

# ETHICS & MEDICS

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A Commentary of The National Catholic Bioethics Center on Health Care and the Life Sciences

■ Also in this issue: “Sacraments and the Pandemic,” by Marie Hilliard  
and “Ethical Concerns with COVID-19 Triage Protocols,” by the NCBC ■

## TRIAGE IN THE PERSPECTIVE OF CATHOLIC BIOETHICS

The Ethicists of the NCBC



Over the past several months, the virus causing COVID-19 disease has been spreading silently throughout the world, infecting hundreds of thousands of people. COVID-19 already has killed over 130 thousand people worldwide as of April 15, 2020, and it threatens to hospitalize and kill countless more as well as to overwhelm systems of health care delivery. As the pandemic spreads in breadth and depth, people are beginning to call for programs of triage and rationing of health care. How should Catholic health care professionals and administrators address these issues?

Triage is an organized process of determining the priority of treating patients based on the severity of their condition. Closely linked to triage in times of crisis or during emergency events is rationing, the controlled allocation of medical equipment, services, or resources, including the time and attention of health care professionals. Health care triage outside war or mass casualty events from accidents, terrorism, or extreme weather has been unusual in the United States. Some guidance for triage in pandemics was developed following the SARS outbreak in 2002–2004 and the H1N1 crisis in 2009. But little research has been done to determine whether this triage guidance leads to optimal outcomes. Implementing strict triage and rationing plans in the context of patient care can raise a number of ethical questions. Patients and families may wonder if they will be abandoned or whether decisions will be based on sound criteria and implemented in a fair and consistent manner. Overburdened health care professionals may suffer moral distress in denying life-saving care to some patients while offering it to others, and they may struggle to make impartial decisions.

Triage and rationing are specific protocols within a larger set of planning initiatives for situations of extreme medical needs and limited resources called “crisis standards of care.” The National Catholic Bioethics Center (NCBC) has utilized materials from several recognized sources on crisis standards of care (listed at the end of this resource), but this resource is focused primarily on the issue of triage and rationing.

The NCBC holds that triage and rationing protocols can be necessary and helpful measures in a pandemic if they are built on

sound ethical principles. Catholic health care providers should support sound secular protocols for triage and rationing but also should strive to improve them by drawing on resources in the Catholic moral tradition. Below, the NCBC provides some suggested ethical principles, considerations, and questions to assist in this effort.

### Ethical Considerations on Triage and Rationing

#### *Substantive Principles and Considerations*

These substantive ethical goods should be addressed in the creation of standards for triage and rationing:

1. *Human Life, Health, and Dignity.* The ultimate standard and goal of triage and rationing should be to save human lives, and to serve human health and dignity, to the greatest extent possible consistent with the common good. In addition, it is important to serve the full range of human needs and to care for those who have been vulnerable or marginalized prior to the current pandemic. In particular, Catholic health care providers should advocate and care for disabled patients who already are oxygen or ventilator dependent.

#### Reflection Questions to Ask:

- Regarding objective standards for triage and rationing (see below), what steps are we taking to care for particularly vulnerable patients (e.g., the disabled) or marginalized (e.g., the poor) outside the context of this pandemic?
  - Apart from services and resources subject to triage and rationing, are we providing the full range of care to all patients, including personal support and palliative and spiritual care?
2. *Objectivity, Justice, and Proportionality.* Standards created for limiting or directing treatment (for example, in the allocation of ventilators and beds in the intensive care unit) should be based on objective measures that best serve human life, health, and dignity. They should be applied in a nonarbitrary, nondiscriminatory manner and only for as long as necessary. To the extent possible, they should be perceived as fair by all.

#### Reflection Questions to Ask:

- Are the triage and rationing protocols accurate, complete, and based on the best standards such as the Sequential Organ Failure Assessment (SOFA) Score?
- In establishing objective standards, have we eliminated grounds for bias or partiality as much as possible?
- Are triage and rationing protocols as specific and limited as possible in terms of the resources to be rationed and the duration of time in which the protocol is in effect?

