LEGAL-ETHICAL GROUNDS OF CRISIS PATIENT PRIORITISATION

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It has been one and a half centuries since an Austrian legal theorist Georg Jellinek wrote his famous remark about the relationship between the two fundamental normative systems: *the law is the minimum of morality*.[2] This formulation, brief and striking enough to be remembered as well as disputed,[3] contributed to the concept of law as an ethical minimum.[4] From this perspective, the law is seen as an instrument to enforce the minimum standards of moral behaviour that are vital for society.[5] The set of moral norms, on the other hand, is much wider and also encompasses the rules that are either less important or can only be carried out by an especially moral person (a "saint" in the broadest sense of the word).

In the outlined way, ethics contributes to the law in at least three ways. First, it defines the fundamental principles of morality, i.e., the criteria by which we can determine whether a certain action is moral or immoral. Since different ethical theories come to various conclusions in this respect, the development of legal regulation throughout the centuries has reflected the changes in predominant ethical approaches in the society. Second, ethics establishes fundamental norms of behaviour that are also protected and enforced by the law. Third, it gives rise to many other norms that are not directly included in the law but contribute to the social context in which the law operates.

Crisis patient prioritisation is a very sensitive activity both from the perspective of ethics and law. Many particular issues arise there that need to be addressed: how exactly the indication to intensive care should be evaluated, what are the

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2 In original: *"Das Recht ist nichts Anderes, als das ethische Minimum."* — literally meaning: *"The law is nothing but the minimum of morality."* Georg Jellinek, *Die Socialethische Bedeutung von Recht, Unrecht und Strafe* (Alfred Hölder 1878) 42.

3 For example, it has been claimed that Jellinek's definition is wrong since many legal norms are morally indifferent, and the content of some legal norms might be even incompatible with moral norms. See Viktor Knapp, *Teorie práva [Theory of Law]* (C. H. Beck 1995) 85–86.

4 See for example Joseph Shatin, 'The Notion of a Minimum Content of Natural Law' (1974) 4 Archiv für Rechts- und Sozialphilosophie 547.

5 See for example Edmond Cahn, *The Sense of Injustice: An Anthropocentric View of Law* (New York University Press 1949) 38–46.

contraindications and how strict or flexible should they be, how to define impermissible discrimination in this context, etc. The answers to these issues form ethical rules that are either directly encompassed in the law, or are given legal relevance by being used to evaluate the compliance with the standard of care and the potential breach of professional duty.

All these particular problems can only be meaningfully addressed by identifying and applying principles of a certain ethical theory (or their combination). Otherwise, the proposed solutions will likely be incoherent, superficial, and unreasonable. We believe that this is precisely what ethics has to offer to the very practical and pressing problems of law: the deeper unifying source of individual norms that can ensure they are not contradictory or arbitrary.

To provide the broader legal context, this chapter starts with the introduction of the very fundamental human rights grounds of patient prioritisation. Then, it looks into the ethical grounds by presenting the most important ethical theories and analysing their (potential and actual) influence on the legal regulation of patient prioritisation.

1. Human rights grounds

The right to protection of health is acknowledged as a human right by international law documents as well as by many national constitutions all around the globe. For example, according to Article 25(1) of the United Nations Universal Declaration of Human Rights, everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including, among others, medical care. The International Covenant on Economic, Social and Cultural Rights of 1966 obligates the States Parties to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Article 12). The demonstrative list of steps the States Parties shall take to achieve the full realisation of this right includes the prevention, treatment and control of epidemic diseases and the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Similar provisions are encompassed in several regional human rights treaties. As important examples, we might mention the African Charter of Human and People's Rights (Article 16) or the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Article 10). In Europe, the right to health care is embodied in the Charter of Fundamental Rights of the European Union (Article 35) as well as in several Council of Europe documents. The European Social Charter explicitly guarantees the right to protection of health in Article 11. The Convention on Human Rights and Biomedicine[6] addresses

