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Ethical Concerns with COVID-19 Triage Protocols
NCBC Ethicists

Since the onset of the coronavirus pandemic, The National Catholic Bioethics Center has fielded numerous questions regarding COVID-19 triage protocols. We have reviewed a number of such protocols from both Catholic and secular sources; and while we do not question the need for appropriate policies or question the good motives of their authors, we do have concerns.

We offer this document to alert Catholic (and other) health care providers of elements within these protocols that may conflict with an institution's mission and Catholic identity.

General Issues of Concern

- Various protocols claim as their goal "maximizing population outcomes" or "providing the greatest good to the greatest number." Such language is utilitarian. The Catholic moral tradition does not accept utilitarian principles as an independent or constitutive source of ethical guidance, because such principles can be used to justify actions that undermine the dignity of the human person. Health care professionals need to be aware of the utilitarian sources of these terms and carefully evaluate the means by which triage protocols seek to "maximize the greatest good."
- Some protocols maintain that triage teams should not incorporate beliefs or ethical principles that are not specifically addressed in the protocol. This is problematic. The majority of protocols we have reviewed were written by secular sources and, as such, do not incorporate Catholic moral teaching in general or the principles of Catholic health care ethics in particular (see the USCCB's *Ethical and Religious Directives for Catholic Health Care Services*). The NCBC stresses that any COVID-19 triage protocol must be implemented in accord with the Catholic moral tradition.

Triage Teams

- Protocols we have reviewed typically call for the creation of a triage team (or committee) whose purpose is to evaluate COVID-19 patients and, utilizing objective clinical indicators, to prioritize which patients will receive critical care treatments, most notably a ventilator. This triage team is also frequently charged with determining—again based on clinical indicators—when clinical care interventions ought to be withdrawn. The NCBC holds that triage teams can be morally justified. They can help ensure objectivity in decision making, minimize conflicts of interests, and mitigate moral distress for the care team. The NCBC recommends that an ethicist or a member of the hospital ethics committee be included on the triage team.
- Some protocols offer the doctor, patient, or family members the ability to appeal a triage team decision. The NCBC suggests that protocols explicitly allow care team members to advocate for their patients during such an appeals process. This will foster transparency, level the playing field regarding medical knowledge, and ensure that any concerns that may have not been adequately addressed are heard and reviewed.

Criteria for Determining Patient Priority Scores

- Patient priority scores for critical care resources allocation should be determined using objective clinical criteria for short-term survival, such as Sequential Organ Failure Assessment (SOFA) or similar. Categorical exclusions based solely on an individual's age, disability, or medical condition (if it does not impact short-term COVID-19 survival) constitute unjust discrimination and are immoral.
- Various protocols we have reviewed calculate a patient's priority score using (1) "likelihood of short-term survival" based on SOFA (or similar) score, and (2) "likelihood of long-term survival" based on the presence or absence of comorbid conditions. Likelihood of long-term survival and the assessment of comorbid conditions deserve attention for the following reasons:
    a. Little if any indication is offered for what "likelihood of long-term survival" means within the context of assigning priority scores to COVID-19 patients. How does a triage team objectively apply "likelihood" as a criterion? How long is "long-term," and do *more years* of long-term survival outweigh *fewer years* of long-term survival? Answering these questions becomes a utilitarian calculus, a values-laden judgment about a patient's quality of life in the longer term, well beyond the acute situation.
    b. Protocols state that the presence or absence of a comorbid condition "may influence" a patient's survival. Again, these offer little or no indication about what "may influence" means, particularly in a triage setting. In addition, no discussion examines whether "may influence" offers sufficient justification for including comorbidity as a criterion for determining priority score.
    c. The protocols offer examples of comorbidities that may influence survival, but they never provide an exhaustive list. (Some acknowledge this fact.) What objective criteria are being used to determine the comorbidities identified in the protocols versus those that are not?
    d. Specific comorbidities listed in the protocols include the qualifiers "moderate" and "moderately severe." What exactly do these terms mean? How does a triage team objectively apply them to determine a patient's priority score?
- Each protocol we have reviewed states that age is not an exclusionary factor for receiving critical care. However, in some protocols age actually becomes a factor through "tie breaker" determinations. Certain protocols state that in situations involving a priority score "tie" between two (or more) patients, age becomes the deciding factor for which of them receives critical care. The terminology varies in different protocols ("life-cycle principle," "saving the most life-years," "experience life-stages," "cycles of life," or "equal opportunity to pass through the stages of life"), but the operative principle is the same: decisions about who will, and will not, receive critical care are based on age.

Withdrawing Critical Care Interventions

- Various protocols state that physicians can withdraw critical care from patients who they believe have no chance at survival *regardless* of the patient's or the surrogate's wishes. While some circumstances might warrant a physician's order to cease critical care interventions, this cessation should only happen after appropriate communication with the patient or surrogate about the triage situation and the medical recommendation. This communication should include the burdens and clinical expectation of no recovery and offer the patient or surrogate the opportunity to voluntarily discontinue the intervention. After appropriate communication and opportunity for voluntary discontinuation, and in light of a triage situation in which others' lives are at stake, physicians should be able to override unreasonable patient or surrogate demands to continue intensive care support.

DNRs

- Various protocols allow physicians to unilaterally assign a code status of "do not resuscitate" (DNR) to critically ill COVID-19 patients. Such a unilateral decision could be problematic if the DNR order is implemented without any input from the patient or surrogate, or if such an order is implemented universally among patients with COVID-19 solely on the basis of their COVID-19 diagnosis. However, in a crisis situation that offers no opportunity to communicate with the patient and/or surrogate, physicians should be able to place DNR orders under a triage protocol when the clinical facts offer no reasonable expectation of recovery from resuscitation.