Tragic Choices, Revisited: COVID-19 and the Hidden Ethics of Rationing

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Early in the COVID-19 pandemic in the United States, concern that there could be a shortage of ventilators raised the possibility of rationing care. Denying patients life-saving care captures our moral imagination, prompting the demand for a defensible framework of ethical principles for determining who will live and who will die. Behind the moral dilemma posed by the shortage of a particular medical good lies a broad moral geography encompassing important and often unarticulated societal values, as well as assumptions about the nature and purpose of health care and the consequences of long-standing choices about health care as a social good. This article explores what COVID-19 has exposed concerning values and choices around health care in the United States. Employing the lens of Catholic Social Thought, it argues for an approach to rationing that is grounded in respect for human dignity, committed to distributing social goods in light of the common good, and self-conscious about the construction of vulnerability to illness and death.

Keywords: Catholic Social Thought, COVID-19, health care, rationing

I. INTRODUCTION

Early in the COVID-19 pandemic, many experts predicted widespread shortages in the availability of ventilators for acutely ill patients. In April of 2020, the World Health Organization reported that one in six COVID-19 patients experienced significant difficulty breathing and could require ventilator support (Gelles and Petras, 2020; Iyengar et al., 2020, 499–501). Rising cases around the world prompted many institutions and health officials to develop or revise protocols for rationing ventilators, some of which proved to be controversial. Aggressive mitigation strategies in hard-hit areas of the
United States, for example, in the city of New York, flattened the curve of the initial wave sufficiently, and fears of turning away dying patients—at least those in need of ventilator therapy—proved unwarranted. Still, the anticipated shortage of ventilators was a defining pandemic moment for some Americans who had seldom before considered seriously whether the treatment they needed would be available.

The prospect of denying patients life-saving care captures our moral imagination, prompting the demand for a defensible framework of ethical principles for determining who will live and who will die. But, behind the moral dilemma—and its resolution—posed by the shortage of a particular medical good lies a broad moral geography encompassing important and often unarticulated societal values, as well as assumptions about the nature and purpose of health care and the consequences of long-standing choices about health care as a social good. Drawing from the work of early voices in the ethics of rationing, such as Paul Ramsey, Guido Calabresi, and Phillip Bobbit, I explore what COVID-19 has exposed concerning values and choices around health care in the United States. Ultimately, through the lens of Catholic Social Thought, I argue that the way we choose to distribute medical resources also reveals our fundamental beliefs about the scope of our obligations to the ill and dying and the content of our commitments to those who are most vulnerable.

II. THE ETHICS OF BEDSIDE RATIONING

On June 26, 2020, the United States Department of Health and Human Services Office for Civil Rights (OCR) announced the resolution of a federal complaint against the state of Tennessee (United States Department of Health and Human Services, 2020). The complaint had been filed by a national coalition of disability advocates, one of a dozen such complaints challenging states’ protocols for rationing intensive care (such as ventilators) under the COVID-19 pandemic (Disability Rights Education and Defense Fund, 2020). Drawing on earlier settlements involving triage plans issued by Alabama and Pennsylvania, OCR required Tennessee to revise its standard of care plan to remove provisions that disqualified patients with conditions such as advanced neuromuscular disease, metastatic cancer, traumatic brain injury, and dementia. As in earlier decisions, OCR prohibited the exclusion of patients from critical care solely on the basis of age or disability and required careful specification of measures such as “life expectancy” in judging candidates for ventilator support. As with Pennsylvania’s revised guidelines for rationing scarce medical resources, OCR required the explicit recognition that “all rationing decisions must be based on individualized patient assessments by clinicians using the best available objective medical evidence,” and that “no one can be denied care based on stereotypes, assessments of quality of life
or judgments about a person’s ‘worth’ based on the presence or absence of disabilities or other factors (United States Department of Health and Human Services, 2020).”

The COVID-19 pandemic is not the first time the prospect of rationing health care has captured national attention, nor the first time “social worth” or “quality of life” considerations have entered into public policy governing the distribution of scarce medical resources. Since the development of organ transplantation, a chronic shortage has required a national policy for the equitable allocation of available organs. Currently, the United Network for Organ Sharing (UNOS) manages the national transplant waiting list. Under evolving UNOS policy, candidates for transplant are prioritized based on a multifactor score, including “medical urgency, outcomes, candidate biology and efficiency of organ transport” (United Network for Organ Sharing, 2021). This approach has developed in response to criticism that earlier policies, for example, privileging tissue match or proximity to the donor hospital, resulted in unequal access to organs, particularly for African American patients (United Network for Organ Sharing, 2020).

