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Tragic Choices in Times of Plague: Ethical Dilemmas in the Allocation of Scarce Therapeutic Resources

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Tragiczne wybory w czasach zarazy. Etyczne dylematy w alokacji ograniczonych zasobów terapeutycznych

Streszczenie

W trakcie ostatniej pandemii COVID-19 personel medyczny stanął w obliczu trudnych decyzji dotyczących rozdzielania ograniczonych zasobów medycznych. Niedostatek aparatury niezbędnej do ratowania życia zmusił go do tragicznych wyborów, który pacjent otrzyma konieczne wsparcie, a który tego wsparcia nie otrzyma. Obowiązujące dotychczas procedury alokacyjne okazały się niewystarczające, a dokonywane wybory zbyt często opierały się na subiektywnej ocenie wartości społecznej pacjentów. Sytuacja ta uwidoczniła pilną potrzebę ponownej i pogłębionej refleksji nad mechanizmami sterującymi procedurami alokacji krytycznych i ograniczonych zasobów terapeutycznych.

Niniejsza praca na początku opisuje mechanizmy dystrybucji deficytowych zasobów medycznych, jakie uwidoczniły się w USA podczas pandemii, ujawniając ich niebezpieczne tendencje w kontekście wartościowania życia pacjentów. Następnie, nawiązując do takich myślicieli, jak Paul Ramsey, Guido Calabresi czy Phillip Bobbit, zaproponuje odpowiednie mechanizmy, pomocne w procesie alokacji ograniczonych środków terapeutycznych. Dodatkowo, sięgając do katolickiej nauki społecznej oraz instrukcji Episkopatu Stanów Zjednoczonych, autor wskaże na cenne uwagi, jakie dokumenty te niosą dla omawianego problemu.

Słowa kluczowe: pandemia, COVID-19, ograniczone zasoby medyczne, Ramsey, Calabresi, Bobbit

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Introduction

Over nearly two years, the COVID-19 pandemic has exacted a lethal toll, transforming what once might have been dismissed as a nightmarish scenario into a harrowing reality. Enduring images of besieged intensive care units, packed to their limits, will remain indelibly imprinted on our col-

lective consciousness, accompanied by the sight of healthcare professionals pushed to the brink by their tireless and valiant efforts. Equally unforgettable is the acute awareness of critical shortages – personal protective equipment and ventilators – essential in the battle against the virus. The dire scarcity of such vital resources precipitated heart-wrenching decisions, as medical staff were forced to choose which patients would receive life-sustaining aid and which would, regrettably, be left without the means for adequate treatment.[1]

The prevailing allocation procedures for limited medical resources, when put to the test during the COVID-19 pandemic, were found severely inadequate. The strategies in place often led to disquieting patient selection biases, inadvertently favoring individuals based on perceived social value rather than medical need. Such practices starkly illuminated the necessity for an introspective discourse on the intrinsic worth of a life and the principles that should govern its defense and preservation in times of medical crisis.

This text aims to dissect and expound upon the allocation mechanisms for medical resources that were laid bare in the United States amidst the pandemic. It will uncover the perilous patterns that emerged, where the valuation of a patient's life seemed contingent upon their societal stature, a situation fraught with moral and ethical implications.

In pursuit of solutions, this study will engage with the intellectual legacy of renowned ethicists such as Paul Ramsey, Guido Calabresi, and Phillip Bobbit. Drawing on their profound insights, it proposes revised allocation frameworks designed to transcend utilitarian calculus, emphasizing compassion, equity, and the sanctity of life. These proposed mechanisms strive to ensure equitable distribution, even when resources are critically constrained.

Moreover, this discussion will delve into the ethical underpinnings provided by Catholic Social Teaching and the guidelines offered by the United States Conference of Catholic Bishops. The author endeavors to parse these documents for their rich, ethical guidance, extracting lessons that resonate with the core humanitarian concerns raised by the pandemic's harsh realities.

