Medical triage principles in wartime and pandemic scarcity: a Catholic perspective

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Abstract

Health care scarcity can occur in several situations, e.g. during wartime or during a pandemic, leading respectively to scarcity of surgical facilities or scarcity of hospital and especially intensive care unit beds.

A first line approach to health care scarcity is to utilize health care facilities further away from the front or pandemic area and transport patients to these locations. In case of more widespread scarcity, selection of patients might be needed. This situation requires ethical principles to do so. Secular principles are basically founded in equity of all humans, most times elaborated from both an egalitarian and an utilitarian perspective. An egalitarian approach fits e.g. to a lottery system (random patient selection); in an utilitarian approach those patients that will have the longest expected life years after the treatment or those that will have the most significant contribution to society will be selected for treatment.

An approach form the Social Doctrine of the Catholic Church (SDC) assumes Creation of man as an image of God. It, therefore, respects human dignity, including individual human life, respect for each human's free will, and recognition of man as a social being. It leads to the four fundamental principles of SDC: personality, solidarity, subsidiarity and the common good. The ultimate goal of life is being with God, not the preservation of life as an absolute value. As a consequence, scarce resources may be a ground for selection of those who benefit the most of scarce means or who have special value to keep society running. It may not lead to discrimination based on age, gender, race, quality of life etc. Special attention must be paid to the vulnerable and poor. The goal of this selection must be in the common good, which includes human dignity, not in utility. At a practical level, it might end in similar solutions as secular approaches. However, being aware of the foundations of Christian (and thus Catholic) foundations guards Christians from acting against God's intention.

Introduction

Scarcity of healthcare resources or facilities can occur in various situations. Obvious situations are war situations, both at the front and in cities where there have been many (civilian) casualties after bombardment or shelling, or during a pandemic. In war situations there will be a particular need for surgical facilities, during a pandemic such as the COVID-19 pandemic of 2020-2022 there was a shortage of resources (personal protective equipment such as mouth masks), intensive care beds and healthcare professionals who could treat patients. When the number of people admitted with COVID-19 in hospitals ran out, the hospital treatment of many others was found to have been delayed, sometimes with irreparable long-term damage, because staff were largely assigned to the care of COVID-19 patients during the peaks of the pandemic. The pandemic and all the discussions held at the time made it clear that severe scarcity of

both health resources and health personnel can occur and that there is no clear vision of how to allocate scarce opportunities.

In such situations of scarcity, several strategies on how to deal with them can be distinguished.

Solving local scarcity with resources and facilities further away

The first-line strategy in case of scarcity of healthcare facilities at a particular frontline location or in a particular city or region is to use facilities located further away from this location. The only form of triage that is then necessary is identifying those who will not survive anyway, selecting those who need to be transported to a more distant hospital, and deciding when the transport must take place. In this approach, basically everyone is treated. People with very urgent problems go first, especially to stabilise them and prepare them for transport. People with a very poor prognosis who will die quickly both on site and elsewhere are not given any priority for transport and life-saving treatment. Some priority may also be given to those who are very important for the continued proper functioning of the army and or health facilities.

Scarcity and the need for triage: secular approach

From the Enlightenment onwards, much attention comes to the human being as an individual. This directly influences political theories that determine how to view society and the "common" that people have in society. John Locke (1632 - 1704) assumes that every human being possesses a *reason* and therefore has as many rights as another. He is thus the founder of egalitarianism and liberalism. In Locke's view, people enter into a kind of "social contract" with each other to ensure that a "government" or "administration" ensures that there is justice, i.e. that the freedom and equal rights of all individuals are protected. How this government should bring about justice was still a matter of debate as time went on. In political and social philosophy, the discussion was about equality, fairness, need and merit. Locke developed egalitarianism, whereby every individual has the same rights and, therefore, the same access to public resources and facilities, including education and health care. His distributive justice, which addresses distributive issues such as situations of scarcity, assumes that everyone has an equal right to that which should be distributed. Practical selection criteria of egalitarianism are:

- "First in, first served": everyone has an equal chance of receiving treatment, because everyone has the same chance of needing healthcare at an early or late stage of scarcity;
- Lottery;
- Fair innings (years criterion): everyone is entitled to a certain amount of life years. Using this selection criterion, young people have priority over older people because they still have "many years to spare".