Now, even before the advent of organ transplantation, one of the most widely discussed exercises in healthcare rationing in the literature of bioethics occurred in the early 1960s in the context of a research program led by a pioneer in kidney dialysis. Often called the “Seattle God Committee,” a lay board at Swedish Hospital in Seattle was charged with determining who among medically qualified patients should receive the then-scarce and unproven treatment (Alexander, 1962, 102–10, 115–28). At the direction of the hospital, the committee rejected outright children and patients over 45 years of age. In a deliberative process famously described as “the bourgeoisie sparing the bourgeoisie,” the committee then weighed factors such as marital status, number of dependents, income and employment history, religious participation, emotional stability, in-state residency, and educational background. At the end of the day, the tendency of the committee to make selection decisions based on comparative and culturally laden assessments of social worth caused one set of critics to fear that “the Pacific Northwest is no place for a Henry David Thoreau with bad kidneys” (Sanders and Dukeminier, Jr., 1968, 378–9).

In his book The Patient as Person, the influential Protestant ethicist Paul Ramsey described rationing as forcing “the most incorrigible social and ethical question” concerning health care and social policy: in our investments in health care and our decisions about access, how are we ordering our social and economic priorities? (Ramsey, 2002, 268). He criticized the role of social worth criteria in the Swedish Hospital dialysis protocol, arguing that comparative judgments of worth between individual patients or estimations of value to others violated the covenant of care and faithfulness that forms the heart of the physician–patient relationship. Ramsey was concerned not only with the ever-present danger of bias in judgments of social worth but
also, in denying life-saving care, assuming a power reserved for God alone: “The more nearly total is the estimate made of an individual, the nearer we would be to presuming ‘to act as gods on the Day of Judgment’” (2002, 259). “In allocating sparse medical resources among equally needy persons,” he argued, “an extension of God’s indiscriminate care into human affairs requires random selection and forbids god-like judgments that one man is worth more than another” (Ramsey, 2002, 259).

In Tragic Choices, Guido Calabresi and Philip Bobbitt (1978) also criticized the Swedish Hospital dialysis protocol for its introduction of explicit and implicit social worth criteria in allocation decisions. Here the dialysis case does more than lay bare the biases that crept into the lay board’s deliberations. It also serves as a window into the “tragic choices” societies confront in distributing burdens and benefits. Rationing decisions such as those faced by the Swedish Hospital or those faced in the COVID-19 ICU are “tragic” in several senses. They are tragic in that they arise from conditions of scarcity that result in suffering, loss, or death borne by some individuals and not others. In Ramsey’s terms, they force the necessity of God-like choices. Further, there are no morally perfect or pure frameworks for resolving the dilemma posed by the need to choose between patients, all of whom could benefit from a treatment, and no approach that is free from the psychological effects of such a decision. First-come-first-served is a recognized principle for distributing goods fairly, but it proves problematic in the context of health care. The first patient to arrive may be a poor recipient and the last may have been disadvantaged by distance from a specialized medical facility. A lottery satisfies conditions for equitable distribution, but it relies on a simple egalitarianism many find inappropriate or distasteful when life-saving medical care is involved. No moral framework allows complete escape from the inevitable trade-offs of goods and competition of values. Finally, and perhaps most important, rationing medical care exposes the conflict between

on the one hand, those values by which society determined the beneficiaries of the distributions [of scarce goods], and (with nature) the perimeters of scarcity, and on the other hand, those humanistic moral values which prize life and well-being. (Calabresi and Bobbit, 1978, 18)

Calabresi and Bobbitt call the decisions by which a society determines its global priorities for social investments, including how much of a scarce good—within natural limits—will be produced, “first-order” determinations (1978, 20). “Second-order” determinations concern who will get what goods are available (Calabresi and Bobbit, 1978, 20). First-order and second-order determinations are often made independently and according to different values. Tragic choices expose both divisions between orders and the necessary interplay between them. As they note “[w]e often move in what appear to be erratic jumps, valuing life at a rather low level in some circumstances at the first-order and at a high level in other situations” (Calabresi and Bobbit,
1978, 21). (Just think, for example, of the differences in expenditures for primary care versus end-stage rescue care in the United States.) Further, the construction of scarcity, the fact that in most cases it results from decisions made by a society to invest in certain goods and services over others, is obscured, making the second-order decisions look “necessary, unavoidable, rather than chosen” (Calabresi and Bobbit, 1978, 21):