3. *Duty to Care.* Health care professionals have an ethical duty to care for patients even in conditions of limited resources and risk. The community has an ethical duty to provide health care professionals with the resources they need, including resources essential for patient care, personal safety, and their own human needs.

Reflection Questions to Ask:

- Are the triage and rationing protocols accurate, complete, and based on the best standards such as the Sequential Organ Failure Assessment (SOFA) Score?
  - In establishing objective standards, have we eliminated grounds for bias or partiality as much as possible?
  - Are triage and rationing protocols as specific and limited as possible in terms of the resources to be rationed and the duration of time in which the protocol is in effect?
4. *Stewardship.* Resources for patient care become increasingly valuable in times of crisis and shortage. Health care providers should use resources in the most efficient, effective ways possible, consistent with respecting human life, health, and dignity.

Reflection Questions to Ask:

- Are we doing everything we can to identify and access additional essential resources and to prioritize essential activities rather than profit?
- In decisions to transfer resources from hospitals not currently experiencing demand (e.g., rural or small facilities) to hospitals facing a shortage, are we taking steps to ensure that the “donor hospitals” will have the resources they need when demand rises?

*Process Principles and Considerations.*

These principles of sound ethical process should be addressed in implementing standards for triage and rationing:

1. *Consistency.* Standards should be implemented on a consistent basis without granting exceptions or exemptions for reasons outside established substantive clinical and ethical principles. At the same time, reasonable efforts should be made to provide a channel for people to express their questions or concerns.
2. *Accountability.* The chain of authority to establish and implement protocols of triage and rationing should be clearly founded and communicated to all relevant parties, especially health care professionals, patients, and families.

Reflection Questions to Ask:

- Do triage and rationing decisions take into account, as much as reasonably possible, the need for professional-patient communication and informed consent, particularly in decisions to withdraw life-sustaining treatment?
3. *Transparency.* Standards for and implementation of triage and rationing should be publicly accessible and proactively explained. As soon as reasonably possible, clinical and organizational leaders should engage the community to explain current standards and to gather input for improving them.
  4. *Regular Review.* Ethical and clinical principles of triage should be reviewed on a regular basis and adjusted as necessary to save more lives, help more patients, reduce moral distress, and increase public trust and support.

*Additional Considerations and Resources for Catholic Health Care Providers*

1. *Need for Prayer and Support.* Health care providers in particular are facing scenarios of fatigue, danger to health and life, and moral distress. In addition to supporting the efforts of health care organizations and public authorities, Catholics should pray in particular for all those involved in direct clinical care during a pandemic, and they should seek additional ways to provide them with personal, social, and spiritual support.
2. *Need for Prudence.* Humans are unique in their psychological and spiritual powers, above all reason and free will. The optimal state of these powers—their ability to work well individually and in an integrated manner consistently—is called virtue. Long discussed in classical and Christian ethical analysis, prudence was most influentially defined by Aristotle as “right reason about things to be done.” Prudence perfects the human ability to use reason to make practical, ethical decisions. Prudential decision making requires discerning the reality of a variety of goods and deciding how best to protect or promote these in practical situations. Prudential decision making is superior to making decisions in an ad hoc manner, based on either emotional considerations or incomplete standards of ethical good such as utilitarianism and consequentialism. Making prudential decisions in triage situations is essential. Sound triage protocols are necessary but not sufficient to achieve ethical outcomes because there is more to making ethical decisions than the mere application of standards. Health care professionals, especially Catholics, must strive to recognize and serve the good of each human person while working within the parameters of the clinical and legal standards.
3. *Need for Charity.* Catholics believe that God revealed the true nature of love through his Son, Jesus Christ, and empowers us to exercise a deeper form of love in union with him. Charity is first and foremost a relationship of life and love between the Christian and God. But Catholics are called and empowered to share this transcendent love with others. In the context of health care, while affirming the legitimacy of triage standards and the requirements of clinical care, charity can empower Christian health care professionals to engage in distinctive efforts to serve others or to promote their dignity in ways that others might miss. Identifying the potential for such efforts will require prayer and discernment.

