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Misguided Triage Ethics

Chances of Survival and Risks of Dying in the Coronavirus Pandemic*

Manfred Spieker
Professor Emeritus of Christian Social Sciences
University of Osnabrück

The corona pandemic has forced us to examine rules for allocating survival chances and mortality risks when ICU beds and ventilators are not sufficient for all patients who need them. In the debate about triage ethics one must distinguish between *ex ante* triage and *ex post* triage. *Ex ante* triage addresses which of the patients arriving simultaneously in an emergency room should receive an intensive care bed and which should not. Urgency and prognosis are the decisive medical criteria. *Ex post* triage determines whether a respirator may be removed from a patient who has already been connected to it and given it to a newly admitted patient. The most frequently made mistake in *ex ante* triage is discrimination based on the patient's age. Frequent aberrations in *ex post* triage are decisions based on the quantification of expected life spans, as well as an equivalence of *ex ante* and *ex post* triage, which is justified by the false equivalence of action and omission or the thesis of the inevitability of human culpability.

Introduction

In the first weeks when the coronavirus pandemic was spreading in Germany in the spring of 2020, there was great concern that the hospital ICUs would not be able to handle the onslaught of COVID-19 patients. The images from Lombardy, Alsace, Madrid, and, later on, New York and London showed hospitals overloaded, doctors and nurses exhausted, and funeral homes overwhelmed. In the summer of 2020, the situation eased up, but during the fall of 2020 concern returned with the second wave of the coronavirus pandemic. How should ICU beds and ventilators be distributed if there were not enough for all who needed

them? This question occupied doctors, medical ethicists, and lawyers—not to mention those in criminal law, who focused on the question of which decisions about distributing these would be lawful and which would be criminal. Meanwhile, in Germany the Federal Constitutional Court has been dealing with the difficulty of triage. Plaintiffs with disabilities want to ensure that the question of triage is not settled on recommendations made by organizations of medical experts alone, in which case they would consider themselves discriminated against because of their disabilities. Rather, they want a law that would prohibit discrimination based on disability, and they want the Federal Constitutional Court to force the legislature to pass such a law.

To avoid having to deal with such questions in the first place, the supply of ICU beds and ventilators in Germany was increased; additionally, field hospitals were set up. As of June 2020, Germany had 38.2 ICU beds per 100,000 inhabitants and was relatively well stocked. The United States had 25.8, France had 16.3, Spain had 9.7, Italy had 8.6, and Portugal 4.2 ICU beds per 100,000 inhabitants.[1] These countries were significantly harder hit by the pandemic. In Germany a general lockdown of the economy, society, churches, and culture; the closure of schools and kindergartens; and a draconian ban on domestic and international contact and travel all helped to flatten the curve. The European border regime of the Schengen Agreement was suspended quickly and without parliamentary debate. Politics apparently was following the outdated teaching that the effectiveness of a measure is proportional to the pain it inflicts. The population accepted the restrictions as long as they held out the hope that the sense of security lost to the coronavirus would be regained. An overload of the hospital system was avoided. Germany will long have to deal with the question of the price that the economy and society will have to pay for this. The turning point was—and is—serious. The sense of security lost in the coronavirus pandemic will not return. The federal and state governments in Germany are trying use less painful measures to deal with the subsequent waves since the fall of 2020, but the people's willingness to put up with the restrictions has fallen.

Although the doctors in Germany were spared from triage situations, the question of which criteria they should use when deciding who will and who will not get an ICU bed or a ventilator if the number of patients exceeds resources (that is, when triage is in fact necessary) still requires an answer. The German Ethics Council, various medical societies and academies, the German Conference of Bishops, the Konrad Adenauer Foundation, legal scholars, medical ethicists, and moral theologians looked for an answer and published papers to show the steps—as well as missteps—for what an ethics of triage should be. To this point, the German parliament did not see the need to legally set triage policies.