Ultimately, this expanded analysis seeks not only to address the distribution dilemmas experienced during the recent pandemic but also to anticipate and prepare for future healthcare emergencies. By establishing a more ethically robust and reflective framework for resource allocation, the inten-

[1] Karl Gelles, George Petras, "How ventilators work and why COVID-19 patients need them to survive coronavirus", *USA Today*, accessed 15 February, 2024, https://www.usatoday.com/in-depth/news/2020/04/10/coronavirus-ventilator-how-works-why-covid-19-patients-need/2942996001/.

tion is to foster a healthcare system that upholds the dignity of all individuals, irrespective of their social roles, ensuring that in moments of scarcity, humanity's commitment to each life remains unyielding and resolute.

1. Amidst the crisis

In April 2020, the World Health Organization issued a warning that the unfolding COVID-19 pandemic was set to precipitate significant shortages in essential supplies, including both personal protective equipment (such as masks and protective garments) and critical medical apparatus.[2]

At that time, authorities raised alarms over the critical shortage of ventilators, an issue that posed a severe risk to patient care. This revelation triggered a comprehensive audit of the medical resource allocation procedures in the United States. Upon examination, several protocols, particularly in states like Pennsylvania, Alabama, and Tennessee, were found to contain contentious clauses.[3] In June 2020, the U.S. Department of Health and Human Services delivered a judgment regarding a grievance lodged by an advocacy group for the disabled, against the aforementioned states. The department's findings highlighted that the practices employed during instances of scarce medical resources were distinctly discriminatory towards people with disabilities. The protocols in question were said to unduly limit access to vital procedures and life-preserving equipment amid the COVID-19 pandemic, especially for patients grappling with advanced stages of cancer, significant neurological injuries, or profound dementia.[4] These restrictive measures sparked a national debate on the ethics of resource allocation in healthcare, particularly concerning vulnerable populations. It underscored the need for policies that safeguard against the infringement of rights and ensure that all individuals, regardless of their health status, receive equitable consideration for medical intervention and support. The scrutiny of these protocols served as a clarion call for reform, emphasizing the imperative to align medical ethics with the principles of inclusivity, fairness, and respect for the dignity of every human life.

The Health Department's verdict forbade conditioning the initiation of essential therapy on the presence of a patient's concurrent illnesses. The Department reiterated that all decisions regarding the commencement of intensive medical care, particularly when it involves the allocation of scarce

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2 U.S. Department of Health and Human Services, *OCR resolves complaint with Tennessee after it revises its triage plans to protect against disability discrimination*, accessed 12 February, 2024, https://www.hhs.gov/about/news/2020/06/26/ocr-resolves-complaint-tennessee-after-it-revises-its-triage-plans-protect-against-disability.html.

3 Ibidem.

4 Ibidem.

medical resources, must rest on „an individualized assessment of the patient's condition carried out by a team of doctors based upon the most pertinent and objective medical evidence."[5] Moreover, the Department underscored that „necessary therapy cannot be withheld from a patient on the grounds of stereotypes or judgments about the value or quality of life."[6]

The COVID-19 pandemic is not an unprecedented event when it comes to the ethical dilemmas surrounding the fair distribution of medical resources-a challenge that deeply impacts both healthcare professionals and the broader community. A notable historical parallel can be drawn with the renowned case from the Swedish Hospital in Seattle in the 1960s, which was a pivotal moment in medical ethics concerning resource allocation.[7]

At that time, a groundbreaking dialysis treatment was being pioneered, but the resources were scarce – specifically, a limited number of dialysis machines. This scarcity necessitated the establishment of a selection criterion to determine which patients would receive treatment. A special committee, which came to be known colloquially as „God's committee," was formed. This group, comprising seven volunteer representatives from diverse professions, was tasked with the onerous responsibility of establishing patient selection parameters.