As befits a land of plenty and a society convinced that an orgastic future awaits if only the proper plans are made, the principle object of the tragic allocation in America has been to avoid owning up to having made a first-order determination. From this as much as from our democratic ideology follows the consistent reliance on limiting second-order criteria to those that seem unchosen, and correcting second-order results before they reveal discriminations which offend a qualified egalitarianism, that is, that persons ought to be treated as equals if they are similar according to generalized efficiency criteria, but also if not treating them as equals displays a disfavored group in some prominent way. (Calabresi and Bobbit, 1978, 186)

From this vantage point, the problem with the Seattle dialysis protocol was two-fold: the second-order principles of allocation evoked outrage by openly valuing the lives of some individuals and groups over others, thereby ratifying existing social patterns of discrimination and offending the generally acceptable notions of equality in the context of medicine. However, the deeper fault exposed in the tragic choice between qualified dialysis patients was the avoidance of “owning up” to first-order decisions concerning medical priorities, including investments in some therapies for kidney disease over others, in relation to social priorities at large. Investments in medical technologies such as dialysis compete with investments in other forms of care, as well as with other social goods, for example, eradicating poverty or providing a high-quality education to all students. At the same time, investments in social goods and investments in health are interrelated. There are well-known correlations between poverty and illness, and between illness and factors such as gender and race. Carving out access to dialysis as the forced, unavoidable moral problem to be solved truncated the moral geography, ignoring the choices that create persistent inequalities both in vulnerability to disease and in outcomes.

Ramsey also called out the failure to own up to first-order determinations, characterizing it as a form of hubris evident in societies like the United States (2002, 268). Predicated on the belief that the right combination of economic resources and ingenuity will allow us to avoid tragic choices, we choose by not choosing or by allowing the most spectacular therapy or the loudest voices to decide our priorities (Ramsey, 2002, 268). (Ultimately, Ramsey thought that the driving force behind our investments in technologies, particularly in medicine, was the unacknowledged belief that we can cheat death itself.) In the end, Ramsey was right about choosing by not choosing. Controversy over the Swedish Hospital protocol ultimately led to a national
policy decision to cover the costs of dialysis for all those who would benefit. As Calabresi and Bobbit note, this decision involved a redetermination of the first-order decision, made possible by the development of widely available and cost-effective dialysis. However, it masked the sort of “failure to own up” with which Calabresi, Bobbit, and Ramsey were wrestling: “A system which offers ‘kidneys for everyone’ distinguishes those dying from renal failure—and prices their lives exceedingly high—from those dying from other diseases, who for similar expenditures could also have been saved” (Calabresi and Bobbit, 1978, 189). With the benefit of time, we also know that it avoided identifying and confronting the inequalities in access to health care and other social and economic inequalities that account for differential rates of kidney disease by race and ethnicity. Currently, Black Americans are four times more likely and Latinx Americans are one and one-third times more likely to suffer kidney failure than White Americans. Moreover, according to Jerry McCauley, MD of UNOS, while great strides have been made in ensuring equity once a patient gets on the organ transplant list, the path preceding referral is rife with inequities. Race and socioeconomic status, in particular, impact what kind of treatment will be received, the stage at which a patient will be referred for transplant, and how compliance with medical regimes will be assessed (United Network for Organ Sharing, 2020).

III. COVID-19’S TRAGIC CHOICES

It is not surprising that initial protocols for rationing care under COVID-19 in Tennessee, Alabama, and Pennsylvania were swiftly and harshly criticized. Disqualifying patients with conditions such as traumatic brain injury or dementia reflects long-standing tendencies in the United States to judge diminishments or losses of cognition as indicators of poor quality of life. Disability advocates rightly called out the thinly disguised stereotypes and comparative judgments about worth underlying the stated exclusions. In Calabresi and Bobbit’s terms, the protocols failed to correct “second-order results before they offend[ed] a qualified egalitarianism” (1978, 186). Two other widely cited approaches to rationing ventilators during COVID-19 largely avoid this fault, drawing either on prevailing understandings of “objective medical evidence” or on utilitarian principles such as maximizing benefits and rewarding social utility. These approaches are useful in understanding how values such as fairness and equity are expressed when faced with a shortage of a particular medical good, as well as in recognizing the limitations of any ethical framework for distributing life-saving care under conditions of scarcity. They are also helpful in mapping the moral geography around COVID-19, especially in beginning to see, to own up to, those first-order choices that construct both vulnerability to disease and outcomes.

