SCARCITY AND CONFLICTING DEMANDS IN TIMES OF PANDEMIC

A Situation of Unavoidable Moral Conflict

Perhaps not given much attention by many during this time of pandemic is the fact that medical practitioners especially in the hospital setting are *doubly burdened* by their professional duties. Not only are they in the forefront of exposure to the contagion, not only do they need to assume the responsibility of treating (finding a cure for) disease and of caring for the sick, they also need to undertake the difficult task of making a prudential judgment on how to allocate health care resources when the demand for them exceeds their availability. Having to make such a judgment can be excruciating inasmuch as it appears to be tantamount to deciding as to who would be given the chance to survive and who might not be accorded the same opportunity. It is a situation in which one may have the sincerest intent of attending to all in need, yet the grim reality is that one can attend only to as many (or as few) as can be accorded the resources that are available. Others frame the issue in more heart-wrenching terms as one involving a decision of choosing who lives and who dies, a decision about who shall be saved when not all can be saved.

One danger that medical practitioners can possibly be exposed to in this difficult situation is the temptation to take the easy route, that is, to use a utilitarian calculus such as the tendency of some protocols that claim as their goal the "*maximization of population outcomes*" or the "*provision of the greatest good to the greatest number*." It must be acknowledged that the situation being described here is one which easily lends itself to a slippery slope when addressed with only the slightest consideration of moral propriety. It is a situation where the *old*, the *physically disabled*, the *mentally impaired*, the *terminally ill*, and especially the *poor*—in other words, those perceived to have little contribution (or nothing at all) to community life, if not who are actually considered a burden therein—are most vulnerable. Indeed, bypassing these sectors of society can appear tempting and persuasive in the face of scarcity, when in the midst on the contrary of overwhelming demand, there seems to be no other realistic and rational option but to yield to the call of simple pragmatism. Within the Christian perspective, however, doing the right thing in a dilemma is much more than just heeding such sense of practicality.

Moreover, those in the vanguard of decision-making are also likely to be overwhelmed by the suggestion that having to decide whom to save when not all can be saved is equivalent to *intentionally killing* those one cannot save. It is as though the decision to save some also means a decision to kill the others one *chooses* not to save. Advocates of *euthanasia* and *physician-assisted suicide* who see no difference between killing and letting die (or allowing death) will be quick to point out that foregoing or denying treatment to those deemed not in line for allocation of resources is actually the same as killing them. After all, they argue, both—foregoing treatment and killing—consist in the taking of life so that there is actually no moral difference. Either one allows to be bothered by that thought and thus be weighed down by the seeming impasse, or one succumbs to the suggestion and be led to the same slippery slope.

For the Christian, therefore, the situation begs for the application of higher moral principles because in such a situation, human life, the most basic and irreplaceable good, is at stake. While there is no way of escaping the burden of decision-making, there is at least a way of taking the

pressure off one's conscience in the aftermath of what one might *decide* to do or not do in a situation where conflict arises between competing claims of need. That is, to have one's decision be guided (informed) by sound moral principles. The best effort expended in their application should spare the medical practitioner unnecessary qualms, guilt or blame. It therefore behooves everyone making such a conflict-laden decision to always take into account these moral principles and to find the best way possible these principles might be made to apply in the best interest of the persons bound to be affected by the consequences of such a course of action.

Fundamental Moral Principles

At the outset then, it must be said that for the Christian allocation decisions must be anchored on several principles of Catholic social teaching, namely, *a*) the fundamental *principle of respect for the inherent dignity of human life and of the individual human person*; *b*) the *principle of the common good; c)* the *principle of subsidiarity*; *d*) the *principle of solidarity* and e) the *principle of stewardship*.

Catholic teaching has always insisted that the human person's right to life is inviolable and inalienable, which must therefore be respected and safeguarded at all times. Scripture makes it clear that each and every (individual) person is created in the image and likeness of God. This radical claim is the source of Catholic belief in the inherent and inviolable *dignity of the human person* and in the *sacredness of human life*. Every allocation (rationing) decision then must reflect this fundamental principle, whether the consequence of such a decision be life-saving or life-depriving. That being the case, one ought not premise such a decision on age, sex (gender), race, or any other descriminatory criterion — for all are equal in terms of the right to life.

