



The Ethics Network of the Catholic Health Alliance of Canada has developed this framework document, one in a series of ethics resources to support each sponsor organization's response to COVID-19. While it reflects a consensus of opinion of relevant principles and moral approaches to address issues arising during the pandemic, the framework is meant to be adapted to each sponsored organization's unique context and circumstances. For more information, please contact Dr. Hazel Markwell, Theology, Ethics and Policy Advisor at hazel.markwell@chac.ca

Canadian Healthcare Triage in the Context of the COVID-19 Pandemic

MARCH 29, 2021

Introduction

The COVID-19 pandemic has placed a tremendous strain on Canada's already-overburdened healthcare systems. Ministry and public health officials across the country have repeatedly warned that if the spread of the SARS-CoV-2 virus is not adequately controlled, local health systems may be overwhelmed by patients requiring acute care and critical care. If a health system were overwhelmed, its agents would have to decide which patients to prioritize for access to scarce medical resources such as nursing care and ventilatory support. To prepare for this possibility, some provinces are drafting so-called "triage protocols," or "emergency standards of care" (henceforth "triage protocols"). These documents aim to set standards and processes to guide prioritization decisions in the event of an overwhelming surge of patients who need acute care and critical care. Triage would be considered a last-resort option, when all other methods of addressing an overwhelming surge were exhausted.

Prioritization is a standard part of healthcare in Canada. For example, patients are routinely prioritized in emergency departments, for surgeries, for admission to long-term care homes, and for access to many other services. However, the decisions contemplated by pandemic triage protocols depart from standard prioritization practices in important ways. Prioritization during normal times focuses on *when* and *in what order* patients will receive access to medical resources. In most normal circumstances, patients with a good chance of benefiting from a publicly funded medical treatment are not denied that treatment outright, though their access might be delayed.¹ By contrast, pandemic triage protocols would deny patients access to life-sustaining treatments from which they are likely to benefit. For example, a triage protocol may dictate that a patient who requires ventilatory support in order to survive

¹ There are some exceptions to this rule. For example, patients in need of organ transplants may be denied that service outright due to scarcity of relevant resources.

will not receive that support if there is another patient who is more likely to benefit from it. Even more significantly, some draft protocols have contemplated the non-consensual withdrawal of life-sustaining treatment from a patient in order to reallocate the resource to another patient more likely to benefit from it.

For Catholic healthcare organizations, the prospect of being forced to implement triage protocols raises many difficult moral questions. The aim of this document is to support Catholic health sponsors in identifying some of these questions. We will highlight questions falling into six categories: (1) the clinical aim of a triage protocol; (2) the decision-making processes set up by a triage protocol; (3) deviations from standard legal and ethical practices supporting informed decision-making; (4) responsibility, authority, and accountability in decision-making; (5) challenges of working within a system-wide environment; and (6) moral distress and crises of conscience.²

1 – The clinical aim of a triage protocol

In situations of scarce resources, when demand overwhelmingly exceeds supply such as in the case of a pandemic, normal prioritization strategies that aim to treat all patients in a timely manner and according to their individual needs become more difficult to sustain. In these instances, the care needs of individual patients may be understood within the context of the common good. Triage protocols should respond to this need by establishing specific clinical aims (e.g. maximizing the number of lives saved) while at the same time honouring the equal value of each human life. In tragic situations such as these one needs to consider the following questions about the clinical aims of a triage protocol:

- a) Is the protocol's aim (e.g., maximizing the number of lives saved) clearly stated and consistently applied in the protocol?
- b) Is triage absolutely necessary to achieve the protocol's stated clinical aims? Does it specify what other options will be exhausted first– i.e., transfer of patients to other facilities with more resources?
- c) By what evidence and argument is the triage protocol supported? If it has not been tested, does it contain an explanation and justification of why its approach will achieve its aim?
- d) How do we respect the patient as person and their autonomy in triage decisions? Are there mechanisms for appealing decisions?
- e) How do we maintain a commitment to compassion and justice while pursuing the aims of the protocol? (HEG 65)
- f) What is the communication strategy to enact the triage protocol within the facility?