Ventilator Allocation Guidelines published by the New York State Task Force on Life and the Law (NYSTLL) in 2015 (in anticipation of an influenza
pandemic) base allocation decisions on the “best objective medical evidence.” The Guidelines’ overall aim is to save the most lives by prioritizing those patients who are most likely to survive the acute medical episode with ventilator therapy (New York State Task Force on Life and the Law, 2015). The triage team uses SOFA (Sequential Organ Failure Assessment) scores, which measure the “number and severity of organ dysfunction in six organ systems (respiratory, coagulatory, liver, cardiovascular, renal and neurologic)” to identify those patients who are unlikely to survive even with intensive care (Jones, Stephen, and Jeffrey, 2009, 1650). The Guidelines specifically exclude considerations such as “quality-adjusted life years,” that is, how many more years this patient might live and at what level of health, and the anticipated life expectancy from other unrelated medical conditions (e.g., advanced neuromuscular disease). Such considerations have been widely criticized as proxies for societal evaluations of age and aging or projections of a “normal” person’s view of the quality of her life should she become disabled in some way (Scully, 2020).

The NYSTLL Guidelines are frequently praised for grounding triage decisions in facts over judgments. However, the Guidelines name some exclusions, that is, a set of comorbid conditions that automatically disqualify a patient from ventilator therapy. These include some identified conditions that would result in “immediate or near-immediate mortality even with aggressive treatment” (e.g., cardiac arrest or severe burns) but also “any other conditions resulting in immediate or near-immediate mortality even with aggressive therapy” (New York State Task Force on Life and the Law, 2015, 236). Even narrowly construed, as in this case, categorical exclusions highlight the ethical limitations of those protocols based on objective judgments, as the exclusions are selectively applied only to some broad classes of patients in need of therapy and do not require the clinical evaluation of individual patients (White and Lo, 2020, E1, E2). Moreover, the Guidelines provide for the removal of patients who are not showing sufficient progress on ventilator support (judged by SOFA scores at 48- and 120-hour intervals) if the treatment is needed for another patient. As Eliza Yadav (2020) has argued, removing ventilator support from a patient who is recovering at a slower rate than desired necessarily involves clinical judgments made in the absence of certainty that another patient will benefit more from ventilator therapy. This is especially true under conditions where the clinical course of illness is not yet well understood, as was the case with COVID-19 especially in the early days of the pandemic. “The heart of the issue,” she observes, “is that these Guidelines are undeniably subjective: while the SOFA is impartial, it is performed by human beings who have flaws” (Yadav, 2020). Put another way, the SOFA is performed by individuals with histories, values, and beliefs, who are subject to social, cultural, and economic influences, all of which come to bear, particularly in comparative judgments.

The NYSTLL Guidelines also illustrate the insufficiency of the “best objective medical evidence” under conditions of scarcity. While explicitly rejecting
criteria such as age or disability in triage decisions, the Guidelines allow age as a tiebreaker. That is, if two medically qualified patients need the only available ventilator, one an adult and one a child, the ventilator should go to the child. According to the Guidelines, this is not a judgment of “social worthiness” but merely a concession to fairness: the child has not been able to experience the full life to which he or she is objectively entitled and therefore should be given priority in access to care. In this case, “the best objective medical evidence” can determine the broad conditions for including or excluding patients from life-sustaining care but cannot by itself resolve the central question posed by the tragic choice: who should be saved when not all can be saved? On what grounds? Using age as a tiebreaker in this way imports moral considerations external to the appraisal of comparative medical outcomes, that is, convictions about a child’s right to an open future.

In their May 2020 comment in the *New England Journal of Medicine*, Ezekiel Emanuel and his colleagues argue that “fair allocation requires a multivalue ethical framework that can be adapted, depending on the resource and context in question” (Emanuel et al., 2020, 2049–55). Their approach is largely utilitarian, although egalitarian considerations come into play at the point of bedside rationing. The framework rests on four fundamental values that emerge in discussions and proposals concerning healthcare rationing under conditions of scarcity: maximizing the benefits produced by scarce resources, treating people equally, promoting and rewarding instrumental value, and giving priority to the worse off. They note that “each of the four values can be operationalized in various ways”: maximization of benefits can be achieved by saving the most lives or saving the most life-years; equality in treatment disallows discrimination based on a particular characteristic or set of characteristics, however “equality” as such can be realized by observing various forms of random selection, such as first-come, first-served or a lottery among similarly situated patients; “instrumental value” could be manifest, depending on background cultural and societal values, in the form of gratitude for past contributions or in giving priority to those who can save the most lives under present conditions; and “priority to the worst off” could translate into privileging the sickest patients or those patients with the most to lose without treatment from a life-cycle standpoint, that is, younger patients (Emanuel et al., 2020, 2051). They offer six recommendations for rationing under COVID-19: (1) when resources are limited, priority should aim both at “saving the most lives and at maximizing improvements in individuals’ post-treatment length of life” (Emanuel et al., 2020, 2052); (2) frontline healthcare workers should have priority in the allocation of COVID-critical goods, such as testing, personal protective equipment (PPE), intensive care unit (ICU) beds, ventilator support, and therapeutics; (3) for patients with similar prognoses, scarce medical treatment should be allocated according to random selection; (4) under the maxim to save the most lives, allocation guidelines should take account of the context and the type of intervention
at issue; (5) those who willingly participate in vaccine or treatment research should receive some priority for COVID-19 interventions, at least as a tie-breaker among patients with the same medical status; and (6) if the pandemic results in absolute scarcity, allocation of healthcare goods and services should not privilege COVID-19.

