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Summary of Triage Principles and Applications for Catholic Health Care Organizations

April 15, 2020

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Triage and limited resource allocation protocols can be ethically appropriate when a genuine crisis situation arises, where the demand for resources (space, staff, equipment) surpasses availability, and when other reasonable efforts to increase supply fail to meet the need. They must be built on a proper, principled moral framework.

Foundational Moral Principles

1. **Human life, health, and dignity**—All persons should continue to be treated with dignity and respect; due care should be offered to all even when recovery is not feasible.
2. **Duty to care**—Health care professionals should not abandon their roles on the basis of elevated risks in a time of crisis, provided their continued service does not compromise a higher or more fundamental duty.
3. **Common good**—Unreasonable demands of individuals need not always be heeded, while the proper interest in promoting the common good must not compromise the dignity of individuals.
4. **Prudential certitude**—Limitations on time, staff, resources, and space have an objective impact on what is demanded of health care providers in crisis situations: the duty is not to absolute certitude of outcomes, but to the best clinical assessments (including prognoses and mortality expectations) under the constraints of the circumstances.
5. **Proportionality of care standards**—The measures and duration of any crisis standards of care, including triage protocols, should be limited in time and scope to what is strictly necessary for overcoming the crisis situation. They should not begin early or last beyond the needed time, and they should not be more restrictive than necessary to justly and charitably respond to the need.
6. **Therapeutic proportionality**—Treatments with burdens that outweigh benefits can be legitimately declined by patients; treatments that offer no reasonable hope of benefit can be legitimately withheld or withdrawn by a health care provider when failing to do so would gravely compromise the health or lives of others.
7. **Subsidiarity**—Decisions about care should be at the local level, between caregivers and patients, as much as possible in a crisis situation; however, some aspects may legitimately shift to higher levels such as triage committees if they cannot be charitably and justly handled at that local level.
8. **Responsible stewardship**—Health care providers must justly and prudently manage the health care resources available to them, first by increasing those resources and then by judiciously employing those resources to best serve the common good while respecting the dignity of each patient. This may mean that patients who would otherwise have access to certain resources and care levels in a non-crisis situation may be unable to access them under a triage protocol.
9. **Justice and objectivity**—There must be no unjust discrimination on the basis of age, disability, cognitive function, quality of life, stage of life, or other value-laden or utilitarian criteria reaching beyond short-term clinical prospects of recovery or mortality and certain limited, unbiased, nonclinical criteria when clinical situations are equivalent.

10. **Charity and solidarity**—Pastoral and spiritual care should be made available and prioritized, given that the highest good of the human person is spiritual and that death and suffering are times of enormous spiritual significance; some patients may wish to sacrifice their just access to treatment in order to help save others.

Process Principles

1. **Consistency**—Resource allocation and triage decisions should avoid arbitrariness and exceptions to the established guidelines.
2. **Accountability**—Authority for decisions and the role of informed consent should be clear.
3. **Transparency**—Standards should be effectively communicated.
4. **Regular review**—Protocols should be regularly reviewed; patient assessments should be frequently repeated to account for changes in clinical criteria.