In the concrete, human life and the rights of every human person are best respected and safeguarded within the context of the *common good*. Building on St. Thomas' teaching, Vatican II defined the common good as "*the totality of social conditions allowing persons to achieve their communal and individual fulfillment*."[1] This definition indicates that the good of the individual human person and the good of the community cannot be fragmented, for the good of the community is the same as the good of one of its members. Given this understanding, even if resources were scarce, no allocation decision should be made that would sacrifice the innate good (dignity) of the individual human person. One cannot simply look at the whole without ensuring the good of every individual member. Thus, one may not depart from a *clinical health approach* that guarantees the individual good, and shift to an approach that guarantees the public good (i.e., the health of a whole population) even if this might mean sacrificing the individual good. Again, the *dignity of the human person* must be the *primordial consideration,* inasmuch as the *common good cannot in fact be achieved by abandoning the good of the individual human person*.

What comes next to mind in these times of scarcity is the *principle of solidarity*. According to Benedict XVI, "*Solidarity* refers to the virtue enabling the human family to share fully the

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[1] *Gaudium et spes*, 26.

treasure of material and spiritual goods."[2] Sharing follows from the fact that every human person is a social being who does not and cannot live alone and on that count would therefore have to be dependent (reliant) on others. As a moral virtue, solidarity allows human persons to support, help, and sacrifice for one another through the sharing of resources. Solidarity, however, is also a social principle in that the sharing which it summons among human persons ought to be regulated by (distributive) justice and ordered to the common good and to the commitment to the well-being of every individual human person in the community. The principle of solidarity then guarantees that in times of health crisis, even the elderly, the chronically (terminally) ill, the disabled, and other vulnerable sectors of society can demand the due attention that they deserve. It can also be the driving force behind the voluntary and supererogatory act of relinquishing something one may be entitled to so that someone else might benefit from it. Not that by this act, one places greater value on the other's life over one's own, but rather that out of sheer love, generosity and solidarity, one is willing to forego what one deserves to allow others to have a chance at life.

That there can be a voluntary aspect in the allocation of resources shows that this issue also requires the application of another principle, that of *subsidiarity*. According to this principle, as Pope Pius XI introduced it in his encyclical *Quadragesimo Anno,*[3] every task of society should be assigned to the smallest possible group that is able to perform it. Only if the smaller group itself is unable to accomplish such task should a group at a higher level assume responsibility. In other words, decision-making and social organisation should be kept as close as possible to the grass-roots. Accordingly, Benedict XVI stated that "…*subsidiarity* is the coordination of society's activities in a way that supports the internal life of the local communities."[4] In matters of life and death, therefore, such as the allocation of health care resources, the decision (consent) of the individual human person matters most. Being able to decide for oneself is an important component of the dignity of the human person. Thus, if a human person is morally and psychologically competent of performing this role, it would be a grave injustice to assign this role to someone else. Or, if the person who is ill loses such competence because of the severity of the illness, it would be morally improper for the health care provider to unilaterally make the decision without the participation of the person's family or next of kin.

Finally, any discussion of resource allocation necessarily also leads to a consideration of the principle of *stewardship*. In general, this principle is grounded in the presupposition that God, and he alone, has absolute dominion over creation being its origin and author. Yet, having been created in God's image and likeness, human beings have likewise been accorded some control over the same creation of which they are part. Such control, however, is simply one of *stewardship*, limited and confined as it is to the protection, care, and judicious use of nature and the environment. Included in this responsibility is respect and care for human life itself, given its inherent sacredness and dignity. The principle of stewardship then requires that the gift of human life be cared for and its natural environment be used wisely in accord with its design and purpose. In a situation of (severe) scarcity of resources, triggered by the excessive demand for them as in this time of pandemic, *wise use* of whatever available resources there are

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[2] POPE BENEDICT XVI, *Address to the participants in the 14th session of the Pontifical Academy of Social Sciences*, May 3, 2008 (Libreria Editrice Vaticana, 2008).

[3] POPE PIUS XI, *Quadragesimo anno* (1931), nn. 79-80.

[4] POPE BENEDICT XVI, *op. cit*.

means their equitable distribution. Stewardship thus presupposes the application of *distributive justice*, according to which limited health care resources are rationed equitably, so that benefits derived from their use are obtained more effectively and efficiently. In this way, health care is administered in the broader perspective with the required commitment to human dignity and the common good. The principle of stewardship is what would allow both medical practitioners and those in need of health care to see that, in times of shortage and limitations, resources need to be prudently and charitably used and that there is a reasonable justification for applying stricter measures for such judicious use than it would otherwise be in noncritical situations.