The multivalue foundation allows for instrumental choices alongside plainly egalitarian ones. In giving frontline workers priority in the allocation of COVID-critical goods, such as testing, PPE, ICU beds, ventilator support, and therapeutics, Emanuel and his colleagues defend a certain form of social utility: healthcare workers are necessary for the control of the pandemic and the care of patients; protecting and restoring their health thus benefits the community as whole. They are careful to distinguish between “instrumental value” and “social worth.” While the latter is an inappropriate criterion for allocating care, the former recognizes the particular service role and expertise of healthcare workers.

In the same way, under the maxim to save the most lives, the meaning of “just allocation” shifts according to the type of healthcare good in question. When allocating vaccines or other preventative measures, it is appropriate to prioritize older patients over younger, and both after frontline healthcare workers. (This ordering would change if research proved that vaccinating younger people resulted in slowing community spread.) The priority is reversed in the case of life-saving care such as ventilator support. They argue that it is ethical to give priority to younger patients if doing so results in greater benefit as measured by more lives saved or more years of life. Moreover, it is ethical to remove a patient from a ventilator, even without that patient’s consent, if it results in greater overall benefit. Those who willingly participate in vaccine or treatment research should receive some priority for COVID-19 interventions, at least as a tiebreaker among patients with the same medical status. In this case, fairness dictates rewarding individuals for voluntary and potentially risky service to the community.

However, under the principle that similarly situated patients should be treated equally when life is at stake, scarce medical treatment should be allocated according to random selection, in this case, by lottery. Although rationing according to first-come, first-served would satisfy the conditions for random selection, Emanuel et al. reject it partly on ethical and partly on pragmatic grounds. First-come, first-served allocation could privilege unfairly those who are closest to healthcare facilities or those who became critically ill early in the course of the pandemic. In addition, in the context of access to therapies or vaccines, first-come, first-served distribution could lead to an unsafe rush on distribution centers.

It is not entirely clear that the center of this multivalue ethical framework for allocation holds. Allocating according to instrumental value, even if defensible in a crisis, is not necessarily compatible with equal regard for all persons, especially equally vulnerable persons. “Saving the most lives”
involves inescapably tragic choices against some lives. The resort to age as a
tiebreaker cannot be freed completely from the risk of being discriminatory
in a society that favors youth and vitality and allows for the marginalization
of the frail elderly.\textsuperscript{3}

The ethical framework offered by Emanuel and his colleagues is not per-
fected, nor are the Guidelines published by the New York Task Force on Life
and the Law. Still, they are good faith efforts to articulate second-order prin-
ciples of allocation that are rational, fair, and as free as possible from ar-
bitrary or prejudicial judgments. However, as we are increasingly aware,
COVID-19’s tragic choices lie as much or more in the unacknowledged moral
geography beyond and around the ICU, in the network of social, political,
and economic choices we have made, particularly the long-standing choices
we have made about the nature of health care.

Much has been made of the way the COVID-19 pandemic has exposed
national and global fault lines along security and vulnerability, wealth and
poverty, and insularity and interconnection. Indeed, Pope Francis called
the pandemic “the moment to see the poor.” In an editorial in \textit{Science},
Joachim von Braun, president of the Pontifical Academy of Sciences, Stefano
Zamagni, president of the Pontifical Academy of Social Sciences, and Marcelo
Sánchez Sorondo, Bishop Chancellor of the Pontifical Academies of Sciences
and Social Sciences, emphasized the precarious existence of many people
around the world, where crowded living conditions make social distancing
a luxury, lack of access to clean water undermines the protection of fre-
quent handwashing, and the loss of income leads to widespread hunger
(Von Braun, Zamagni, and Sánchez Sorondo, 2020). The “moment to see the
poor” is a call to confront and reorder our global priorities and challenge
global distribution and access patterns, especially in science and technology,
that create and maintain a digital divide between wealthy and poor nations
and result in serious gaps in science capacity in underresourced areas.