The criteria they established included marital status, the number of children, income, employment history, earnings, religious involvement, emotional stability, place of residence, and educational background.[8] Intriguingly, the committee elevated ‚social value' to the forefront as the principal determinant in the selection process for access to the experimental dialysis treatment. Their choices were guided by the notion that the benefits of the scarce medical intervention should accrue to those who could, in their view, contribute most significantly to society.[9]

This approach, while pragmatic during a period of acute shortage, raised profound ethical questions. It sparked a broader conversation about the values that should guide such life-and-death decisions, and whether such criteria could ever be justly and equitably applied. The committee's work underscored the persistent tension between utilitarian calculations and the principle of equal regard for all human lives.[10] As a historical lesson, the Swedish Hospital case continues to inform current debates on medical ethics, espe-

[5] Ibidem.

[6] Ibidem.

[7] United Network for Organ Sharing, *The road to racial equity in kidney transplantation*, accessed 15 March, 2024, https://unos.org/voice/the-road-to-racial-equity-inkidneytransplantation/.

[8] Ibidem.

[9] Sahan Alexander, "They decide who lives, who dies", *Life*, no.53 (1962): 102-125.

[10] Ibidem, 111.

cially in situations mirroring the dire conditions of the COVID-19 pandemic, where similar tragic choices are made under pressure of resource limitations.

In his seminal work „The Patient as Person," American ethicist Robert Paul Ramsey confronts the vexing issue of rationing limited medical resources, which he identifies as „the most arduous social and ethical issue to address,"[11] one that mirrors our societal values and influences how we prioritize in areas such as healthcare investment and patient procedure availability. Ramsey casts a critical eye on the role that ‚social value' plays in this process, positing that employing such a criterion to determine which patient receives therapeutic resources – and by extension, which does not – erodes the essential trust that underpins the doctor-patient relationship.

He contends that prioritizing patients based on an assessment of their social worth not only strays from medical impartiality but also invites the peril of discriminatory practices.[12] These practices, Ramsey argues, could potentially taint the allocation process with biases, be they conscious or unconscious. Such a system could inadvertently validate societal prejudices, further entrenching inequities within healthcare provision.

To mitigate this, Ramsey advocates for a randomized selection process in situations where the demand for medical resources outstrips supply and where decision-making could become mired in ethical controversy.[13] By introducing an element of chance, this method seeks to eliminate personal bias, uphold the principle of equal regard, and reinforce the integrity of medical ethics. It is a bold proposition that calls for a reassessment of allocation policies, urging a move towards strategies that are more equitable and just, thus strengthening the crucial bond of trust that must exist between healthcare providers and those they serve.

2. Tragic choices

In their landmark text „Tragic Choices" (1978), Guido Calabresi and Philip Bobbitt delve into the contentious practice of utilizing social value as a yardstick, particularly critiquing its application within Seattle's healthcare framework. The philosophers contend that an inherent tragedy of such decision-making is that no process for rationing finite medical resources can ever be wholly free from moral blemish or completely impartial.[14] Moreover, they argue, each decision is invariably laden with a profound psychological toll on those who must choose.[15]

[11] Robert P. Ramsey, *The patient as person: Explorations in medical ethics* (New Haven: Yale University Press, 2020), 78.

[12] Ibidem.

[13] Ibidem, p.81.

[14] Guido Calabresi, Philip Bobbitt, *Tragic choices* (New York: Norton, 1978).

[15] Ibidem.