*Sources of Guidance on*

*Crisis Standards of Care and Triage*

John L. Hick et al., “Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2,” *NAM Perspectives* (March 5, 2020): 1–13, doi: 10.31478/202003b.

Institute of Medicine, Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations, *Crisis Standards of Care: A System Framework for Catastrophic Disaster Response* (Washington, DC: National Academies Press, 2012).

Kathy Kinlaw and Robert Levin, *Ethical Guidelines in Pandemic Influenza* (Atlanta: CDC, 2007).

Oak Ridge Institute for Science and Education, “Pandemic Influenza Triage Tools,” Centers for Disease Control and Prevention (CDC), accessed April 2, 2020, <https://www.cdc.gov/cpr/healthcare/pan-flu-app/desktop/d.index.html>.

## SACRAMENTS AND THE PANDEMIC

Marie Hilliard, RN



Catholics may become more aware of the need for the sacraments when they become unavailable. Access to the sacraments is a right of the faithful “who seek them at appropriate times, are properly disposed, and are not prohibited by law from receiving them.”<sup>1</sup> The local bishops, working with public health authorities, have been reviewing the issue of what constitutes “appropriate times” during the current pandemic, with emphasis on protecting the individual parishioner, the congregation, the general public, and the ministers of the sacraments.

Certain facts and considerations related to the sacraments must be reviewed by the local diocesan bishop when discerning how to ensure that the sacraments are available during these extraordinary circumstances. Perhaps the most urgent matter is access to the sacraments of Penance and Anointing of the Sick as well as to the Apostolic blessing. (The Apostolic blessing is a plenary indulgence remitting all temporal punishment for sin. It is given to those facing death, usually after the Anointing of the Sick.) In light of these challenges the Apostolic Penitentiary recently issued provisions for special indulgences and addressed collective, or general, absolution during the COVID-19 pandemic.

### Penance and Reconciliation

There is no more applicable canon than 978 §1: “In hearing confessions the priest is to remember that he is equally a judge and a physician and has been established by God as a minister of divine justice and mercy, so that he has regard for the divine honor and the salvation of souls.” Canon law dictates not just who can forgive sins, but also the place for it to occur: “The proper place to hear sacramental confessions is a church or oratory. The conference of bishops is to establish norms regarding the confessional; it is to take care, however, that there are always confessionals with a fixed grate between the penitent and the confessor in an open place so that the faithful who wish to can use them freely. Confessions are not to be heard outside a confessional without a just cause” (can. 964; see also can. 967 §§1–3).

The pandemic clearly would equate to a just cause. Social distancing and even quarantine are necessary to protect not only the priest but also the penitents. A number of priests have developed creative ways to respect confidentiality, the sacrament, and the health of all involved. Some priests have engaged in outdoor “parking lot” confessions in which the penitent sits in the car (of course, only one person per car), and the priest sits a prescribed distance from the car window, with a confessional screen placed so the identity of the penitent is protected. Traffic control agents

are placed to ensure proper distance between cars. Some diocesan bishops have prohibited this, and of course the permission of one’s local diocesan bishop should be sought before pursuing this strategy. The local health department also should be contacted, for example, with questions about the danger of droplet contagion due to the manner in which confessions are heard. The Church’s Apostolic Penitentiary has identified prudential measures for celebrating Penance, including “the celebration in a ventilated place outside the confessional, the adoption of a suitable distance, the use of protective masks, without prejudice to absolute attention to the safeguarding of the sacramental seal and the necessary discretion.”<sup>2</sup>

But what about vulnerable individuals who are unable to travel: those in hospitals, hospices, or nursing homes without a Catholic chaplain? Creative alternatives are proposed. In cases of grave necessity, the diocesan bishop may determine that it is lawful to impart general absolution, as described by the Apostolic Penitentiary, “for example, at the entrance to hospital wards, where the infected faithful in danger of death are hospitalised, using as far as possible and with the appropriate precautions the means of amplifying the voice so that absolution may be heard.” One priest indicated that his local bishop has approved his use of a bull horn outside of a nursing home to impart general absolution. Perhaps with the permission of the diocesan bishop, this could even be followed by the Apostolic blessing.