The need to own up to the role of social, economic, and political choices
in creating differential vulnerability to COVID-19 and its impacts pertains not
only to global and geopolitical relations but also to the course of the pandemic
in the United States. COVID-19 has overwhelmingly affected older Americans
and communities of color. While the higher likelihood of comorbidities in
people over the age of 65 and among African Americans accounts for some
of the higher mortality in these groups, their vulnerability to infection, illness,
and death from COVID-19 is the product of a complex set of social, political,
and economic choices made and reaffirmed for decades. An article in the
\textit{New England Journal of Medicine} described nursing homes in the United
States in March of 2020 as “tinderboxes, ready to go up with just a spark”
and attributed the then unfolding tragedy in nursing homes to “decades of
neglect of long-term care policy” (Werner, Hoffman, and Coe, 2020, 903). By
May 2020, COVID-19 had claimed the lives of 28,000 nursing home residents,
accounting for 35% of the nation’s deaths; since the onset of the pandemic,
more than 153,000 residents and employees of 7,700 US nursing homes had contracted COVID-19 (Werner, Hoffman, and Coe, 2020, 904).

The authors argue that long-term care in the United States is a low priority in federal welfare policies; both in-home and institutional care for those who cannot care for themselves is underfunded by Medicaid and insufficiently monitored. In the height of the COVID-19 crisis in urban areas such as New York City, nursing homes faced critical shortages in PPE, respiratory support and equipment, medications, and staff. Low wages for nursing home staff meant many held more than one job, spreading the virus from one facility to another. Underlying all the gaps in long-term care policies is the first-order choice: a failure to “take the care of aging Americans seriously and fund it accordingly” (Werner, Hoffman, and Coe, 2020, 904).

COVID-19 has also differentially affected communities of color, although it is often claimed that viruses do not discriminate, that “we are all in the same boat.” As compared to White Americans, as of October of 2020, Black Americans were 2.6 times more likely to contract COVID-19, 4.7 times more likely to require hospitalization, and 2.1 times more likely to die; American Indian or Alaskan Native Americans were 2.8% more likely to contract COVID-19, 5.3 times more likely to require hospitalization, and 1.4 times more likely to die; Hispanic or Latinx Americans were 2.8 times more likely to contract COVID-19, 4.6 times more likely to require hospitalization, and 1.1 times more likely to die.4

In testimony before the US House of Representatives Committee on Education and Labor, labor economist Valerie Wilson explained the disparate racial impact from COVID-19 as rooted in deeper disparities in health status, access to health care, wealth, employment, wages, housing, income, and poverty (Wilson, 2020). In the COVID-19 economy, there are three main groups: those who have lost their jobs; those who are essential workers and face health insecurity as a result; and those who can continue working safely from home. As Wilson notes, Black, Latinx, Native Americans, and low-income workers are most likely to be in the first two groups. Moreover, access to high-quality health care, including preventative care for comorbid conditions such as hypertension and diabetes, differs significantly by geography and ability to pay. In other words, while we as Americans may all have been floating in the same sea with respect to the infectious nature of the coronavirus, we were hardly in the same boat.

As we saw earlier in the context of interventions for kidney disease, prior choices help shape the conditions of scarcity. How we prioritize end-stage rescue care over preventative care, whether to resource the hospital or the community clinic, how we decide which of the promising scientific discoveries merit investment and, on the most fundamental level, whether to treat health care as a right or a commodity are exercises in ordering our social and economic priorities. These exercises occur in concert with choices we make concerning access to other social goods such as employment,
education, and housing. Although it is important and necessary to articulate the ethical principles according to which scarce medical treatment will be allocated, it is not enough to be fair only at the bedside, the door to the ICU, or the transplant list. As COVID-19 shows, rationing begins with the choices that define who ends up there, when, and why.

IV. RATIONING HEALTH CARE AND CATHOLIC SOCIAL THOUGHT

In 1991, the Catholic Health Association (CHA) published a framework for rationing health care. The context for With Justice for All? The Ethics of Health Care Rationing was not a pandemic or a predicted shortage of ventilators, but rather the advent of managed care and the effort to identify a basic minimum standard of care for coverage under the national health plan then under discussion (see, e.g., McDonough, 2007, 226–7). The CHA drew its framework from the Ethical and Religious Directives for Catholic Health Care Services (ERDs) issued periodically by the United States Catholic bishops (United States Conference of Catholic Bishops, 2018). The ERDs address both the broad vision guiding health care as a ministry of the Catholic Church and the principles governing specific policies and practices for Catholic health-care institutions.