The notion of ‚tragedy' extends to the dynamic intricacies of healthcare investment decisions themselves – determining which medical procedures merit funding and which do not. This methodology inherently creates a disparity, potentially relegating those deemed of ‚lesser' social value to a disadvantaged position, especially in situations where there is a looming shortage of specific therapeutic resources. Calabresi and Bobbitt's critique is a profound call to examine the ethical frameworks within which life-altering medical decisions are made, challenging us to find more equitable approaches to resource allocation.[16]

Calabresi and Bobbitt articulate that societal decisions on directing investments, including those about the availability of limited medical resources, are, first-order determinations'. ‚Second-order determinations', in contrast, revolve around decisions about who will have access to these limited resources and the method by which this access is granted. Typically, these first and second-order decisions are taken independently and are informed by disparate sets of values. In the context of limited medical resources, the tragic choices that emerge underscore a stark divide between these two levels of decision-making, underscoring the critical need for a more integrated approach. As they remark, „errors in first-order determinations can lead to situations where human life is sometimes not regarded as inherently valuable, whereas in different contexts, it may be assigned greater significance."[17] This dichotomy is manifest in the contrast between the financial outlays for essential healthcare and prevention and the investments made for end-of-life medical procedures. Furthermore, decisions regarding the allocation of restricted means or procedures are often in the hands of „a select group of decision-makers, frequently associated with the business sector rather than healthcare or patient advocacy groups."[18]

Such a framework implies that second-order decisions are not so much a product of careful deliberation as they are the inevitable outcome of prior first-order determinations. The tragic nature of choices made in resource-limited environments is frequently due to a failure to address and take responsibility for these foundational decisions.

In the specific instance of the Seattle hospital, a deliberate choice was made to increase funding for the innovative practice of kidney dialysis, potentially altering the landscape of first-order determinations.[19] Yet, investments in such medical technologies are in competition with other healthcare and social initiatives, including efforts to alleviate poverty or enhance ed-

[16] Calabresi & Bobbitt, 67-71.

[17] Ibidem, 69.

[18] Ibidem.

[19] Maura Ryan, "Tragic choices, revisited: Covid-19 and the hidden ethics of rationing", *Christian Bioethics: Non-Ecumenical Studies in Medical Morality*, 28/1 (2022): 58-75.

ucation standards. Therein lies the complexity, as investments across the spectrum of social and healthcare projects are inherently linked, each influencing the other in profound ways.[20]

There exists a well-documented link between a society's level of poverty and its general health. Impoverished individuals, notably African Americans and Latinos in the USA, more frequently consume inadequate diets rich in sugars, elevating their risk of developing obesity, diabetes, and hypertension.[21] These conditions can in turn magnify the risk of contracting additional illnesses. During the COVID-19 pandemic, comorbidities such as diabetes or obesity were key factors contributing to severe disease progressions, necessitating hospitalization and mechanical ventilation.[22]

The social dimension also plays a critical role in combating the spread of the virus among various societal groups. Locations where maintaining social distancing is challenging, such as densely populated dwellings with poor sanitation or nursing homes, were the hardest hit by the pandemic. Similarly, the contagion was often spread by underpaid caregivers working in multiple facilities, inadvertently transmitting the virus between their places of employment. This led to devastating effects on nursing home residents, among whom COVID-19 claimed the highest mortality rates.[23]

Do we not recognize an issue with fundamental planning? To quote Robert Paul Ramsey, ‚we make a choice by not making a conscious choice or decide by a lack of decision.'[24] Furthermore, Ramsey contends that the priorities set in healthcare investments betray a perilous inclination toward ‚cheating death'. Disproportionate sums are invested in life-sustaining treatments compared to the modest funding allocated to preventive measures and primary care.

The most prevalent ventilator allocation protocols in the USA during the COVID-19 pandemic circumvented the errors observed in the states of Pennsylvania, Tennessee, and Alabama.[25] These protocols abandoned categories such as the presence of disabilities or dementia, concentrating instead on the individual assessment of each patient's condition and objective medical evidence. They also incorporated utilitarian concepts aimed at maximizing overall benefits and fulfilling societal values.

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[20] Ibidem, 60.

[21] Jackie Leach Scully, "Disability, disablism, and covid-19 pandemic triage", *Journal of Bioethical Inquiry*, 17/4 (2020): 601-605.

[22] Ibidem.