The Need for Triage and Rationing Protocols

The harder part of course in all these discussions is determining *how exactly* in the concrete are limited resources to be allocated and distributed in a way that is consistent with the moral principles outlined above. In response to this question, most ethicists propose that triage and rationing protocols, based on sound and objective criteria, be formulated and developed to guide both health care providers and patients (and their families) alike.

Triage is the process of sorting or categorizing people, who are sick or who have been injured, for the purpose of *immediate* medical treatment, according to the seriousness and urgency of their condition or injury as compared to their chance of benefiting from such intervention. The need for such a process usually arises during emergency (e.g., during disasters and mass casualties incidents) when, due to the sheer number of patients at a given time, limited and insufficient medical resources must be allocated at once to maximize the number of beneficiaries who are deemed most likely to benefit from the use of such resources.

Through triage, for instance, crisis situation response teams or hospital emergency personnel are able to know who among the patients are expected to survive, even if medical intervention were to be postponed, inasmuch as their sickness or injury is less severe and critical. There are patients, on the other hand, who may be seen through triage as having a chance of survival but are likely to die if not accorded immediate attention and treatment because of the severity of their condition. Or, there may be, finally, patients who would likely die just the same even if given immediate care and intervention and who are therefore “beyond help” though not necessarily “beyond at least a *modicum* of attention”.

Triage data then help determine who among the patients in a crowded medical facility, for instance, are to be given, based on the classification above, the priority for the use of *space* (e.g., a slot in the emergency room, the ICU, or operating room), *medical equipment* (e.g., the ventilator or the personal protective equipment), *medical supply* (e.g., oxygen), or for the administration of *medicine* itself. Thus, consequential to triage findings in critical and emergency situations is *rationing* and the *prudential* and *proportionate allocation* of medical equipment, services, or resources already mentioned, including the amount or length of *time* and *attention* that is to be accorded to patients as may be required of health care providers in such an extraordinary setting.

Criteria in Determining Triage and Rationing Priority

The *moral imperative* that is the whole point in the application of the moral principles detailed above in situations requiring triage, and allocation and rationing decisions due to scarcity of resources, is obviously the avoidance of *arbitrariness* and of *unfair* and *unjust discrimination*, all patients being of inherent and equal worth and dignity. Thus, when choices are made in situations of competing demands for medical intervention, that must be the overriding concern, aside of course from the intent of saving as there are to be saved. To ensure that no such discrimination take place, health care providers need to base their allocation decisions on sound criteria in keeping with the demands of objectivity and justice.

What immediately comes to mind, of course, is the priority that should be given to the needs of *medical practitioners* and *health care workers*[5] themselves on whom the administration of health care depends. This is typically illustrated by an adult having to put on the oxygen mask first to himself or herself before putting it on a child when cabin air pressure drops in the course of a flight. Similarly, in times of pandemic, the first concern is the health and safety of health care providers and workers themselves so they could discharge their duties more efficiently and thereby also ensure the safety and health of the patients under their care. Vulnerable to high risk of infection, they should be given priority of access to tests, protective gears, medical/surgical masks, vaccines, etc., for without them, it is difficult to keep critical health care infrastructure working. Giving them priority of access to health care resources in the measure that they need them is, in fact, also an expression of care and concern for the sick they are meant to serve.

In dealing with patients with competing claims, the ideal is to obtain an *objective clinical prognosis* that takes into account the (brief) medical history of the complaint, identification of clinical symptoms, and measurement of vital signs (e.g., heart rate, respiratory rate, temperature, and blood pressure) because these initial data should help identify the severity or gravity of the health condition and thereby determine at first instance who among the patients require immediate care. Subsequent clinical tests should be performed to validate initial findings and eventually help determine who among the patients require priority of attention and intervention.

As is becoming clearer from what has been said so far, triage and rationing protocols should be based *first* and *foremost* on *objective clinical criteria*, as opposed to *nonclinical criteria*. Based on these criteria, one gets the information about the actuality and degree of seriousness of the illness, the urgency, immediacy, and necessity of the medical intervention required, the chance of survival and the moral certitude of success in the immediate short term if the intervention were to be applied.

