CANADIAN CATHOLIC BIOETHICS INSTITUTE
INSTITUT CANADIEN CATHOLIQUE DE BIOÉTHIQUE

BIOETHICS MATTERS
ENJEUX BIOÉTHIQUES

March 2020 Volume 18, Number 4

Preamble

During this period of abundant information and social distancing for the common good, CCBI will email and post messages that are meant for timely reflection and consideration. We hope they may answer your questions, alleviate worry and be of some practical use.

Advice to be prepared for serious illnesses or even for death can be helpful at all times, and perhaps especially right now. As Catholics, there are spiritual and practical matters to organize, and most involve making arrangements and having discussions with other people, usually members of our family.

In that spirit, here is our first message to you.

Decision-Making in Light of COVID-19

Moira McQueen, LLB, MDiv, PhD

Now that matters are developing and more cases of COVID-19 are appearing in Canada, the reality is dawning that there is the possibility that many of us could fall seriously ill at the same time, and that resources will not be adequate for everyone's needs. We have to hope and pray that the 'curve will be flattened' by our collective efforts, and that the Government will be successful in its push to obtain equipment, including respirators and ventilators.

The hope is that time can be bought to have some effect on the spreading of the virus, time that will be valuable to buy and make more equipment.

Some nurses are reporting that they do not have access to proper masks, since those are being kept for staff who are working with people being tested or who have tested positively for the virus. If it is difficult to provide the required amount of masks and protective clothing, how much more difficult it must be to provide sufficient numbers of respirators and ventilators. It is practically impossible to be adequately prepared for a pandemic.

Given the shortage of respirators and ventilators for intensive care, we will soon be facing the question of who should receive treatment when supplies are scarce. Catholic teaching provides some general guidelines for this type of question, but naturally cannot provide 100% clear answers, depending on situations that occur.

OBJECTIVE MEDICAL ASSESSMENT

We are told that older people are more likely to succumb to COVID-19, based on medical statistics. But not *all* old people will fall ill if they contract the virus, although, statistically, it seems those with underlying medical conditions are more likely to develop serious health problems. A major question in light of this fact is whether a person's age should

be a factor in deciding who receives intensive care treatment? I would give a qualified 'yes' to that question, but in situations where age is only *one* of the factors in an objective medical assessment.

The main criterion of any assessment should be whether or not the treatment has a good, statistical chance of success. That will depend on the individual circumstances of the patient, including his or her medical history, overall health and the presence or absence of any complicating factors. So, a younger person's overall health could be poor because of lack of care or because of existing health issues, and therefore could be considered less likely to benefit from treatment. Age alone is not a criterion, and should not be used as such.

Ageist views already exist in society, presenting a danger for older people in many fields, whether in employment or in health matters. A recent article in the British *Daily Telegraph* said there could be an interesting benefit from the coronavirus: "Not to put too fine a point on it, from an entirely disinterested economic perspective, the COVID-19 might even prove mildly beneficial in the long term by disproportionately culling elderly dependents." There is no fine point there at all: the opinion is extremely blunt and objectionable, as is using the word 'cull,' as if the elderly are a breed that needs to be cut back to protect the rest of the herd.

Economics do factor in moral decisions, as, for example, in our present situation we do lack equipment and may have to make decisions that otherwise would be unnecessary. The suggestion, however, that some good might come of older people dying from lack of treatment is morally reprehensible, and is patently ageist and discriminatory.

GUIDELINES, ALLOCATION OF HEALTH RESOURCES, OBJECTIVE DECISION-MAKING

There is no doubt that the situation in Italy has spiralled out of control, and accounts and photographs of piled-up coffins awaiting burial testify to the high death rate, and there is also no doubt that most of the dead are elderly.

The Italian College of Anesthesia, Analgesia, Resuscitation and Intensive Care has issued guidelines that doctors and nurses should follow, and, among other things, the guidelines compare the moral choices doctors might have to make to types of wartime triage. It may be necessary to follow "the most widely shared criteria regarding distributive justice and the appropriate allocation of limited health resources." This sounds reasonable and the document recommends that patients with the highest chance of therapeutic success should be treated. Doctors are advised to take a patient's age and general state of health into account in treatment decisions, knowing that patients with existing health issues are more likely to die.

So far, so good. The guidelines, however, go on to say: "What might be a relatively short treatment course in healthier people could be longer and more resource-consuming in the case of older or more fragile patients," and this is followed by a startling statement: "It may become necessary to establish an age limit for access to intensive care."

These two statements do not follow, morally or logically. Assessing a person's benefit from treatment in his or her particular situation is an objective, medical opinion. Deciding on treatment because of age alone is, as explained above, not a moral criterion, *per se.* This reflects the same approach as that given in the *Daily Telegraph* article, that non-treatment of people, just because they are old, would result in some sort of benefit to society. This type of immoral, utilitarian stance must be strongly resisted. It represents a ruthless disregard for the elderly, seeing them as a means to an end instead of as dignified 'ends' in themselves, as Catholic teaching reminds us, with the same rights and claims on life as everyone else in society.

If such a guideline were to be followed, and the elderly were seen as expendable, there could be further risk to those whose quality of life is viewed negatively in society. If someone with a disability, physical or mental, were to contract COVID-19 and were in need of intensive care, would doctors start to think in terms of dismissing them in favour of patients with similar needs but without those disabilities? We should never allow decision-making which relies on subjective assumptions about disabilities or quality of life at any stage. We must insist that decisions be made on an objective basis, meaning that any person with COVID-19 should be treated if the prognosis for recovery is favourable. Age, disability and 'quality of life' judgments should not enter the equation.

Society has had similar discussions about transplants. It is unfortunate that these, too, count as scarce resources, but it means that decisions have to be made about recipients. Again, it is the objective situation of the person needing a transplant that is assessed, on the basis of possible benefit. For example, what happens when there is only one kidney available, but two candidates? The first is a 40 year old, long-term smoker with obesity issues, and the second is a 72 year old who still runs competitively. The physical condition of each person would be assessed here, not only their age and their projected 'life years.' Making the decision on age alone is unacceptable, since the older person here could easily be assessed as being more likely to benefit, given his lifestyle. Condition, not their age, should be key to decision-making.

CATHOLIC TEACHING

Since it upholds life and the equal dignity of every person, Catholic teaching also takes seriously the notion of the common good and the notion of solidarity.

While we can be sure that we are making a good moral choice in opting for treatment if our situation shows it is likely to be successful, we should remember that it is possible that some older people (and even some younger) will take the view that, if there are competing claims for resources, they might decide to forgo their opportunity in favour of someone younger or in favour of any other person. That would be a praiseworthy work of charity, perhaps even heroic, but we must also remember that our teaching is clear that no one is morally obligated to act in this manner. It must be the person's free choice, made out of an abundance of concern for other people, and, of course, no one should ever be pressured to make such a choice.

The practice of the virtue of solidarity with our fellow human beings is another area where some people might choose to forgo treatment, regardless of their age or other factors, but purely from a sense of charity. These responses do happen and should not be discounted. People, however, should not be persuaded in this direction, since a free moral decision is needed.

Finally, we depend on our health care workers, and we know that many of them are putting their lives at risk for the rest of us. We owe them an enormous debt of gratitude. We also pray they will maintain objective standards as the guiding light in their approach to this pandemic. The Catholic Church supports this approach, which in any event has been the longstanding approach of the ethical goals of medicine in treating disease. ■

Moira McQueen, LLB, MDiv, PhD, *is the Director of the Canadian Catholic Bioethics Institute. She teaches moral theology in the Faculty of Theology, University of St. Michael's College.*