While individual confession is the ordinary way of celebrating the sacrament of Penance (can. 960), general absolution can be imparted under certain circumstance. The first scenario is when there is an imminent danger of death, and there is insufficient time for the priest or priests to hear the confessions of the individual penitents. The second scenario is when there is grave necessity—that is, when there are not enough confessors available to hear the confessions of the number of individuals, and thus persons will be deprived of the sacrament for a long while (The United States Conference of Catholic Bishops has determined this to be one month.) The diocesan bishop determines if the conditions of a grave necessity are present, consistent with criteria of the USCCB (can. 961 §§1–2). The Apostolic Penitentiary believes that, especially in the places most affected by the pandemic and until the phenomenon recedes, the cases of serious need will occur. If a sudden need exists for collective absolution, the priest is obliged to warn the diocesan bishop. If the priest cannot, he should inform the bishop as soon as possible.

For general absolution to be valid, the penitent must intend to confess serious sins within a suitable period of time (can. 962 §1). Canon 963 cites the obligation to approach individual confession “as soon as possible; given the opportunity, before receiving another general absolution, unless a just cause intervenes.” The Apostolic Penitentiary uses the term “in due time.” Insofar as it can be done, the penitent is to be instructed on this obligation and exhorted to make an act of contrition before absolution if there is time (can. 962 §§1–2).

There is increasing evidence of priests’ being denied access to health care facilities as they attempt to impart the sacraments to the sick and dying. There also could be situations in which a priest is called to hear Confession and provide Anointing of the Sick for a seriously ill patient for whom direct and private access is prohibited. In this situation, the priest is physically present to the patient but remotely so—such as standing outside a patient’s room—where

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## THE NATIONAL CATHOLIC BIOETHICS CENTER

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— Enrollment Opens in June 2020 —

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The NCBC offers educational programs designed for health care workers, clergy, chaplains, educators, and others who are interested in learning more about the Catholic moral tradition in health care. Visit our website for more information about these popular programs.

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— up to 10 graduate credits available —

This one-year distance-learning program was developed to offer students a systematic formation in the application of the *Ethical and Religious Directives for Catholic Health Care Services*, so that dioceses, hospitals, and ethics committees will have advisors better qualified to apply the Catholic moral tradition to challenging and contemporary issues in health care.

**Graduate credit is available either through Holy Apostles College and Seminary, an accredited distance-learning program, or through the University of Mary, an accredited university in Bismarck, North Dakota. Credits earned in the NCBC program may be applied toward a master of theology degree with a concentration in Catholic bioethics at Holy Apostles or toward a master of science degree in bioethics from the University of Mary. Visit [HolyApostles.edu/ncbc-2](http://HolyApostles.edu/ncbc-2) or [online.umary.edu/academics/masters-doctoral-programs/bioethics.php](http://online.umary.edu/academics/masters-doctoral-programs/bioethics.php).**



### Fall Two-Day Seminars

The NCBC two-day seminar is designed to provide health care professionals, pro-life workers, clergy, teachers, and others with a clear understanding of the *Ethical and Religious Directives for Catholic Health Care Services* and their application to clinical cases. Seminars are taught by NCBC staff and other noted professionals. **Continuing education credits are available for doctors, nurses, and chaplains.**

August 7–8, 2020  
The University of Mary  
Bismarck, ND

September 11–12, 2020  
Rockville Centre, NY

October 30–31, 2020  
Archdiocesan Pastoral Center  
Philadelphia, PA

For additional information on these programs, visit the NCBC website at [www.ncbcenter.org/programs](http://www.ncbcenter.org/programs) or email Julie Kelley at [jkelly@ncbcenter.org](mailto:jkelly@ncbcenter.org).