[6] The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (also known as the Oviedo Convention) of 1997.

several aspects of such right, including the right to equitable access to health care in Article 3 or the right to the provision of health care in accordance with relevant professional standards in Article 4. The European Convention on Human Rights[7] does not explicitly address the right to protection of health. Nevertheless, the most serious failures to enable the access to health care attributable to the Member States might represent violations of the right to life (Article 2) or the right to respect for private and family life (Article 8).[8]

According to the European Court of Human Rights (hereinafter the "ECtHR"), the right to life does not only oblige the Member States to refrain from depriving persons of their lives but also *"to take appropriate steps to safeguard the lives of those within its jurisdiction"*[9]. *While it was made clear in several ECtHR decisions*[10] that the inaccessibility of health care might infringe the right to life, the Strasbourg court only rarely finds such violation. There are two types of situations when it might occur:

– When the patient's life was *"knowingly put in danger by denial of access to life-saving emergency treatment"*.[11]

  An incorrect or delayed treatment is not sufficient to be a basis for this type of violation.[12] An example might be found in a Turkish case in which a pregnant woman was, with a delay, diagnosed with spontaneous abortion and indicated for a life-saving emergency operation. The medical facility that could perform the surgery, however, required the deposit to its operating found, which the patient's family did not have enough money to pay. For this reason, the hospital declined to hospitalise the patient. She died during the transfer to another hospital in a private ambulance where no medical personnel was present.[13]

  In relation to the pandemic rationing, this type of fundamental right violation might occur if the patients were denied the life-saving treatment even though there still were available resources to provide such care: for example, if they were not admitted to intensive care simply to leave some beds available for more perspective patients, or if their exclusion from the provision of care was based on impermissible discriminatory criteria.

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7 Convention for the Protection of Human Rights and Fundamental Freedoms of 1950.

8 The paragraphs below containing an overview of the ECtHR case law regarding violations of Article 2 and Article 8 of the European Convention on Human Rights by failing to ensure the access to health care is based on an apt analysis in Petr Šustek, 'Non-Compliant Patients and the Restrictions of their Exercise of Right to Health' in: Pavel Šturma, Milan Lipovský (eds) *70th Anniversary of the Universal Declaration of Human Rights* (rw&w Science & New Media 2019) 136–138.
Martin Šolc, 'The Pandemic and the Law: Challenges of Covid-19 to the Ethical and Legal Paradigm of Health Care' in: Pavel Šturma (ed) *Czech Yearbook of Public & Private International Law. Česká ročenka mezinárodního práva veřejného a soukromého. Vol. 12* (Česká společnost pro mezinárodní právo 2021) 378.

9 See *L. C. B. v. the United Kingdom* App no 23413/94 (ECtHR, 9 June 1998) § 36.

10 See for example *Nitecki v. Poland* App no 65653/01 (ECtHR, 21 March 2002), or *Pentiacova and Others v. Moldova* App no 14462/03 (ECtHR, 4 January 2005).

11 *Lopes de Sousa Fernandes v. Portugal* App no 56080/13 (ECtHR, 19 December 2017) § 191.

12 See ibid § 191.

13 See *Mehmet Şentürk and Bekir Şentürk v. Turkey* App no 13423/09 (ECtHR, 9 April 2013).

– A *"systemic or structural dysfunction in hospital services"* that resulted in the deprivation of access to life-saving emergency treatment.[14]
  Such a violation is attributable to the respective Member State if *"the authorities knew about or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger"*[15].
  It might be illustrated with another case from Turkey. A premature infant was born in a hospital that had no neonatal unit. She was transferred to another facility which nevertheless lacked available space and equipment. The baby passed away even though she could have been saved, was she provided with necessary medical care in time.[16]
  In the context of the pandemic rationing, the second type of violation of the right to life is conceivable if there were no scarce resources available at the time when the patient needed them, but the lack of such resources was the result of the State's wrong policies leading to the systemic failures that made the health system especially vulnerable to the consequences of public health crises.