[23] Ibidem.

[24] Ramsey, 14.

[25] Julain Savulescu, James Cameron, Dominic Wilkinson, "Equality or utility? ethics and law of rationing ventilators", *British Journal of Anaesthesia*, 125/1 (2020): 10-15.

3. Whom to Save?

In 2015, New York State released guidelines for the allocation of ventilators in response to the imminent threat of the avian flu outbreak. The document stressed the imperative to be guided by „the best, objective medical data."[26] The primary objective outlined was „to save the greatest possible number of patients by prioritizing those for whom intensive medical therapy is likely to yield the most favorable outcomes."[27] Patient triage teams employ a methodology known as the Sequential Organ Failure Assessment (SOFA), a multi-factorial evaluation of organ failure that assesses six critical systems: respiratory, coagulation, hepatic, cardiovascular, renal, and neurological. The intention is to pinpoint those patients who are unlikely to benefit from intensive care and are at imminent risk of dying. The guidelines explicitly prohibit basing patient selection on prognostic criteria concerning „predicted life span and quality."[28] Nonetheless, they delineate specific circumstances where interventions should be withheld, such as in the presence of terminal comorbidities that are expected to lead to imminent death (for example, cardiac arrest or severe burns). There is also a protocol to discontinue ventilator support if no significant improvement is observed within 48 and 120 hours, especially if the ventilator is needed for another patient.

As noted by Eliza Yadov, deciding to withdraw a ventilator from a patient with a slower recovery rate on the presumption that another patient may recover more quickly introduces a dimension of medical uncertainty and is fraught with profound moral quandaries.[29] This issue has become even more acute during the COVID-19 pandemic, given the incomplete knowledge about the disease progression and recovery process.

When faced with the dilemma of two patients requiring one ventilator, the guidelines from New York State suggest that age can be a decisive factor, with a tendency to favor the younger individuals. This policy is justified not on the grounds of „social value" but rather „social equity."[30] This principle posits that a child has the right to live through the entirety of their potential lifespan, whereas an elderly patient may have already had the opportunity to experience life's various stages.

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[26] New York State Task Force on Life and the Law and New York State Department of Health, *Ventilator Allocation Guidelines*, accessed 15 March, 2024, https://nysba.org/app/uploads/2020/05/2015-ventilator_guidelines-NYS-Task-Force-Life-and-Law.pdf.

[27] Ibidem.

[28] Alan Jones, Stephen Trzeciak, Jeffrey Kline, "The Sequential Organ Failure Assessment Score for predicting outcome in patients with severe sepsis and evidence of hypoperfusion at the time of emergency department presentation", *Critical Care Medicine*, 37/5 (2009): 1649-1654.

[29] Eliza Yadov, "New York state ventilator allocation guidelines: Legal and ethical dilemmas in the materialization of policy", *Juxtaposition*, 30 Jun 2020.

[30] New York State Task Force.

In a May 2020 publication in the *New England Journal of Medicine*, Ezekiel Emanuel and his team contended that „ethical allocation of scarce medical resources demands a framework that acknowledges multiple values and is contextually appropriate."[31] They advocated a predominantly utilitarian approach, anchored in four essential values: benefit maximization, equal treatment, promotion of instrumental value, and prioritization of the most vulnerable. The interpretation of each value is complex and dependent on the specifics of each clinical scenario.

Benefit maximization is dual-faceted: it could mean saving the largest number of patients or extending the individual life expectancy of each patient as much as possible. The equality principle is designed to counteract patient discrimination based on idiosyncratic traits. Nevertheless, it often results in methods like lottery selection, which, while intending to be impartial, may not completely offset discriminatory outcomes.[32] For instance, individuals with better access to healthcare facilities due to geographic proximity or transportation availability may inadvertently have an upper hand in resource allocation.