The ethics of triage deals with the rules by which a doctor should assign chances of survival or risks of dying when patients are admitted to the ICU. The concept comes from French: *triage* means “selection.” In emergency, combat, or disaster medicine, triage refers to the initial check of victims on the scene of an accident or on the battlefield, to decide who should be given priority for treatment and who should be given palliative support to die if the medically necessary care cannot be given to all. There is broad consensus that prioritizing only among those with COVID-19[2] is “unacceptable”; every decision about the distribution of limited ICU beds must also consider patients with other maladies.[3]

One important distinction in the debate about the ethics of triage in the coronavirus pandemic is the distinction between triage *ex ante* and triage *ex post*. Triage *ex ante* involves deciding which patient receives a bed when multiple patients arrive at the ER at the same time and there are not enough beds for all who need them. Triage *ex post* involves the question of whether a patient who already is on a ventilator can be taken off so that it may be made available (for whatever reasons) for a patient who has just been admitted. Reinhard Merkel and Steffen Augsberg also distinguish between these and a third form of triage: preventative triage (*ex ante*), which denies a needed and available ventilator to a patient who already has been admitted when other patients are expected who either will need it more urgently or will have a better prognosis of recovery.[4] In the present debate, triage *ex post* raises the difficult questions, and the answers given are controversial.

Triage *ex ante*

In triage *ex ante* the questions are easier to answer. If two patients need an ICU bed but only one bed is available, the doctor first asks whether treatment in the ICU is medically indicated and whether the patient consents (i.e., there is no advance directive that proscribes such treatment). If a patient has refused intensive treatment either in writing or verbally, the doctor will not initiate it. If no such direction is available, the doctor will make a decision based on medical criteria that focus on how urgent and reasonable the therapy is, how likely it is to succeed, and the presence of any comorbidities—just as is done for transplant surgery, which follows the same criteria when distributing a limited number of organs. In decisions of triage, the guidelines of the Swiss Academy of Medical Sciences, as well as of the German Interdisciplinary Association of Intensive and Emergency Medicine, allow priority to be given to those patients “whose prognosis for leaving the hospital is good with intensive treatment but unfavorable without it.”[5] Patients who are turned away by these decisions, do not receive

intensive therapy, and die, are not killed due to neglect; they cannot be saved, due to a shortage of resources,[6] and thus the doctor incurs no guilt.

If the rapid spread of the pandemic makes it clear that there are not enough resources available, one still cannot justify withholding a medically indicated ICU bed from a patient who already has been admitted in the expectation that other patients will need that bed even more. “According to the rules of triage, patients who are anticipated and not present at the moment are not considered when making a decision.”[7] If the doctor nevertheless did make such a consideration, he or she would have to be accused of having neglected to provide help from the perspective of the patient whose bed had been delayed and of his or her family.

First Misstep: Discriminating

But even triage *ex ante* can raise questions with controversial answers. If one patient is old (or very old) and the other is young, if one is a doctor or nurse and the other is a worker or saleswoman, if one is the mother of several young children and the other is single, if one is rich and the other is poor, then many doctors and ethicists would tend to, and find reasons to, decide in favor of the young and against the old, in favor of the doctor or nurse and against the worker or saleswoman, in favor of the mother of young children and against the single person—according to the motto “First, rescue the rescuers,” or “First, rescue those who are responsible for others”[8] or “those who perform essential state functions.”[9] They probably would shy away from deciding in favor of the rich and against the poor, because in that case it would be all too obvious that they would be violating the prohibition against discriminating. But the prohibition against discriminating applies in the other cases too, and it is just one aspect of the constitutional framework for a doctor’s decision.

The other aspects are the inviolable dignity of human beings and the right that each has to life and physical integrity, which is not dependent on a prognosis of life expectancy or quality of life. The German Basic Law states these aspects in article 1, paragraph 1, sentence 1 (“Human dignity is inviolable”) and in article 2, paragraph 2, sentence 1 (“Every person has the right to life and physical integrity”). These form the basis for the prohibition against discriminating in article 3. They create an obligatory framework of conditions not only for the legislator who might consider legally setting triage guidelines but also for the doctor. When deciding how to assign chances of survival or risks of dying, he must refrain from making any judgment about the value of the patient or about how long the patient has to live. This is why the maxim that saving lives “only makes sense when the life saved is worth living” is unconstitutional.[10] For that

matter, the constitutional guidelines for medical treatment during the coronavirus pandemic are not uniquely German. Even the UN's General Declaration of Human Rights (1948) assumes in article 1 the human dignity that grounds the prohibition against discriminating in article 2 and for the right to life and freedom in article 3.