In both types of situations, four criteria must be cumulatively fulfilled so the Member State will be held responsible for breaching the right to life:[17]

1) A provider of health care denied a patient emergency medical treatment despite being fully aware that it puts the patient's life at risk; such an act or omission goes beyond a mere error or medical negligence.
2) The dysfunction at issue is objectively and genuinely identifiable as systemic or structural; individual instances of dysfunction do not qualify as sufficient to be attributable to the state authorities in this context.
3) There is a causal link between the dysfunction and the harm sustained by the patient.
4) The dysfunction at issue has resulted from the failure of the State to meet its obligation to provide a regulatory framework in the broader sense.

If the lack of access to health care does not threaten the patient's life but interferes with their private and family life (for example, by preventing them from improving their quality of life), Article 8 of the European Convention on Human Rights might be breached. Nevertheless, these cases have only been identified by the ECtHR very rarely.[18]

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14 See *Lopes de Sousa Fernandes v. Portugal* App no 56080/13 (ECtHR, 19 December 2017) § 192.
15 ibid § 192.
16 See *Aydoğdu v. Turkey App no 40448/06 (ECtHR, 30 August 2016).*
17 See *Lopes de Sousa Fernandes v. Portugal* App no 56080/13 (ECtHR, 19 December 2017) §§ 191–196.
18 See Petr Šustek, 'Non-Compliant Patients and the Restrictions of their Exercise of Right to Health' in: Pavel Šturma, Milan Lipovský (eds) *70th Anniversary of the Universal Declaration of Human Rights* (rw&w Science & New Media 2019) 137.

Even in light of the ECtHR case law, the right to protection of health remains rather vague to interpret and apply, especially in very specific situations such as the pandemic. It is the aim of this book to summarise and analyse how selected jurisdictions approach the difficult dilemmas that arise from this uncertainty.

2. Ethical grounds

Normative ethics has traditionally been divided into three major theories: deontology, consequentialism (mainly in the form of utilitarianism), and virtue ethics.[19] In this chapter, we will briefly introduce the fundamentals of these basic normative theories and outline their possible practical consequences for crisis patient prioritisation. We will also briefly address several newer approaches — principlism and case-based moral reasoning.

2.1. Deontology: inherent morality of an action

Deontology (from the Greek *deon* = duty) is a traditional approach to moral reasoning which attributes moral significance to the inherent character of an action. In other words, moral goodness or badness is an inherent property of an action and does not depend on its consequences. A central figure of contemporary deontological ethics is the Enlightenment Prussian philosopher Immanuel Kant.[20]

According to Kant's moral philosophy, agents act based on maxims, i.e., practical rules usable in real life. A maxim might be "always help others in need", but also "lie anytime it suits your interests", etc. Triage rules could arguably also be defined as maxims (such as "always treat those who come for your help first", or "prioritise those with higher chances of survival"). It is clear that we can define mutually exclusive maxims, which means that some of them are morally good while others are wrong. The test is rather straightforward: a particular maxim is good if it fits all the four formulations of the so-called categorical imperative.[21]

For patient prioritisation, the following two formulations of the categorical imperative might be considered especially relevant:

– *"[A]ct as if the maxim of your action were to become by your will a universal law of nature"*[22]

[19] See 'Virtue Ethics' (*Stanford Encyclopedia of Philosophy,* 8 December 2016) <https://plato.stanford.edu/entries/ethics-virtue/> accessed 4 May 2022.

[20] For an introduction to deontology, see 'Deontological Ethics' (*Stanford Encyclopedia of Philosophy,* 30 October 2020) <https://plato.stanford.edu/entries/ethics-deontological/> accessed 23 May 2022.

[21] See Immanuel Kant, *Groundwork of the Metaphysics of Morals* (Cambridge University Press 1997) 31, par. 4:421.

[22] See ibid 31, par. 4:421.