Problems of distribution are approached differently in utilitarianism, conceived by David Hume (1711 - 1776) and further elaborated by Jeremy Bentham (1748 - 1832). In utilitarianism, the aim of choices to be made must be that as many people as possible will be happy as a result, where happiness means "pleasure minus pain". Thus, in this approach, scarce resources may be allocated to groups of people who benefit greatly from them or only need to use the scarce facilities for a short time. In this way, not everyone

is treated equally. Egalitarianism and utilitarianism as elaborations of justice can therefore be at odds with each other in certain situations.

In the Netherlands, an analysis into equitable distribution in situations of scarcity of healthcare resources and facilities was conducted by the Raad voor de Volksgezondheid en Zorg (Council for Public Health and Care) in 2012. (1) The authors of this opinion list a number of considerations, but fail to strike a balance between egalitarian and utilitarian values. In the end, they do not arrive at a unified guidance on how resources should be distributed. The alert ends with "procedural transparency", an advice that one should be transparent about the procedures that will ultimately lead to choices. In 2023 another Dutch council made another attempt to formulate moral principles for equitable distribution of scarce healthcare resources (2). This analysis also wrestles with egalitarianism, utilitarianism and need, and ultimately also arrives at transparency and workable procedures (guidelines). The principles mentioned in this exploration that need to be balanced against each other for distributive justice are 1) health equity; 2) equality; 3) need. Emanuel describes at the time of the COVID-19 pandemic ethical values that can be used in triage due to scarcity of healthcare resources. He leans heavily on utilitarian principles, i.e. maximising the profit of resources deployed. (3)

Scarcity and the need for triage: approach from the Social Doctrine of the Roman Catholic Church
The Social Doctrine of the Catholic Church (SDC), based on the Christian view of humanity and handily brought together in the Compendium of the Social Doctrine of the Church (CSDC), has 4 fundamental principles: (4-7)

- Personality (CSDC 105-114). This is the premise that every man is created in God's image: man is not identical with God, but rather a reflection of it. (8) Man is thus unique and equal to all other human persons. In his creation, man has responsibility for that which he has received from God: his life. He was created with a free will, but has limited freedom to dispose of his life. The preservation of his life is not the ultimate goal: the ultimate goal of human existence is to offer his life and what he has done with it to God and be allowed to be with Him. In this view of man, life is a gift for which man must later show himself to be a good steward when he offers it to God.
- Solidarity (CSDC 192-196). Closely linked to the principle of personhood, is the principle of solidarity. Man, as the image of God, does not stand alone. The image of God is the image of trinity: God who is in himself already relationship and love. Man is therefore also a social being created in a network of relationships, starting with his Creator in addition to other people. These relationships of groups together form society. People further share their human (sinful) nature, but also share their hope for a better future. People also have responsibility to each other through solidarity.
- Subsidiarity (CSDC 185-188). This principle is the consequence of personhood and solidarity. It seeks to express that what can be regulated at a lower level should also be regulated at a lower level. Higher organs, especially the state, should not take over what can be carried out by the individual and by his primary connections (family, family, association, neighbourhood). However, the higher organs can help the lower organs to fulfil their function, through subsidies or regulations, but preferably as minimal and

temporary as possible. In this way, the free development of society can be guaranteed - in accordance with its purpose. It also ensures that human dignity is fully respected. Finally, this freedom provides the best guarantee for optimal participation in society and its political bodies.
- Bonum commune (CSDC 164-170). This last principle flows from the previous three. The common good says that society should be so arranged that the social conditions should be present "by which both groups and individuals can attain their own perfection more fully and quickly". Everyone and every institution, especially the state, should ask itself what its contribution to this is. Linked to this principle is the premise of the universal destination of property. While the SDC sees private property as one of the constituent elements of the ordering of society, it also recognises that this should not mean that goods may be accumulated resulting in people's needs. Everyone may share in the fruits of the earth; what is produced is at the service of everyone on earth.