The ERDs expand on four core values: respect for human dignity; the preferential option for the poor; concern for the common good; and the stewardship of resources (United States Conference of Catholic Bishops, 2018, 8). Health care in the Catholic tradition has long been seen as a powerful extension of the healing ministry of Jesus, whose recorded miracles in the Gospels often related to physical or emotional healing. Indeed, Jesus’s healing touch is one of the most common and most profound signs in the Gospels that human history has become salvation history, that Jesus has come to redeem all of creation and to break the bonds of sickness and suffering.

However, the ERDs presume not only that suffering people should be cared for, but that all human beings have a right to health care by virtue of being human. To acknowledge the fundamental and universal equality and dignity of all persons is to recognize both their equal potential for human flourishing and their shared vulnerability before the threat of illness, disability, and death. Access to health care is important in a just society for the same reason that access to a range of political and economic goods is important. They are conditions, or in some cases avenues, for social participation, self-determination, and the pursuit of opportunity.

The biblical mandate to care for the poor and the most vulnerable is often stated as a “preferential option for the poor.” This second core value entails both particular attention to addressing the healthcare needs of the least-well-off or the most marginalized within a community and also the obligation to assess current social, political, and economic arrangements from the perspective of the margins.
The ERDs value Catholic health care as a contribution to the common good. As described by the bishops, the “common good is realized when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals” (United States Conference of Catholic Bishops, 1986, #80, 19). The most basic form this contribution takes is in the provision of and advocacy for health care without regard to the ability to pay. The US bishops have long called for universal and affordable health care as an urgent national priority and a moral imperative. It is presupposed that health care is a social or public good rather than a private good, in part because science and medicine are maintained by social investments. But, it is also public in the sense of being necessary for realizing the opportunities and obligations of the common good, for example, governance, work and leisure, family life, and intellectual development.

Finally, the ERDs call on Catholic healthcare ministries to practice responsible stewardship of resources. Responsible stewardship is understood both as promoting equitable access to health care and also enhancing public health. Thus, resources should be used to guarantee healthcare systems that are responsive to the needs of communities and not only to the interests of individuals. Under conditions of scarcity, distributive justice should be guided in particular by the needs of the least-well-off: the uninsured or underinsured, the poor, children and the unborn, the elderly, undocumented immigrants, and those who are incarcerated (Daly, 2020).

Although there are areas of overlap with the approach by Emanuel and his colleagues, the CHA framework for healthcare rationing gives rise to a significantly different ordering of values. While the former gives priority to “saving the most lives and maximizing improvements in post treatment length of life,” the latter advances a qualified egalitarianism, assuming that persons should be treated equally as far as possible, and resolving conflicts to the benefit of the most vulnerable in the community. Not surprisingly, the CHA framework rejects rationing care on the basis of overt or covert appraisals of social worth. A commitment to care for persons as befits their human dignity, particularly the most vulnerable, opposes triage by disability, cognition, or age, as well as protocols that decide between patients on the basis of considerations of anticipated quality and length of life following treatment. At the same time, the commitment to care (or a right to health care) does not mean that every treatment available must be given in every case. In the Catholic tradition, biological life is a basic good, but it is not and never could be an absolute good. Under the doctrine of “ordinary/extraordinary treatment,” introduced into bioethics by Catholic theologians, there is no obligation either to offer or to receive extraordinary treatment, that is, treatment for which the burdens exceed the benefits either from the patient’s, the family’s, or the community’s standpoint (United States Conference of Catholic Bishops, 2018, #57, 21). This doctrine supports giving priority for scarce
medical treatment to patients who are most likely to benefit from care and would allow for removal from a ventilator if the burdens of care exceed the benefits. In both instances, the decision turns on an assessment of the benefit of the treatment for a particular patient. In all cases, the duty to care requires continued support for those who do not receive priority in the allocation of scarce medical treatment. Even when there are no more life-preserving treatments available, those charged with a patient’s care are obliged never to abandon her: palliative and pastoral care should always be provided (United States Conference of Catholic Bishops, 2018, #61, 22).5

Although respect for human dignity as understood in the Catholic tradition inclines toward random selection as the principle for allocating scarce treatment, some Catholic theologians have invoked values such as “the common good” and “responsible stewardship” to defend choices to provide care to some patients over others. Daniel Daly has argued that a commitment to the common good justifies giving priority to medical professionals in the distribution of scarce medical treatment under COVID-19 (2020). The service of medical professionals, especially in a public health crisis, preserves the conditions under which the rights of individuals to receive care will be protected. Daly and others have also defended the use of age as a tiebreaker. Although it is discriminatory to use age as a broad exclusion category, under the “life-cycle principle” if two patients display a similar medical status, priority in allocating treatment may go to the younger patient. Unlike Emanuel et al., who used age as a measure of fairness, Daly invokes a commitment to responsible stewardship: the younger patient enjoys the benefit of the intervention for a longer period, thus making the best use of a social good.6