confidentiality will be breached. As stated above, canon law dictates that “individual and integral confession and absolution constitute the only ordinary means by which a member of the faithful conscious of grave sin is reconciled with God and the Church. *Only physical or moral impossibility excuses from confession of this type; in such a case reconciliation can be obtained by other means*” (can. 960, emphasis added). The roles of the diocesan bishop and the USCCB in determining situations in which those impossibilities exist is less clear. In this scenario, the requirements for absolution include an expression of sorrow—if the person is capable of such expression—and the intention to confess serious sins within a suitable period of time, as referenced for general absolution. This individual absolution is not unlike when Anointing of the Sick imparts the forgiveness of sin when the individual, especially an unconscious patient, is unable to make an individual and integral confession.

When it is impossible to receive sacramental absolution, one should not forget that it is possible to obtain forgiveness of sin, even mortal sins, by expressing perfect contrition coming from one’s love of God. It must be accompanied by the firm resolution to have recourse as soon as possible to sacramental confession.<sup>3</sup>

### Anointing of the Sick

Anointing of the Sick not only is a sacrament of healing, but it carries with it the forgiveness of sins. That is why it can be administered only by a priest (can. 1003 §1). The sacrament should be administered, and even repeated consistent with canonical requirements, if requested by a person or his or her surrogate decision maker for an appropriate reason (e.g., danger due to sickness or old age). This applies for all people who have reached the age of reason, even if they are no longer able to exercise it. The canons speak to the administration of the sacrament in cases when the person “implicitly requested it” when he or she was competent. However, the presumption that the person, if capable, would have asked for it—especially with grave illness or danger of death—could suffice (cann. 1004 §§1–2, 1005, 1006). Before the penitent receives the sacrament, he or she must confess all serious sins that have not been confessed. If unable to do so, the penitent is to confess them as soon as possible, given the opportunity.

All priests entrusted with the care of souls have an obligation to administer this sacrament at the appropriate time (cann. 1001, 1003 §2). The sacrament is conferred by anointing with oil and pronouncing the words prescribed in the liturgical books (can. 998). “In a case of necessity, however, a single anointing on the forehead or even on some other part of the body is sufficient, while the entire formula is said. The minister is to perform the anointings with his own hand, unless a grave reason warrants the use of an instrument” (can. 1000 §§1–2). Contagion presents a significant problem because of the proximity and physical contact between the priest and the person being anointed. This is not a sacrament administered at a distance. Also the container of the oil of the sick cannot be brought into proximity of a patient nor reused between patients. The logistical hazards of contagion are very significant, and they affect not only the minister of the sacrament, but potentially everyone with whom he later has contact, and with all the individuals those persons later have contact.

Health care units can provide protective gear for the priest, who can use an individual pre-oiled glove, a long cotton-tipped swab, or a similar item for anointing. Because of the significant hazards,

it may be prudent to rely on general absolution or individual absolution at a distance without hearing individual sins enumerated, according to canon 960 and the prescripts of the diocesan bishop. Once the sacrament is administered and death is anticipated, the Apostolic blessing can be administered without close proximity to the person.

### Notes

1. Canon Law Society of America, *Code of Canon Law: Latin-English Edition* (Washington, DC: CLSA, 1999), cann. 213, 843 §1. Subsequent references given in text.
2. Apostolic Penitentiary, Note on the Sacrament of Reconciliation in the Current Pandemic (March 20, 2020).
3. *Catechism of the Catholic Church*, 2nd ed. (Vatican City: Libreria Editrice Vaticana, 2012), n. 1452.

## ETHICAL CONCERNS WITH COVID-19 TRIAGE PROTOCOLS

The Ethicists of the NCBC



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:
  1. 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.
  2. 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.

3. 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?
  4. 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

- Some 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 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 diagnosis. However, in a crisis situation that offers no opportunity to communicate with the patient 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.

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We hope that you remain safe in these extraordinarily difficult times.

