



The Coronavirus Pandemic and the Ethics of Triage

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March 25, 2020

As the COVID-19 pandemic continues in Italy, many hospitals are [overwhelmed](#) with patients, necessitating difficult [triage](#) decisions that can seem like choosing who lives and who dies. In the United States, already some hospitals and caregivers are [overburdened](#), with expectations that things will soon become even more difficult. Hospitals and health authorities are releasing guidelines on the [rationing](#) of ventilators, with those guidelines already under criticism by [disability groups](#) and others. And the stress on our health systems is really just beginning—things will likely worsen, perhaps dramatically, in the next days.

Doctors, nurses, and administrators will need to make difficult decisions, possibly with tragic consequences for individual patients. Likewise, some patients and their families may wonder if they should forgo or end treatment, allowing another the use of a scarce ventilator, for example.

How ought we think ethically about triage and rationing during a pandemic? How do we decide which patient is given a ventilator and which goes without? Is it permissible to refuse a ventilator so that another may live, even if it means we die? Some basic principles follow, although it must be remembered that such general principles provide guidance without supplanting the needed prudential judgments of qualified and conscientiously informed authorities in concrete situations.

1. All voluntary human action is governed by moral law. A pandemic or existential threat does not negate our moral obligations. We may never knowingly and intentionally do wrong, even for good results, even in a crisis situation. In addition to general moral norms, professional codes of ethics continue to apply.
2. The duty to care persists. Members of the health care profession assume an obligation to provide care and to be available during an emergency, even at some risk to their own health and life.
3. Providing care under conditions of triage or resource scarcity involves care for patients *and* the system of care itself. There is a duty to provide for current patients while stewarding resources for future patients. Additionally, while providers must bear some risk, the duty to steward resources

includes protecting personnel and the infrastructure itself. Protecting infrastructure may entail protecting personnel with specialized knowledge or skill.

4. For current patients, the best criterion for determining prioritization is *greatest need*. Other options, such as *lottery* or *first-come* are neither reasonable nor just. Of course, even in times of crisis, normal requirements of justice apply, and factors such as race, sex, income, or creed are not to be used to determine priority of care.
5. Neither, it must be insisted, are *age* or *disability* reasons to prioritize or restrict care. Age is irrelevant, and unjust, as an independent reason to withhold or provide care. That one patient has had “a long life” while another is young is an unjust reason to ignore the priority of need for the older patient. Similarly, perceived “low quality of life” for a disabled person, no matter how significant the disability, and no matter the type of disability, is a morally unacceptable factor in determining priority of care. In the same respect, care must not be given on a priority basis to those considered more “useful” to society or of a higher economic or social class, such as a politician, movie star or scientist.
6. When age or disability is accompanied by other factors which make treatment unlikely to succeed, or the degree of probability for recovery is disproportionate to that of other patients, it is only the likely failure which is relevant in prioritization, not the age or disability. Prioritization reasonably and justly distinguishes those who will likely survive without care, those who will likely die even with care, and those who will likely improve with care, and upon that judgment provide distinct care, if available (palliative care, for instance, rather than receiving a ventilator when needed for another).
7. The absence or shortage of medicine, resources, or treatment may mean that care is unavailable and cannot be provided to a patient. This is not equivalent to withholding care, which is always impermissible. Probability for recovery must, by necessity, be considered among those needing treatment according to the limits of care and the resources available.
8. As treatment commences, the improvement or decline of a patient is an acceptable and reasonable standard by which to reassign scarce resources. A patient who earlier was deemed to be likely to improve with care, but who is now declining and unlikely to improve, may be reprioritized and given available palliative treatment. In such situations, transparency is required, with patients or their proxy informed of the decision *and* informed that appropriate care is not being withheld.
9. With respect to end of life, it is morally impermissible to knowingly and intentionally cause death or to cooperate with the actions of another toward the same end. This is true even if the patient consents or requests such actions. Euthanasia or assisted suicide are illicit. Similarly, *available* normal, basic care, such as food or fluids may not be withheld, although the *absence* of or inability to provide normal basic care is not equivalent to withholding care.
10. If death is imminent or likely, a care giver may refuse to provide, or even cease, treatment that would serve only to maintain a precarious and burdensome prolongation of life. A care giver may likewise transfer those resources to another who is likely to improve—so long as available normal basic care is not withdrawn.

11. It is not required by justice, although it is morally permissible as a supererogatory act of charity, to decline a scarce resource—like a ventilator—for oneself or a proxy so that another may benefit from the resource. One may not, however, decline available normal basic care. To do so would constitute a willful infliction upon oneself of injury or even death and cannot be considered altruistic.
12. Even when performing an act of charity that goes beyond the demands of justice, such as giving up a ventilator for another, one may not intend one's own death. One's death may be foreknown and accepted as a result of the action, but this must be an unintended consequence not chosen in itself. It is, thus, morally impermissible to cooperate in euthanasia or assisted suicide, even for the good or survival of another.
13. This principle, often known as double-effect, is true also for providers of care. One can foreknow and accept acts which would be immoral to directly intend, without thereby choosing or intending, those consequences so long as the act is not directly chosen.
14. Moral demands remain human and humane. Actions which may be objectively wrong in themselves may entail very little or no subjective culpability if the agent acted in ignorance, or without full consent, or in confusion or crisis when it would be unreasonable to expect the agent to have full knowledge or ability. That is, morality is not unkind or unfeeling to those who act in moments of grave difficulty, even though the demands of morality remain in full effect.

Finally, care givers have a responsibility to continuously seek out, evaluate, and absorb information that undergirds their treatment decisions and options. In the case of a medical event where both a disease and potential preventative or curative measures are moving swiftly, the obligation of care givers to review, as means allow, options to confirm, refine, or alter a course of treatment is continuous and compelling. While the principles cited above provide stable pathways, they cannot replace the informed and responsible decisions of care givers in the concrete situations and cases. In the end, a determination of "likely to improve" or "unlikely to improve" cannot be made in the abstract, and the prudential judgments of medical professionals of competence and sound conscience must be relied upon. While moral principles such as these obviously say little about prudential medical decisions, they can provide a solid footing in forming a sound conscience, an educated conscience.

They are offered in that spirit, and with our generosity and good will to men and women laboring for the sake of us all, to them we offer our profound gratitude.

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The Charlotte Lozier Institute is the education and research arm of Susan B. Anthony List.