Applications

1. **Triage criteria**
    a. *Clinical*—Triage priority levels can be established on the basis of (1) clinical determinations of short-term (immediate or near-immediate) mortality even with use of critical care resources (i.e., will not survive to discharge) and (2) clinical indicators of short-term readmission risk (i.e., likelihood of needing critical care again during the resource shortage).
        i. Triage priority levels should not be affected by considerations of long-term survival, "life-years," life stage considerations, or similar criteria based on considerations extending beyond the short-term crisis period.
            1. Major comorbidities may be factored into triage scores only when they impact immediate mortality risk and/or short-term readmission risk. These should not be factored into triage scores on the basis of long-term mortality risk (e.g., if moderate dementia is associated with likely mortality in less than one year, but it presents no elevated risk of immediate mortality or short-term readmission, it should *not* be a factor in triage priority level).
        ii. Different scoring systems may be appropriate for assessing short-term mortality; one common example is the Sequential Organ Failure Assessment (SOFA) score.
    b. *Nonclinical*—When clinical considerations among different patients are equivalent, priority may be given rarely on the basis of certain unbiased considerations.
        i. **Unbiased**, grounded in justice and charity—highest nonclinical priority
            1. Health care workers who have become ill in the line of duty
            2. Sole caretakers for minors or other dependents
            3. Pregnant women
        ii. **Unbiased**, not grounded in justice or charity—tie breakers or last resort
            1. First-come, first-served
            2. Randomization
        iii. **Biased**, unjust and discriminatory: age (e.g., prioritizing "youth"), disability, race
    c. *Exclusion criteria vs. scores*—While triage scores can be helpful for distinguishing among cases that may seem similar, triage priority does not always require calculation of a score.
        i. **Scores**—Scores are helpful for distinguishing among patients who might be "borderline" between priority levels or for any patient whose priority level is not readily ascertainable using basic exclusion criteria.
        ii. **Exclusion criteria**—Certain clinical criteria may capture the most significant contributors to triage priority scores without having to calculate a numerical triage score. Such clinically based "exclusion criteria" can be used when there is sufficient urgency, if they reliably predict short-term mortality.

2. **Triage committees and officers**—These are acceptable to promote objectivity, consistency, and transparency when scoring is needed and decisions of priority are needed; should not eliminate a proper physician–patient relationship accounting for the particulars of each patient's case.
    a. Physician–patient conversations and voluntary care plans should obviate the need to make triage decisions (by triage officers and committee) as much as feasible.
3. **Triage score appeals process**—Such a process should exist for physicians, patients, and families or surrogates to bring to light any concerns about scoring.
4. **Periodic reassessment of triage scores**—Every forty-eight hours or similar, patients should be reassessed; clinical scenarios can change rapidly.
5. **Allowance for trial critical care**—Wherever the resources are available at the time of the need, allow trial critical care to determine whether the clinical situation improves. Trial period does not require continuation—patients who worsen or do not improve can be transitioned to palliative or other appropriate noncritical care if a higher priority patient arrives.
6. **No patient abandoned**
    a. Appropriate care should be provided for all (e.g., palliative care or hospice). Ensure availability and quality of alternative forms of care for those who cannot receive critical care.
    b. Basic human care should be provided for all—including nutrition and hydration, even by medically assisted means—unless causing or expected to cause serious harm or complications, or unless not tolerated (not assimilated, i.e., not nourishing and hydrating).
7. **Reallocation of resources**—This process can be morally sound when withdrawing limited resources in accordance with clinically established triage priority levels. Informed consent for withdrawing treatments should be obtained wherever possible (see next item).
8. **Informed consent for withdrawing or withholding interventions**
    a. Informed consent is always preferred, with reasonable efforts to obtain fully informed consent that can avoid the need to enforce triage assessments without patient input.
        i. Informed consent for transitioning to palliative care, removing ventilators, placing DNRs, or similar actions should be sought first in clinical context with the care team (subsidiarity) before a triage team may need to implement any triage decisions.
    b. Informed consent is not always necessary, if the patient's triage score is in a range that does not qualify for the resources in question. Examples of when it may not be necessary:
        i. When it is unreasonable, because of time constraints and urgency, to obtain fully informed consent (e.g., unable to reach surrogate decision maker)
        ii. When patients or surrogates or families insist on unreasonable demands for disproportionate interventions, while the lives of others who would benefit from the resources are at immediate risk
    c. Communication must always be a priority, even when consent is not required or possible.
9. **DNR orders**
    a. Voluntary DNRs are always preferred and promoted in the clinical relationship context; they are not always necessary, as in item 8 (above), if unreasonable due to time constraints and due to objective clinical factors when other lives are at risk.
10. **Pastoral care and spiritual support**—Such support must be made available and made a priority. Allowances and means should be provided to promote such support, especially access to Catholic sacraments.

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