The most significant contribution of the CHA position on rationing is not in offering a novel approach to triage that is morally unambiguous or free from the element of tragedy, but rather in making explicit the relationship between first-order and second-order determinations. Decisions concerning the allocation of particular medical goods are set within broader reflection on the demands of distributive justice and the significance of access to particular goods, such as health care, in achieving the common good. With Justice for All? argues that the need for rationing must be demonstrable and the principles for determining social priorities transparent. This calls for an ongoing conversation about social investments in scientific, technological, and medical advances, and their relation to other social investments such as housing and education. To borrow from Ramsey, this entails choosing rather than allowing decisions to be made by the most powerful lobby or those with the most resources to invest.

This also requires a collective reckoning with the rationing of goods and services outside of pandemic conditions that determine people’s positions within them. As we saw earlier, differential vulnerability within the COVID-19 pandemic resulted not only from susceptibility to the virus but from prior choices made concerning access to basic health care and affordable housing,
financing for elder care, availability of personal protective equipment, and the conditions of labor. Honesty about indirect rationing does not obviate the need to make tragic choices in a public health crisis. But, a commitment to the common good ensures that social priorities reflect respect for human dignity, guaranteeing all members a basic level of accessible health care and equitable access to those other goods and services supporting human flourishing. This incorporates considerations of fairness and respect for human dignity into the challenge of setting social, economic, and political priorities, rather than relegating them to the bedside.

Finally, With Justice for All? argues that under conditions of implicit or explicit rationing, ethical priority should be given to the unmet needs of the poor and uninsured (in McDonough, 2007, 227). This means, in part, that special attention should be paid to those who are least able to advocate for themselves. But, in the most basic sense, this obligation to “see the poor” is a challenge not only to view current patterns of distribution and access from the perspective of the least-well-off, but to acknowledge the differential ways in which human life is valued in a society. The tragic choice posed by the scarcity of ventilators brings the equal value of each threatened life into view, while the failure to address the unequal worlds of health care in the United States obscures the low value placed on some lives when even basic health care is a commodity.

V. CONCLUSION

Under triage conditions, it is tempting to see the ethical challenge of rationing care, the tragic choice, as arising only in the presentation of two very ill patients both needing a scarce treatment. It is also tempting to think that developing a set of principles for rationing that can be defended as “fair” and “rational” answers the ethical questions. Taking a lesson from COVID-19, I have attempted to draw out the broader moral geography of the pandemic in the United States, in particular, the construction of vulnerability according to race, ethnicity, and socioeconomic status. I have tried to show the necessary relationship between our first-order choices concerning access to goods such as health care and the conditions of fairness at the bedside, as well as to challenge the notion that rationing care is only done in the United States during public health crises. Ultimately, placing a framework for rationing care within commitments to honoring human dignity in the setting of social and economic priorities, ordering decisions about access to the common good, and viewing social arrangements from the vantage point of the poor and most vulnerable lends the same moral gravity to both kinds of tragic choices: those we are forced to make when not everyone can be saved, and the everyday, sometimes unquestioned, decisions that determine the contours of scarcity and expose the true value of one human life versus another. While the pandemic has made everyone
acutely aware of the ways in which we are vulnerable by virtue of our co-existence, we will ultimately overcome the threat, and others to come, only by committing to action on behalf of those who are on the wrong side of the distribution networks.

NOTES

1. See Disability Rights Pennsylvania (2020).
2. See, for example, National Kidney Foundation Information on Race, Ethnicity and Kidney Disease at kidney.org/atoz/content/minorities-KD.
3. See Savulescu, Cameron, and Wilkinson (2020). Savulescu et al. (2020) argue that although “criteria based on length of life and quality of life do not necessarily constitute direct discrimination,” they may constitute indirect discrimination. Age and state of health contribute to assessments of the likelihood of survival. Such considerations may be required but should be used proportionally, that is, not in cases where the benefit to be realized is marginal.
4. See https://www.cdc.gov/coronavirus/2019-ncov/downloads/covid-data/hospitalization-death-by-race-ethnicity.pdf.
5. See also J. Paris (n.d.)
6. Although Daly does not elaborate, it could be argued that, while sometimes necessary, such choices nonetheless risk indirect discrimination, and therefore require proportionate reason. That is, the more marginal the benefit to be realized (40% greater chance of survival versus 30%), the less defensible the use of a life-cycle principle.

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