Instrumental value can be perceived as acknowledging one's societal contributions or the significance of their ongoing societal roles, presenting a dilemma of whom to prioritize – a veteran who has served the country or a currently active healthcare worker? The concept of aiding the „worst off" also bears varied interpretations. It might mean giving precedence to those in direst physical condition, or it could imply prioritizing those with the most to lose, such as young individuals on the cusp of their life's journey.

Emanuel's team recommends six guidelines for pandemic response, particularly during COVID-19.[33] The first underscores the urgency of saving the most lives and maximizing the life years that intensive treatments like ventilators can prolong. The second advises priority access to medical resources for frontline healthcare and emergency workers, which extends to preventive interventions like vaccinations and personal protective equipment.

Their third recommendation advocates for random allocation in situations where resource scarcity leads to conflicts. The fourth accentuates that life-saving decisions should consider the specifics of the medical intervention. The fifth guideline gives priority to volunteers in vaccine trials for access to therapeutic resources. The sixth addresses the overwhelming strain on healthcare systems, suggesting that resources not be exclusively reserved for COVID-19 patients during such periods of extreme pressure.

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31 Ezekiel Emanuel et al. "Fair allocation of scarce medical resources in the time of covid-19", *New England Journal of Medicine*, 382/21 (2020): 2049-2055.

32 Ibidem, 2053.

33 Emanuel, 2049 - 2055.

Despite these comprehensive guidelines, the clinical choices in a landscape of limited medical resources are invariably laden with tragedy. Determining who receives the opportunity for life when resources are scarce is an inherently heavy decision, both emotionally and ethically. It underscores the necessity of integrating clinical judgment with ethical considerations, fostering a holistic approach to decision-making in such harrowing circumstances.

4. Recognizing the Impoverished

In deliberating the distribution of scarce therapeutic resources within the framework of Christian morality, it is poignant to reflect on Pope Francis's words at the pandemic's outset: „this situation is a moment to recognize the impoverished."[34] The American Episcopal Conference's document on health care underscores the need to adhere to core values when allocating limited resources, highlighting respect for human life, a preferential option for the poor, the pursuit of the common good, and prudent resource management.[35] Within the Christian ethos, life and health hold significant value, yet they are not considered supreme values; they are subordinate to the imperatives of salvation and eternal life. Consequently, moral theology differentiates between ordinary and extraordinary means of therapeutic intervention. Ordinary means, including basic hygiene, pain mitigation, and spiritual support, ought to be universally accessible. The use of extraordinary means, conversely, may be limited when they impose undue strain on the patient, their family, or the wider community, surpassing the anticipated health benefits.[36]

Furthermore, the Catholic tradition justifies the allocation of scarce therapeutic resources to patients more likely to derive substantial benefit from treatment. This approach embodies the principle of „wise and responsible management of resources."[37]

In a deadlock, when two patients are in need of one ventilator, Catholic doctrine, adhering to the precept of judicious resource use, accords priority to the younger individual, assuming that the procedure will lead to a great-

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[34] Joachim von Braun, Stefano Zamagni, Marcelo Sánchez Sorondo, "The moment to see the poor", *Science*, 368/6488 (2020): 214-214.

[35] United States Conference of Catholic Bishops, *Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy*, 1986, accessed 15 March, 2024, https://www.usccb.org/upload/economic_justice_for_all.pdf.

[36] Ibidem.

[37] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services. 6th Edition*, 2016 accessed 20 March, 2024, https://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf.

er benefit in terms of additional years of life potentially gained. It is also essential to recognize that Catholic Social Teaching has long advocated for a comprehensive reflection on both primary and secondary planning. The intention is to curtail the complex moral quandaries that arise amidst the allocation of scarce medical resources, ensuring that healthcare practitioners make decisions that are considerate of patient welfare and aligned with their moral compass.