2 – The decision-making processes set up by a triage protocol

A triage protocol should include decision-making and assessment procedures that are intended to ensure its aims are achieved. For example, a protocol might include assessment tools for ensuring that patients are appropriately prioritized, a tie-breaking procedure for addressing

² *NB: below, the Catholic Health Alliance of Canada's *Health Ethics Guided* is cited as 'HEG'.

disagreement between clinicians about a patient's priority, or a committee structure for making final triage decisions. Against this backdrop, some questions you might consider include:

- a) Are the protocol's tools/processes clearly explained and able to help realize the protocol's aims?
- g) Could any person, or group of persons, reasonably object that the protocol's tools/processes unfairly disadvantage or discriminate against them? What safeguards have been put in place in order to avoid discrimination against patients, such as on the basis of race, disability and age?
 - Consider whether, for example, the protocol's tools/processes are sensitive to legal and ethical duties concerning the human rights of persons with disabilities.
- b) Does the protocol ensure that any external party's (e.g., a clinician's) assessment of a patient's quality of life is not a factor in decisions about limiting treatment?
- c) How would we communicate the protocol's tools/processes to our clinicians, and what would we need to do to prepare to implement its procedures in our facilities?
- d) How would we communicate the protocol's tools/processes to our patients, families, and communities? Are there government or regional resources for communicating this with the community? Are these tools/processes understandable to persons without clinical training, or will they require interpretation and explanation?
- e) Are the protocol's tools/processes responsive to the special obligations of Catholic healthcare facilities, particularly with respect to the poor, vulnerable, disadvantaged, and marginalized (HEG, pp 8-9)?
- f) Do the different levels of decision-making respect the value of subsidiarity (HEG, pp 116-117) and at the same time provide support to clinicians at the front line?

3 – Deviations from standard legal and ethical practices supporting informed decision-making

Respect for autonomous decision making of a patient or their surrogate decision maker (SDM) is one of the most widely accepted ethical principles in North American health care ethics. The standard of practice in medicine requires that a health care provider provide a patient or their SDM with information in order that they understand the risks, benefits, consequences and alternatives of the requested decision. The act of making this choice or decision is referred to as 'informed consent.' While there are limitations on autonomous decision making (for example, patients should not be offered treatments that are inappropriate or ineffective (HEG p 14), generally speaking patients or SDMs are "in charge" of their health care decisions. This includes the ability to consent to or decline interventions.

The implementation of a triage protocol may significantly limit both the ethical and legal protection of autonomous decision-making. There is the possibility that an individual may not be offered certain interventions or receive indicated treatments due to the inclusion/exclusion criteria in a triage protocol. It is important to note that limitations imposed by triage protocols are distinct from the 'everyday' limitations in which a provider may not offer treatment that is considered medically non-beneficial. In the situation of triage, the treatment may very well have a benefit, but the protocols may prevent or exclude the patient or their SDM from engaging in decision-making that aligns with the patient's preferences. These types of scenarios deviate from typical ethical and legal standards protecting the ability for patients and their

SDMs to make decisions, and requiring clinicians to offer treatments that fall within the standard of care.

- a) Does the protocol specify if/when it departs from the prevailing laws/legislation and ethical norms concerning informed decision-making?
- b) Under what circumstances does the protocol permit a physician/institution to withhold beneficial treatments from a patient?
- c) Does the protocol permit a physician/institution to give a patient a “Do Not Attempt Resuscitation” status without a conversation with the patient or their substitute decision-maker. If so, under what circumstances?
- d) Does the protocol permit a physician/institution to withdraw treatment from a patient (e.g., ventilatory support) without consent, so that resources can be reallocated to another patient? If so, under what circumstances?
- e) Does the protocol offer legal and ethical justifications for the departures noted above?
- f) Does the protocol address whether clinicians will be protected from liability for complying with the protocol?
- g) Are any planned departures from the prevailing legal and ethical norms concerning informed decision-making consistent with the principles of Catholic moral theology?
 - For example, under what conditions, if any, would the non-consensual withdrawal of life-sustaining treatment be compatible with the Principle of Double Effect? Under what circumstances would it be incompatible with the Principle of Double Effect?