Several things need to be adequately pointed out and understood in this statement. First, the aim of the intervention is *survival in the immediate short term*. In other words, one needs to ask who will survive here and now, albeit only in the short term. The prognosis should exclude

[5] One would think, for instance, of *doctors* and their *assistants*, *nurses* and *nursing aids*, *caregivers*, *pharmacists*, *medical facility operators* and *technicians*, and *support staff* in the hospital (e.g., *dieticians* and those who prepare food for the patients, etc.).

considerations that go way beyond the immediate emergency situation. It would be unfairly discriminatory, for instance, to give immediate priority to a *younger* patient over an *older* patient for the simple reason that the former has more years ahead to live than the latter would normally have—that is, in the long term. Long-term survival in this context can never be used as a criterion without falling into the trap of utilitarianism. In any case, it is enough that one obtains *moral certitude* in determining short-term survival probability for as long as this is based on scientific and objective clinical indications. One way, for instance, of obtaining moral certitude as regards short-term survival is to assess the opposite but correlative short-term *mortality* risk, which in recent years has been made easier through the application of scoring systems (usually in the ICU setting), such as the *Sequential Organ Failure Assessment* score (SOFA),[6] the *Acute Physiologic Assessment and Chronic Health Evaluation* score (APACHE II),[7] and the *Simplified Acute Physiology Score* (SAPS).[8] Nonclinical criteria, on the other hand, are secondary considerations as they become relevant only when clinical prognosis among competing claimants is more or less the same for they serve as deciders. Such is the basis for instance in giving priority to health care providers as already mentioned above.

Moreover, utmost judiciousness must be exercised in dealing with patients who have already been admitted and made to benefit from resources that may be required by new incoming patients. It could be that these patients may exhibit clinical indications that show that their lease on life is becoming slimmer, thus indicating that others with greater chance of survival may stand to benefit more from the resources that have been accorded them. One thinks, for instance, of terminally ill patients whose death is almost imminently certain. Even in situations of scarcity, it would be morally wrong to positively hasten the death of these patients (euthanasia), or to withdraw (withhold) life-sustaining measures from them, not unless these measures have been deemed as *extraordinary means* that only unnecessarily prolong their lives.

In such situations when it might be justifiable to withdraw such extraordinary means, the patients themselves, their immediate family members, or surrogates, should be properly informed so as to obtain their consent. It must be adequately explained to them why these measures have become extraordinary, and that withdrawing their use is the reasonable (ethical), even the charitable thing to do, in the midst of scarcity and insufficiency of medical resources. Only when patients or their surrogates unreasonably demand not to discontinue use of extraordinary means, even if it has been clearly demonstrated that there is no reasonable hope of benefit to be derived from them without imposing excessive burden, and even after the grave situation of shortage has been adequately explained to them, might physicians exercise their right to defy their wishes and authorize the cessation of medical intervention.

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[6] The *Sequential Organ Failure Assessment* score (SOFA score), previously known as the *sepsis-related organ failure assessment score*, is used to track a person's status during the stay in an *intensive care unit* (ICU) to determine the extent of a person's organ function or rate of failure.

[7] The *Acute Physiology And Chronic Health Evaluation* II (APACHE II) is a *severity-of-disease classification system*. It is applied within 24 hours of admission of a patient to an *intensive care unit* (ICU).

[8] The *Simplified Acute Physiology Score* (SAPS) was developed and validated in France in 1984, using 13 weighted physiological variables and age to predict risk of death in ICU patients. More on ICU scoring systems in JEAN-LOUIS VINCENT & RUI MORENO, "Clinical Review: Scoring Systems in the Critically Ill," in *Critical Care*, Vol. 14, n. 207 (2010). (https://doi.org/10.1186/cc8204)

Conclusion

Decision-making becomes even doubly difficult in emergency situations. The current pandemic has further heightened such difficulty. Rather than ease moral standards, given the fact that there may be not enough time to make adequately reasoned decisions, the pandemic on the contrary is a time that requires strict adherence to moral principles. For indeed, it is a time when the marginalized, most especially the disabled and the poor, become vulnerable to injustice and discriminatory practices. If there is anything to be learned in this critical situation of competing claims and demands, it is the conviction that all human persons are of equal worth and dignity and that each one deserves health care in the measure that is appropriate and proportionate to each one's needs and medical condition.

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