Such reflections on the ethical dimensions of medical resource allocation also implore a broader societal discourse on healthcare priorities and the moral obligations towards the most vulnerable. It invokes a collective conscience that seeks to balance equity, compassion, and the ethical stewardship of communal resources, particularly in times of crisis. The nuanced approach to healthcare ethics proposed by Catholic teaching encourages a compassionate prioritization that not only addresses immediate medical efficacy but also embodies a deeper commitment to social justice and the inherent dignity of every human life.

Conclusion

Faced with the profound dilemmas that the COVID-19 pandemic has thrust upon healthcare systems globally, there is an imperative and ongoing obligation to seek solutions that are equitable and fair. Such a mission necessitates deep introspection regarding the decision-making processes that govern the allocation of scarce medical resources. Furthermore, it appears indispensable to foster an interdisciplinary collaboration that melds practical knowledge with ethical acumen, ensuring that healthcare delivery is not only efficient but also compassionate, upholding the imperatives of justice and equality.

The scholarly endeavors of thinkers like Ramsey, Calabresi, and Bobbitt illuminate the broader social and ethical ramifications that each medical resource distribution decision carries, implications that reach well beyond the individual circumstances of a single patient. It is vital to delineate between primary planning – the strategic allocation of resources at the macro scale – and secondary planning, which zeroes in on the immediate accessibility of care. This distinction is foundational in pursuing the most equitable distribution strategies. Primary planning should be governed by the doctrines articulated in Catholic Social Teaching, advocating for the creation of infrastructures that foster the collective good and uphold the sanctity of every human life. Conversely, secondary planning, in alignment with the directives put forth by the United States Conference of Catholic Bishops, calls for a personalized evaluation of each patient's needs, grounded in unbiased

medical and ethical criteria, eschewing prejudicial biases and the subjective appraisal of life's worth.

The insights garnered from the tumultuous recent years ought to inform the groundwork for evolving paradigms of care that advocate for the vitality and wellness of all community members, unequivocally rejecting any form of discrimination or inequity. By weaving in the insights of such eminent scholars as Ramsey, Calabresi, and Bobbitt, along with the tenets of Catholic Social Teaching, into our decision-making frameworks, we endeavor to sculpt a healthcare ecosystem that embodies fairness and possesses the robustness to withstand forthcoming adversities. There lies a hopeful anticipation that the severity of choices medical professionals have confronted can be alleviated, enabling these weighty decisions to be managed with a greater sense of solace and moral clarity.

In this light, it becomes clear that crafting a healthcare system that can navigate the ethical complexities presented by a pandemic is not merely a matter of policy, but a challenge that calls for philosophical rigor and the highest standards of moral fortitude. It's a clarion call for a system where the value of human life is not just measured by medical outcomes but also by the compassionate processes that lead to those outcomes, ensuring that dignity, above all, is preserved in the face of trying circumstances.

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Tragic Choices in Times of Plague: Ethical Dilemmas in the Allocation of Scarce Therapeutic Resources

Summary

During the last COVID-19 pandemic, medical staff faced difficult decisions regarding the distribution of limited medical resources. The lack of life-saving equipment forced them into tragic choices about which patient would receive the necessary support and which would not. The existing allocation procedures proved to be inadequate, and the choices made too often were based on a subjective assessment of the patients' social value. This situation highlighted an urgent need for a renewed and deeper reflection on the mechanisms controlling the procedures for allocating critical and limited therapeutic resources.

This paper will first describe the mechanisms of distribution of scarce medical resources that became apparent in the USA during the pandemic, revealing their dangerous tendencies in the context of valuing patients' lives. Then, referring to thinkers such as Paul Ramsey, Guido Calabresi, or Phillip Bobbit, it will propose appropriate mechanisms helpful in the process of allocating limited therapeutic resources. Additionally, by reaching into Catholic Social Teaching and the instructions of the Episcopate of the

United States, the author will point out valuable insights that these documents bring to the discussed problem.

Keywords: pandemic, COVID-19, limited medical resources, Ramsey, Calabresi, Bobbitt