One occasionally hears in the coronavirus pandemic that the constitution is reaching its limits. But this does not affect doctors' obligations during triage; it affects the political decision-making process in the fight against the pandemic. Restrictions of basic rights, rulings that prohibit contact, closing national borders, the lockdown of the economy and the education system, and the unimaginable debt that the state is incurring to save the economy—all of these necessarily demonstrate a dominance of the executive branch federally and in the states, and they raise questions both about the role of the legislative and judicial branches and about balance in a system that has a division of powers.[11] In Germany the federal system cushions the dominance of the national government. The courts determine whether the basic principle of constitutionality is being maintained in all these invasive measures. Thus, the constitution is being tested during the coronavirus epidemic, but it has not been suspended. The same is true of the professional obligations for medical workers: these obligations are being tested in the pandemic, but they have not been suspended.

In its *ad hoc* recommendation "Solidarität und Verantwortung in der Corona-Krise [Solidarity and Accountability in the Coronavirus Crisis]" of March 27, 2020, the German Ethics Council underscored the binding character of the constitutional guidelines:

> The fundamental guidelines of the constitution are a binding framework for medical ethics too. The guarantee of human dignity requires an egalitarian basic equality and thereby establishes a corresponding fundamental protection against discrimination for all. Moreover, the principle of indifference toward the value of life applies to the state, as the audience to which the constitution's basic rights are directly addressed: It is forbidden from valuing (and certainly from devaluing) human life. Every direct or indirect distinction that the state makes regarding the value or remaining duration of life—and every guideline that the state consequently sets regarding the inequitable assignment of the chances of surviving and risks of dying in acute crises—is prohibited. Every human life enjoys equal protection, and this does not only forbid distinctions on the basis of sex or ethnic background. The state also must refrain from classifying on the basis of age, role in society (and its accepted "value"), or prognosis of life expectancy.[12]

In contrast to the guideline that the prognosis of life expectancy must not be a criterion when distributing a medically indicated ICU bed, some suggest that patients should be excluded from admission to the ICU if they are over a certain age or have only a very limited time to live. The protocols of the Swiss Academy of Medical Science state that patients over eighty-five must be denied admission.[13] This criterion is omitted in the updated version of the protocols, dated November 2020. Now, age plays a role only in combination with a specific rating on a scale of infirmity. But this can spell disaster for someone who is just sixty-five years old. Elisa Hoven considers a life expectancy of less than twelve months to be the cutoff point. According to her, no one would "seriously claim" that the prospect of having only a few months to live is "equivalent in value" to that of expecting to live for many years.[14] This is patently unconstitutional.

It is also both legally and ethically problematic to pressure the especially vulnerable group of nursing home residents to draw up an advance directive in light of the coronavirus pandemic. Bettina Schöne-Seifert and Hugo van Aken, of the University Clinic of Munster state, "It must be clarified right now whether every resident in a nursing home, if possible, wants to be transferred to a hospital and put on intensive care in the event of a severe case of COVID-19." Death by pneumonia "need not be fought in every individual case" at an advanced age; it would be "wrong and unfair to treat patients who are willing to die at the expense of those who want to live."[15] Using scarce resources to pressure people into drawing up a living will contradicts the admission that nursing home residents, among whom the incidence of dementia is particularly high, often do not even understand what the coronavirus pandemic is and why rigorous prohibitions against personal contact are being issued to fight it. Pressuring them to agree to such a declaration and into periodically "reevaluating" it does not become more acceptable by claiming that this avoids "paternalism and excessive treatment." Here too, the goal is "to keep resources available for those who want medically indicated intensive care." Anyone who has not already refused this therapy, with an advance directive, wants it. According to a paper written by the bishop of Essen, Frank-Josef Overbeck, and his coauthors, those who now have been pressured into such a directive, however, must not "feel that they are being indirectly urged to a 'death by social contract.'"[16] Schöne-Seifert and van Aken write that those who are pressuring others into an advance directive must not give the impression that they are "eager for a 'no'" to the question of intensive care "in order to provide a cushion for the threatening shortages of care."[17]

