation, even when it could sustain life.

In this way the Catholic tradition differs from some other traditions (such as orthodox Judaism) in which it is not obligatory to start but it may obligatory to maintain continuous life-sustaining therapies.[8] On the other hand, the Catholic moral tradition also differs from other moral approaches which take as an absolute principle the *complete ethical equivalence* of withholding and withdrawing treatment as though the same criteria should always be applied to both.[9]

Most people recognise that the decision whether or not to take something away (for example, whether to call in a loan) is often different to the decision whether or not to give it in the first place. The circumstances are different. What is important here is that doctors should be willing to give treatment on a trial basis to see if it is successful, and they should not withhold treatment that might be beneficial just because they would not wish to face the difficult decision to withdraw it.

Advance decisions to refuse treatment

One good reason not to provide treatment is that the patient or his or her legitimate representative declines consent. The primary responsibility for a competent adult's health lies with that person. It is the person who will bear the suffering of illness and the risks or burdens of treatment. It is an *injustice to impose treatment that has been refused* by the patient, unless sanctioned by legitimate authorities for urgent or overriding reasons, for example, compulsory testing during a pandemic or compulsory treatment for mental illness. The principle of consent, and thus the *prima facie* right to forego or decline treatment, is accepted by the Catholic Church.[10]

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[5] CBCEW *A practical guide to the spiritual care of the dying person*, 2010: 2.9.

[6] Matthew 25:31-46; *CCC* 2447.

[7] Pius XII 'Address to the International Congress of Anaesthesiologists', 24 November 1957 emphasis added.

[8] See for example, Avraham Steinberg and Charles Sprung 'The Dying Patient Act, 2005: Israeli innovative legislation', *IMAJ* (2007) 9: 550-552.

[9] See for example, GMC *Withholding and Withdrawing Life-Prolonging Treatments*, 2002: 19, but note that this doctrine of moral equivalence is not asserted in the updated guidance, GMC *Treatment and care towards the end of life*, 2010, 33. See also CBCEW *A practical guide to the spiritual care of the dying person*, 2010: 2.9.

[10] See for example, USCCB *Ethical and Religious Directives for Catholic Health Care Services*, 2018: 26. Even in the case where the reasons for the refusal are unjust or unethical, for example an overtly suicidal refusal, it seems that lawful authority would be required to intervene in the face of a clear refusal of consent.

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As the law may authorise compulsory treatment in exceptional circumstances, for certain purposes and with specific safeguards, so the law may clarify what weight should be given to advance statements or to the decisions of proxy decision makers. As it may sometimes be reasonable for a person to decline a current offer of treatment, it may sometimes be reasonable for someone to decline treatment in advance. The Church is *not opposed in principle to the making of advance decisions*.[11] However, decisions to decline treatment should be made for good reasons on the basis of the burdens and benefits of this treatment for this patient.

In contrast, the use of an advanced refusal of treatment as a means to hasten death, for example by the blanket refusal of all life-sustaining treatment or care if the person contracts a certain illness and is unable to make a contemporaneous decision, is a form of conditional suicide. Those who promote this form of advance refusal of treatment are effectively *promoting suicide by omission*. The blanket refusal of all life-sustaining treatment and care without consideration of potential benefits or burdens is not compatible with a Catholic understanding of the dignity of human life.

Allocating scarce resources

Where resources are limited it may not be possible to provide a treatment to everyone who could benefit from that treatment. In this case treatment may have to be rationed. The alternative to rationing is that the available resources go to groups or individuals who are wealthy or powerful, and those who are disadvantaged in society face a further disadvantage in accessing healthcare. This need for rationing is more overt in emergency situations, such as the present pandemic, but even outside emergency situations *rationing already exists* in all modern healthcare systems. The Church accepts the need to ration healthcare resources but requires that it is done in accordance with the norms of distributive justice and encourages it to be done transparently.

The key principle of justice in healthcare allocation is that *healthcare should be distributed in accordance to need*. However, there are different possible criteria for healthcare need. Archbishop Anthony Fisher and Professor Luke Gormally give ten measures of healthcare need: (1) greater urgency, (2) greater likelihood to benefit, (3) likelihood of greater benefit, (4) likelihood of lesser burden from treatment, (5) lesser likelihood of harm from treatment, (6) likelihood of greater harm without treatment, (7) likelihood to gain the same benefit from less treatment, (8) likelihood to need less treatment, (9) lack of alternative methods to satisfy need, and (10) greater likelihood to infect others if untreated.[12] It is evident that these measures may pull in different directions: for example, someone who is very ill may have more urgent needs but may be less likely to benefit.

Usually, and reasonably, greater urgency is taken as the primary criterion for emergency treatment. However, if there are not enough resources to treat all urgent cases then it is also reasonable, and need not be unjust, to *favour a patient who is more likely to benefit*. On the other

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[11] CBCEW *The Mental Capacity Act and 'living wills': a practical guide for Catholics*, 2008: 4.2.

[12] Anthony Fisher and Luke Gormally, *Healthcare Allocation: An Ethical Framework for Public Policy*. London: Linacre Centre, 2001: 129 see also. Paul Gately, Ashley Beck and David Albert Jones *Healthcare Allocation and Justice: Applying Catholic Social Teaching*. London: CTS, 2010.

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hand, there is no ethical requirement always to use this criterion. The treatment is not wasted if given to a patient who has urgent need and who has some prospect of benefit even if someone else might have benefited more. Nor need it be an injustice to save one person even if more could have been saved had you acted differently.[13] There is also a virtue in attending to the person in front of you and, even more, in continuing to treat someone whom you have started to treat. The beginning of treatment constitutes a human relationship and this changes the circumstances of the decision.

It is therefore reasonable for hospitals to have a system of queuing ('first come first served') combined with the priority of more urgent cases and, among these, priority for those most likely to benefit. Similarly, those receiving treatment should be reviewed regularly to assess whether the treatment is effective in relation to its goals. Healthcare professionals will often use tools to help with these assessments but these tools should reflect the actual health condition of the person. Policies that institute age limits or that exclude people on the basis of specific diseases or of specific disabilities do not necessarily reflect the condition of the person. Such approaches are both inaccurate (and hence contrary to prudence) and discriminatory (and hence unjust) and in many jurisdictions they would be unlawful.

There are no perfect solutions here. Decisions require the virtue of prudence and, even when the right decision is made, it will often be painful because it is hard not to be able to save everyone. It also takes courage to make the hard decisions that need to be made even though this involves the possibility of making a mistake. It is important that healthcare professionals who have to make these decisions are supported emotionally and that they are not judged too harshly in retrospect (nor judge themselves too harshly) where they have acted in good faith on limited knowledge.

There are reasonable disagreements about how to apportion resources justly when not everyone can have everything. Nevertheless, there also some truths that can be affirmed unequivocally. Decisions must never be made on the basis of negative value judgements about the worthwhileness of someone's life. People should not be excluded purely on the basis of age or disability. There are no lives unworthy of life. If a decision is made about who is next allocated a ventilator, this may be done on the basis of whether the ventilator is more or less likely to save this or that patient, but must not be done on the basis that this or that patient is more or less worth saving.

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[13] As argued by Elizabeth Anscombe in 'Who is Wronged? Philippa Foot and "Double Effect!"', Mary Geach and Luke Gormally (eds.) *Human Life, Action and Ethics*, Exeter: Imprint Academic, 2005: 249-252.

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