4 – Responsibility, authority, and accountability in decision-making

In triage, particularly in pandemic situations, it is important that it is clearly determined and understood who is making individual prioritization decisions; that the criteria and the decisions be made in a way that ensures consent, where possible; that the process and decisions are transparent; and that those making decisions remain accountable for their decisions and actions. Drawing on ethics in the Catholic tradition, among the questions one should ask are:

- a) Who makes the specific triage decision (e.g., single-physician determination; physician collaboration; committee/panel determination; administrative determination)?
- b) How is it made? The Health Ethics Guide (HEG) states that when providing medical care, which may involve rationing limited resources, the decision-making and decisions
 - Be objective and transparent (HEG 153),
 - respect a person’s dignity (HEG 16),
 - are just (HEG 5),
 - involve consultation with the patient / SDM in advance, taking full account of their wishes (HEG 82), and
 - avoids particularly unfairly burdening members of marginalized or disadvantaged groups (HEG 12).
- c) Are the best interests of the patient always being taken into consideration, within the context of the common good? For example:
 - c1. Have the criteria for the decision been made clear/explicit to the patient/SDM?
 - c2. Is there a process for appeals? (HEG 158 states that ethics consultants or committees may be a resource)
 - c3. Is there a possibility of a re-evaluation of the decision as time goes on?

- d) Are those making the decision held (fully) responsible and accountable for their decisions (see HEG, p 6)?
 - For example, removing individual accountability might tempt a physician to ignore key values, such as treating individuals with dignity.
- e) Is there an individual or body that oversees and ensures that the decision-making processes are being properly carried out?
- f) Is there a mechanism in place for an 'after the fact' review, to determine that ethical standards had been observed (e.g., whether the process of decision making, and the decision, were followed and implemented appropriately)? Has an individual or body been identified as having responsibility for ensuring that this review takes place? How are the outcomes acted upon?

5 – Challenges of working within a system-wide environment

Triage protocols are likely to be designed at the provincial level and applied to health regions or whole provinces, rather than individual healthcare facilities. Further, planning for and responding to an overwhelming surge of patients will require extensive cooperation and communication among healthcare facilities to share resources, transfer patients, etc. This means that Catholic healthcare facilities will be implementing triage as part of a system-level response. Some questions that arise in this context include:

- a) Who is responsible for the upstream decisions that may help prevent the need for triage, such as ramping down of elective surgeries, closing programs, and transferring patients to other facilities?
- b) Who has the authority to enact a triage protocol, and under what circumstances will that authority be exercised? Similarly, who has the authority to de-activate the triage protocol, and under what circumstances?
- c) Does the triage protocol become enacted at a provincial level, a regional level, or at a single facility? Does the declaration of triage include a temporary time frame with the obligation to revisit and deactivate when appropriate?
- d) Can a facility refuse or opt out of a triage protocol or some aspect of the protocol?
- e) Who (individuals or groups such as committees) makes the decision to allocate a scarce resource to one or multiple patients and therefore decides that other patient(s) will be palliated?
- f) What kinds of cooperation, communication and coordination does the triage protocol require between facilities (e.g., communicating about spacing and staffing; transferring patients out; receiving patients; repatriating patients)? Are there incentives to encourage truthful communication (or penalties)?
- g) Does the character of a facility (e.g., acute care, rehab, LTC) affect its obligations under the triage protocol? If so, how?
- h) Are monitoring measures in place during the period of activation to ensure that ethical considerations are properly being considered? and what are the processes to address matters of concern?]

6 – Moral distress and crises of conscience

It is likely that clinical work during triage will generate even more moral distress than typical (and already overwhelming) work during the pandemic. In light of this, consider:

- a) Does the protocol contain any resources or recommendations for responding to increased moral distress from direct care providers (e.g., spiritual care services, mental health resources, ethical debriefing, adjustments to the staffing model, etc.)?
- b) Direct care providers may ethically object to aspects of the triage protocol's directives and verdicts (HEG 81). According to the protocol, how will these objections be managed and what kinds of responses will they receive?
- c) Does the protocol respect the professional duties/obligations of health care professionals?
- d) Does the protocol address the issue of conscientious objection (HEG 165-166)? If so, is the treatment of the issue adequate? If not, what work remains to be done at the institutional level?
- e) Can we identify ways of implementing the protocol that will minimize or mitigate the moral distress it is likely to generate?
 - For example, are there ways of ensuring that front-line clinicians are not directly responsible for priority judgments concerning their own patients?