A glance at the initiatives of public and civic health services in England and the United States makes it clear that this concern is unfounded. In a letter dated March 27, 2020, the English National Health Service urged older patients with

severe comorbidities to add a do-not-resuscitate order to their advance directives so that family members would know not to seek emergency attention if their health deteriorated due to COVID-19, and so that resources would be reserved for younger and stronger patients, with better chances of surviving COVID-19. The group Compassion and Choices, which advocates for assisted suicide in the United States, urged its members to add a COVID-19 addendum to their advance directives and refuse intensive care if they contracted COVID-19.[18] Save Other Souls and the National Hospice and Palliative Care Organization recommended similar advance-directive addendums.[19] Pressuring older people in order to provide relief for scarce resources by way of advance directives, or by reevaluating or amending them, remains a misstep in the steps to an ethics of triage.

Triage *ex post*

In triage *ex post* we again encounter the suggestions that a specific age or a life expectancy of less than twelve months be a criterion for refusing to admit, or that a life expectancy of a few months must be weighed against a life expectancy of many years. Now the question is no longer whether to admit a patient to the ICU or not; rather, it is whether a ventilator may be taken from a patient with a limited life expectancy so that it may be given to a patient with a longer life expectancy. Numerous doctors, as well as legal experts and medical ethicists, answer this question in the affirmative and seek justifications for their decision.

Second Misstep: Quantifying

The maxim "Save as many lives as possible" is not sufficient by itself to justify transferring a ventilator from a patient already on it to a patient who has newly arrived. More people would not be saved with the transfer than without it, assuming that intensive care is necessary for both patients and that the patient to whom it is not (or no longer) given would die without it. This is why the maxim "Save as many lives as possible" is often supplemented with the maxim "Save as many years of life as possible."[20] Three doctors who studied this question published a plea in the newspaper *Frankfurter Allgemeine Zeitung* that they wanted to "quantitatively assess as many of the results of triage decisions as possible." They constructed an anonymous "collective whole" to which a patient with a poor prognosis could be sacrificed if the ventilator to which he or she was already attached were given to a patient with a considerably better prognosis.[21] This is why the protocols of the Swiss Academy of Medical Sciences exclude the admission not only of patients over eighty-five but also of patients over seventy-five if

they have specific other comorbidities.[22] Additionally, the Austrian Association for Anesthesiology, Resuscitation, and Intensive Medicine grants the possibility of "terminating intensive care for a COVID-19 patient … when the supply of resources for treatment is considered as a whole" if that treatment then can be provided for another patient whose "outcome is expected to be better."[23]

The doctors who argued in the *Frankfurter Allgemeine Zeitung* that triage decisions should be viewed quantitatively want to derive "consequences for ethical concepts" from "numerical probabilities." That would mean the capitulation of ethics to statistics. They also accused the German Ethics Council of "contemptuously engaging with the concept of utilitarian thinking." They claimed that the Ethics Council cared only about individual cases and that it didn't think "the big number" worth mentioning; in fact, "utilitarian thinking" is what will save "our hides as a society and as a nation."[24]

There is a tendency, especially common among those in the medical profession, to look at triage ethics in a utilitarian manner. In response, we can say that people's lives must not be weighed against each other, neither from the perspective of maximizing the benefit to society nor from that of how long one might expect to live. Each life is equally valuable.[25] The German Constitutional Court underscored this in its decision regarding an aviation-safety law on February 15, 2006: It rejected as unconstitutional the action of authorizing a passenger airplane hijacked by terrorists to be shot down in order to protect people on the ground (e.g., in a filled soccer stadium) from a targeted, launching kamikaze attack. The court said that shooting the plane down cannot be reconciled with the right to life and the Basic Law's guarantee of human dignity as long as people on board the plane who were not involved in the act were impacted: "Human life and human dignity enjoy equal protection under the constitution, regardless of the duration of an individual person's physical existence."[26]