From the SDC, a number of suggestions can be made for the distribution of scarcity.

It is reasonable that in times of scarcity no one, not even a government, can be obliged to do the impossible: choices have to be made then. (9) However, it is true that for the sake of the equality of all people, everyone should receive treatment or care. When the best treatment is not available to everyone, second-choice treatment or palliative care may suffice. Special attention is paid here to poor and vulnerable people: care a attention should also or especially be given to them.

From the perspective of good stewardship, which, as mentioned, stems from the Christian view of humanity, it is logical, especially in times of scarcity, not to burden the healthcare system unnecessarily. It is then obvious to prefer treatments whose effectiveness has been proven to those whose effectiveness has not been established. The movement in medicine that took off at the end of the 20th century, Evidence Based Medicine (EBM), ensured that certain treatments were abolished because they were not found to be useful in scientific research. What was also found is that a fair number of treatments have not been studied for effectiveness. So EBM can help with choice, but in many situations in medicine, scientific research results are not available for certain conditions, certain stages of conditions or certain target groups. When they are, abandoning non-effective treatments certainly does a service to the common good (no waste of resources). If resources are limited then the provision of the most necessary treatments will have to be secured, with priority over the less urgent ones.

A further elaboration of good stewardship is to apply scarce treatments preferentially to those who can benefit most from them. This involves a proportional trade-off between the deployment of resources and the expected return (utility). In order to serve the public interest, it is in itself acceptable to choose to apply scarce resources to those who can benefit the fastest or the most, but it should not lead to discrimination against groups. As a result, selection for the benefit or profit of treatment cannot be based on age, disability, quality of life, nationality, race or ethnicity, criminal record or health insurance taken out. (6, 9, 10) The German bishops' conference, in particular, warned during the COVID-19 pandemic against extensive use of utilitarian principles, which could lead to discrimination. (9)

When attempts are made at the group level to direct available resources to those who will benefit most, it also has direct consequences at the individual level. During the COVID-19 pandemic, the question arose as to what extent certain people could be denied ICU admission, possibly with artificial ventilation. These would then be people who could expect little or no benefit from ICU admission. First of all, in the Christian view of man, preservation of life is not absolute: the ultimate goal of life is union with God. If in certain circumstances special resources, such as ICU admission and artificial ventilation, are not available or their deployment is not proportional to the expected outcome, there is no obligation on the government and the individual to deploy these resources. The government does not have to make these resources available to everyone; the individual can claim a resource if the deployment is proportional, but can also refrain from deploying these resources if they are not proportional. (11, 12) Another approach is that from general welfare interests: one sick person may gain more from an ICU admission, e.g. in life years, than another patient. It may also be the case that older people or those with more comorbidities need a longer ICU admission and therefore impose more scarcity on others, so to speak. For the sake of the common good, a choice may be made not to deploy scarce resources, ICU beds, where the profit of treatment is limited relative to deployment. This may include, where there are equal gains (e.g. chance of survival), the duration of the benefit of treatment (weeks versus years) per se, provided it does not lead to discrimination.

The common good can also be served by the availability of people with certain skills to keep society running: e.g. in times of war soldiers and army officers and/or medical and nursing staff, in times of pandemic workers in health care, nursing home care and home care. In that light, it is justifiable to defend giving these people preferential access to scarce healthcare resources to keep the country's defence or sick and nursing homes and other parts of society running. (13)

Finally, distribution of scarcity means that triage applies to everyone: not just war victims or victims of a pandemic: those already admitted for some other medical problem or those who have to undergo medical treatment should also become subject to the triage system.