– *"So act that you use humanity, whether in your person or in the person of any other, always at the same time as an end, never merely as a means"*[23]

Based on the former formulation, a maxim is only good if it could be a universal law. There can be no situational exceptions from general rules. Therefore, the principles of patient prioritisations should be the same regardless of the severity of the crisis and must not be sacrificed for the perceived greater good.[24]

According to the latter above-cited formulation of the categorical imperative, it is impermissible to sacrifice the life or health of another. By doing so, the agent would use the humanity in another merely as a means to help the third person. In the Kantian understanding of morality, the abandoned person would be stripped of their dignity.

At this point, it might be important to mention that Kant distinguishes between perfect and imperfect duties. Perfect are duties *not to act* according to maxims that are not even conceivable as a universal law since they would lead to a contradiction — for example, if there was a universal law that everyone should lie, nobody would believe anything and lying would become useless. Imperfect duties, in turn, regard maxims that could theoretically make a universal law, but we cannot rationally will it (e.g., a maxim that no one should help others in need).[25] The fulfilment of perfect duties deserves no special praise, but their breach is blameworthy. On the other hand, the failure to act on imperfect duties does not deserve blame, but their fulfilment is praiseworthy.

In an admittedly simplifying manner, this dichotomy resembles the above-outlined understanding of law as the minimum of morality. Legal obligations are similar to perfect duties in the sense that compliance with them is not particularly praiseworthy, but their violation should be sanctioned. Less crucial moral obligations that are not enforced by the law might be understood as close to imperfect duties.

What does it mean for patient prioritisation? We might, for example, imagine health professionals who undergo extreme personal risks to care for the sick, or a patient who refuses life-saving treatment so it can be provided to someone younger. Such heroic acts should rather be considered imperfect duties. Voluntary self-sacrifice may be, in some cases, highly moral and admirable. As a rule, though, sacrificing one's life or health for the sake of others is not required by the law (while this should not be confused with the obligation to bear a reasonable risk).

On the contrary, not sacrificing others is considered a perfect duty. Nobody is praised for not destroying others for the greater good, while any attempt to do so would be morally impermissible and most likely illegal. That is why the

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23 See ibid 38, par. 4:429.

24 See Petr Šustek, Martin Šolc, 'Prioritizace pacientů v intenzivní péči: etika a právní odpovědnost v době pandemie [Patient Prioritisation in Intensive Care: Ethics and Legal Liability at the Time of Pandemic]' (2022) 3 Jurisprudence 6.

25 See Immanuel Kant, *Groundwork of the Metaphysics of Morals* (Cambridge University Press 1997) 31–33, pars. 4:422-4:424.

deontological ethical approach tends to be restrictive and supports a rather passive position towards the external risks. If the risk materialises, it might be very bad for the affected person, but at least nobody bears the moral guilt.

In the context of crisis patient prioritisation, this means that health professionals cannot sacrifice the patient for the sake of others. It is, however, not trivial to understand what such a "sacrifice" means. Arguably, it is not necessarily defined according to the active-passive behaviour distinction (which raises many questions such as whether withdrawal of life support is rather an action or cessation of action[26]). From the Kantian perspective, the crucial issue is whether the patient is solely used as a means to achieve the goals that are external to them. If the life-sustaining treatment that might still be beneficial for the patient is withheld or withdrawn from them because it is deemed potentially more beneficial to another person, the patient is used as a means to free the scarce resources. They are not being dealt with as an end in themselves. For this reason, it can be argued that health professionals are not allowed to withhold or withdraw life-sustaining treatment from the patient for the sake of other patients.[27]

On the other hand, deontology puts stress on a dignified approach to others, which can be interpreted as a reason for strong support for quality palliative care. Prolonging suffering without a real benefit to the patient — the so-called dysthanasia — can sometimes be understood as the use of the patient to achieve external goals, especially if it is motivated by a mere habit, insensitivity, or even financial interests. It might be considered a categorical duty to terminate life-sustaining treatment when it puts a heavy burden on the patient that is disproportionate to its potential benefits. Knowing when to transfer the patient to full palliative care can be the best the doctors can do for them. In this perspective, the benefit for other patients who may now use a scarce resource (such as a ventilator) is just a lucky side-effect.

