Ethical Principles for Resource Allocation in the event of an overwhelming surge of COVID-19 Patients

30 April 2020

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Preamble

Calvary was established by the Sisters of the Little Company of Mary in 1885 at a time when many were people experiencing poverty and disadvantage and were unable to access care elsewhere. As the Little Company of Mary Constitutions state:

> *In the spirit of Mary on Calvary, our vocation impels us to enter into the sufferings of others, to bring about equality and dignity for all, and to collaborate with others to create a world of justice, love and peace (Lk 4:18; VC82) In this way we make visible the healing presence of Jesus (C 1999. 1.05).*

Our services are committed to compassionate care, available to all, which has a focus on Jesus' ministry of healing, restoration and accompaniment in the light of a Hippocratic understanding of the role of medicine and healthcare. This does not change because of challenges we face in responding to COVID-19.

In fact, the public health challenge posed by COVID-19 is a time to uphold these commitments and continue with our Mission, holding together our concern for the dignity of each individual person and the requirements of the common good.

We have a responsibility at this time to ensure that our ethic of care is active and available to those who need it.

Our Mission guides our response to the challenge of COVID-19, in particular when it comes to committing to the care of those who may not be able to access treatment in other contexts. We reject any approach which discriminates unjustly against the elderly, the weak, those living with disabilities, those who are homeless, or other vulnerable groups. We retain a commitment to the dignity of all people, which leads to a special concern for those otherwise excluded.

When needs conflict and resources are limited

We may encounter circumstances in which the needs of patients (or patient groups) conflict, and not everyone's needs can be met simultaneously in the way that they would be in normal circumstances. It is anticipated that this will be particularly challenging in the context of Intensive Care Units.

The starting point for decision-making in such circumstances is medicine's long-standing commitment to treat those patients whose need is most urgent.

Catholic healthcare has always been committed to avoiding the imposition of treatment where there is no hope of benefit or where there is a disproportionate burden. In this regard it is important to note that, on occasion, the

burdens of treatment may include excessive demands on family, carers or healthcare resources.[1]

In Catholic healthcare, our concern is both for the individual person *and* the common good. This means that we avoid unjust discrimination based on age, disability, socioeconomic status, social worth, etc.

In light of the above commitments to therapeutic treatment, respect for the inherent dignity of each person and ensuring distributive justice, the principles set out in this document are formulated to help to guide decision-making. They should be adequately and integrally considered when making decisions.

Communication and Support

Demonstrating our concern for the intrinsic dignity of the person means that we endeavour, wherever possible, to ensure that people understand, participate in and accept the decisions being made, especially where this entails withholding treatment.

In accordance with the guidance provided in this document, Calvary will **support** the decision-making of responsible clinicians and their teams which is informed by the principles set out in this document.

> *"I cannot but feel I have had a call from God to devote myself to help save souls in their last hour. I have been drawn so strongly to pray for the dying."*
>
> Venerable Mary Potter

[1] *Code of Ethical Standards,* Part 2, no. 1.14

Ethical Principles for Resource Allocation in the event of an overwhelming surge of COVID-19 Patients[2]

1. All patients (or their substitute decision makers) will be consulted regarding their goals of care, and asked whether they wish to forgo specific medical treatment such as intensive care, CPR or intubation. Informed refusal of these interventions is respected and clearly documented.
2. Do not resuscitate (DNR) orders are written with patient or family involvement as per normal hospital procedures. Cardiopulmonary resuscitation (CPR) may be withheld from patients for whom it would be therapeutically futile, as per normal hospital procedures.
3. All alternatives are pursued before clinicians consider the allocation of ventilators or ICU care. These include therapies that are equivalent or nearly equivalent, sharing of equipment, transfer, or (with consent) therapeutic innovation with a reasonable prospect of success.
4. Allocation of resources is based on patient need, prognosis and the prospect of success for therapy (i.e., the chances that the patient will recover).
5. Decisions are based on clinical assessment of the patient's prognosis and existing co-morbidities and current health status; aided where possible by validated clinical tools.
6. Resource allocation is based on whether the treatment is therapeutic. It is not based on whether the patient is worth treating. Resource allocation is not based on factors such as social 'worth'. It is not based on the principle of maximising total life years or total quality-adjusted life years.
7. Resource allocation judgments are made by a team of at least 2 people, one of whom should be an intensivist.
8. Artificial ventilation is withdrawn, in accordance with normal clinical practice,[3]
    a. when based on medical judgment that (to a reasonable degree of certainty) the patient will not survive to hospital discharge; OR
    b. after a discussion with the patient or their substitute decision-maker from which it is agreed that the burdens of treatment outweigh the benefits[4].
9. Patients who are not expected to survive continue to receive supportive care relevant to their condition, including palliative and pastoral care.

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[2] These principles have been developed in collaboration with Dr Bernadette Tobin, MA (Melb) MEd (Melb) PhD (Cantab), Director, Plunkett Centre for Ethics, Reader in Philosophy, Australian Catholic University.
[3] The normal clinical practice applies. Trial a treatment until, in the judgment of the senior clinician it is either therapeutically ineffective or overly-burdensome. Calvary will support decision making made in accordance with relevant Calvary guidelines and those of the relevant jurisdiction or Department of Health.
[4] "The burdens of treatment to be properly taken into account may include pain, discomfort, loss of lucidity, breathlessness, extreme agitation, alienation, repugnance and cost to the patient. In some cases, the burdens of treatment may also include excessive demands on family, carers or healthcare resources…." (1.14 *Code of Ethical Standards*)

Appendix

Application of ethical principles of resource allocation in the context of a pandemic

If allocation of resources becomes necessary, it is based on patient need, prognosis and the prospect of success for therapy (i.e., the chances that the patient will recover).

Medical needs are thus addressed in order of importance and preference given to patients in greater need (i.e., patients who will likely suffer damage to life or health if left without the treatment concerned).

In specific circumstances, applying this principle may involve consideration of one or more of the following:

(a) which patient has the more urgent need,

(b) which patient is more likely to benefit therapeutically from the available treatment,

(c) which patient is likely to gain the greater therapeutic benefit from the treatment,

(d) which patient is likely to suffer the lesser burden from the treatment,

(e) which patient is likely to suffer the greater harm without the treatment,

(f) which patient is less at risk of various ill-effects from the treatment,

(g) which patient is likely to gain the same therapeutic benefit from less of the treatment,

(h) which patient is likely to need the treatment for a shorter time or less frequently, or

(i) which patient has fewer or no alternative avenues of satisfying the need.

These considerations are *illustrations* of how clinicians might use the principle of allocation on the basis of patient need. They are intended to help clinicians decide which patients they are in a position to treat. [5]

These considerations are extensions of normal Hippocratic medicine and are consistent with the common humanitarian duty of care. They accord with a Christian commitment of service to and advocacy for people whose social condition puts them at the margins of society.

They should be read in conjunction not only with relevant commonwealth, state and territory legislation but also in conjunction with guidelines, policies and standards promulgated by government and other statutory bodies.

Revised 30 April 2020

[5] If a choice has to be made between two patients with equal capacity to benefit, then it may be reasonable (other things being equal) to give priority to the person who is likely to gain the longer therapeutic benefit from the treatment (i.e., children) or to the person who has responsibilities to provide care for other members of the community (i.e., parents/guardians, carers).