In all this, the SDC advocates triage considerations on a case-by-case basis in a specific situation under the virtue of prudence, at the level of the individual (subsidiarity) and thus not protocol-based selection of predefined groups. Transparency is always important. (13)

In a later phase of the COVID-19 pandemic, another problem of scarcity arose in the distribution of the limited amount of available vaccines against SARS-CoV-2. In practice, richer countries had access to many good vaccines because they had the financial resources to pay a lot of money for the vaccines. The number of vaccines available to poorer countries was much more limited. The Vatican's COVID-19 Commission in 2020, therefore, referring to the SDC, publicly urged fair distribution of vaccines. (14)

The question is to what extent the SDC now approaches triage and selection in times of scarcity differently from secular guidelines struggling with egalitarianism and utilitarianism. Some feel that there is seemingly

little difference: the Church also pays attention to equal rights of all individuals and uses purposiveness as in utilitarianism. Nevertheless, there are substantial differences. In the Christian view of man, every human being is an independent individual with his own dignity and thus his own rights, but always in the context of Creation, in which man was created in relation to others with the same dignity. Finding the right balance between individual and common good is thus an essential part of Creation. The purpose of the principles of the SDC to be used in scarcity is to serve the common good, of which human dignity is a part. The goal is not "utility" or "as much utility as possible", as in utilitarianism. The advantage of the Church's approach is that the valuation of the individual and the common good are linked and not at odds. In addition, sustaining life is not an absolute value and, therefore, scarce resources can be chosen to be allocated to individuals who clearly benefit from them. Such an approach from the SDC does not lead to discrimination against groups.

References

1. Raad voor de Volksgezondheid en Zorg. Rechtvaardige selectie bij een pandemie. Den Haag: Centrum voor Ethiek en Gezondheid; 2012.
2. Centrum voor Ethiek en Gezondheid. Code Rood. Verkenning van morele uitgangspunten bij langdurige schaarste in de zorg. Den Haag2023.
3. Emanuel EJ, Persad G, Upshur R, Thome B, Parker M, Glickman A, et al. Fair Allocation of Scarce Medical Resources in the Time of Covid-19. N Engl J Med. 2020;382(21):2049-55.
4. Pontifical Council for Justice and Peace. Compendium of the Social Doctrine of the Church. Citta del Vaticano: Libreria Editrice Vaticana; 2004.
5. van Wissen G. De grondslag van de Katholieke Sociale Leer. Jubileumbundel 10 jaar Centrum voor de Sociale Leer van de Kerk. Weijers PS, editor. Vogelenzang: Centrum voor de Sociale Leer van de Kerk; 2018.
6. Daly DJ. Guidelines for Rationing Treatment During the COVID-19 Crisis. Journal of the Catholic Health Association of the Unted States Health Progress. 2020;101(3).
7. Kenny N, Kotalik J, Herx L, Coelho R, Leiva R. A Catholic Perspective: Triage Principles and Moral Distress in Pandemic Scarcity. Linacre Q. 2021;88(2):214-23.
8. Sacrosanctum Oecumenicum Concilium Vaticanum II. Gaudium en spes, constitutio pastoralis de ecclesia in mundo huius temporis (7-12-1965), nr 12. Acta Apostolicae Sedis. 1966;58:1025-120.
9. Bischofskonferenz D. Triage. Medizinische Allokationsprobleme angesichts der Covid-19-Pandemie in ethischer Beurteilung 2020 [updated 08-04-2020. 007:[Available from: https://www.dbk.de/presse/aktuelles/meldung/triage.
10. Pontifical Academy for Life. Global pandemic and universal brotherhood: note on the Covid-19 emergency. Rome; 2020.
11. Pius XII. Le dr. Bruno Haid. Adstantibus multis honorabilibus Viris ac praeclaris Medicis et Studiosis, qui Romam convenerant invitatu et arcessitu Instituti Genetici « Gregorio Mendel », Summus Pontifex propositis quaesitis de « reanimatione » respondit. * (24-11-1957). Acta Apostolicae Sedis. 1957;49:1027-33.
12. Sacra Congregatio pro Doctrina Fidei. Declaratio de euthanasia (5-5-1980). Acta Apostolicae Sedis. 1980;72:542-52.
13. Rhodes KC, Naumann JF, Coakley PS. Bishop Chairmen Issue Statement on Rationing Protocols by Health Care Professionals in Response to Covid-19. 2020.

14. Vatican COVID-19 commission, Pontifical Academy for Life. Note of the Vatican Covid-19 Commission in collaboration with the Pontifical Academy for Life “Vaccine for all. 20 points for a fairer and healthier world. Rome: Holy See Press Office; 2020.

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