2.2. Consequentialism: morality lies in the consequences

While deontology understands morality as an inherent property of an action, consequentialist ethical approaches[28] judge actions as moral or immoral based on their consequences. As a result, it cannot be said that some action is always good or wrong — circumstances and context always co-determine their moral value. There

[26] See for example Tomáš Holčapek, 'Rozhodnutí soudu jako zdroj oprávnění zásahu do integrity [Judicial Decision as a Source of Right to Interfere with Integrity]' (2018) 3 Časopis zdravotnického práva a bioetiky 3–6.

[27] See Petr Šustek, Martin Šolc, 'Prioritizace pacientů v intenzivní péči: etika a právní odpovědnost v době pandemie [Patient Prioritisation in Intensive Care: Ethics and Legal Liability at the Time of Pandemic]' (2022) 3 Jurisprudence 7.

[28] See 'Consequentialism' (*Stanford Encyclopedia of Philosophy,* 3 June 2019) <https://plato.stanford.edu/entries/consequentialism/> accessed 4 May 2022.

are many possible ways to apply consequentialism in ethical considerations. The especially influential one is utilitarianism.

2.2.1. Utilitarianism: the greatest good for the greatest number

Classical utilitarianism is built upon four basic principles.[29] The first one is the principle of consequentialism, that answers the question of how to morally evaluate actions with the above-outlined answer: every action is as good or wrong as its consequences. Nevertheless, we need to ask for a criterion based on which we can judge whether the consequences are good or not. According to utilitarianism, this criterion lies in the principle of utility: the consequence is good if and only if it is useful for something that is good in itself. According to the principle of hedonism, the good in itself is found in happiness, that is, in pleasant experiences. Since probably everything is mixed with a certain discomfort, the principle of hedonism requires utilitarian calculus. If the calculus of the amounts of pleasures and pain is positive (there is more pleasure than pain), then the consequence is good; but if there was another option with a greater surplus of pleasure over pain, such an option would be even better.

At this point, utilitarianism might seem disturbingly egotistical. Nevertheless, it also encompasses the social principle, according to which it is the social utility that matters. In other words, the agent should act not to maximise their own pleasure, but to achieve the highest possible surplus of pleasure over pain overall, for all people affected.

These principles are often summarised in the rule that the utilitarians should aim at achieving *"the greatest amount of good for the greatest number"*. More precisely, utilitarianism strives for maximising the net good in the world (the highest positive calculus of pleasure and pain possible).[30]

It is easy to see why utilitarianism has been so influential since the second half of the twentieth century. In the contemporary political, economic, and social discourse, the calculus of costs and benefits (monetary or other) is often crucial. However, even utilitarianism has several serious problems. Perhaps most importantly, it makes it very difficult to explain why a minority should not be sacrificed if it fits the majority's interests.[31] The possible consequences of unlimited utilitarian policies might include a total lack of care for certain minorities or even their active oppression or destruction, which is often perceived as inhumane, probably suggesting

[29] See Arno Anzenbacher, *Úvod do etiky [Introduction to Ethics]* (Zvon 1994) 32–34.

[30] See 'Consequentialism' (*Stanford Encyclopedia of Philosophy,* 3 June 2019) <https://plato.stanford.edu/entries/consequentialism/> accessed 4 May 2022.

[31] See Martin Šolc, 'The Pandemic and the Law: Challenges of Covid-19 to the Ethical and Legal Paradigm of Health Care' in: Pavel Šturma (ed) *Czech Yearbook of Public & Private International Law. Česká ročenka mezinárodního práva veřejného a soukromého. Vol. 12* (Česká společnost pro mezinárodní právo 2021) 374.