Third Misstep: Equating Triage *ex ante* and Triage *ex post*

When doctors, legal experts, and ethicists view things in a utilitarian manner, the distinction between triage *ex ante* and triage *ex post* is leveled out. According to four legal experts in the journal *Medstra*, there is "no categorical difference in the opposition between *ex ante* and *ex post*." They further state that "in the case of a patient with a 20 percent chance of survival who happens to be hooked up to an available ventilator, there is no constitutional or legal justification for *not* reconsidering continued treatment simply because removing that patient from the device would apparently be to actively act (and thus kill), if this meant that a newly admitted patient who also urgently needs treatment but has an 80 percent

chance of survival would die."[27] In response, we can say that the patient with the 20 percent chance of survival did not "happen" to be hooked up to the ventilator; rather, this was done because of medical indication and with trust in the doctors' concern for the patient's survival and in their commitment to follow the classical first principle of medical treatment: to do no harm to the patient. Subsequently removing the ventilator from a patient in favor of another patient with better odds of survival would be a breach of trust and not only "apparently" but genuinely "to actively act (and thus kill)." "If someone is being treated with a ventilator and still has a chance of survival, that person retains a claim to continued treatment, regardless of whether others might have been given priority if the device had not yet been assigned.… Taking the device away from someone with a chance of survival means actively killing that person, and this cannot be justified."[28]

Now, if the patient is in the process of dying, changing the goal of therapy by removing the ventilator and continuing with palliative care can be medically legitimate. As passive euthanasia, it also would be ethically legitimate.[29] Such a case can also become problematic when the motivation for turning off the ventilator is not the doctor's intent to no longer stand in the way of the dying patient, but rather when the motivation is to treat a waiting patient who has a prognosis of surviving longer. A case is similarly problematic when scarce resources are used to justify the recommendation to continually and critically review the goal of therapy.[30] The doctor's motive, then, is what determines whether removing a ventilator is legitimate. The competing claim of second patient must not play a role in terminating a patient's intensive care.[31]

The patient whose chances of survival are lower is not obligated to offer up his or her life for the patient with higher chances of survival. "Anyone who cannot be saved, because the only way to save him is not legitimate, becomes the victim of an evil fate," says Reinhard Merkel. "Anyone who is chosen to die for the benefit of another [becomes] the victim of killing. No legal system can accept this as a valid norm." It is "the prosecutable, textbook case of an unlawful killing when [medical personnel] intervene in a life-sustaining clinical procedure, with fatal results, in order to save another's life with the device that is now available."[32] The German Ethics Council, too, leaves no doubt about the illegality of a triage *ex post* in which an ongoing treatment that is still medically indicated is actively stopped for the purpose of providing ventilation for a third party. Like Reinhard Merkel, who cowrote the Ethics Council's recommendation, though, the Ethics Council does grant doctors a legal benefit of the doubt in borderline situations like this.[33] Doctors "can be wrong, but they are not criminals."[34]

Distinguishing between triage *ex ante* and triage *post ante* continues to be an essential component of the ethics of triage. Not only the German Ethics Council

and the German Conference of Bishops, but also a number of other papers, insist on this.[35]

Fourth Misstep: Equating Acting and Neglecting to Act

Those who challenge the distinction between triage *ex ante* and triage *post ante* usually justify their position by equating acting and neglecting to act, sometimes also arguing that guilt is inevitable. Equating acting and neglecting to act, or "not acting and terminating,"[36] according to Ulrich Schuler, Axel R. Heller, and Barbara Schubert, assumes that, from ethical and legal viewpoints, actively terminating life-sustaining ventilation is to be judged no differently from not providing ventilation in the first place. Allegedly, according to Elisa Hoven, it makes no difference whether a treatment "is not started or whether it is prematurely ended"[37]—both ways of euthanasia are "normatively of equal value,"[38] according to Bettina Schöne-Seifert. The doctor is just as obligated to the newly admitted patient as to the patient who already is being treated in the ICU. "In terms of the equal standing of the legal rights concerned," to Hoven there is "no reason, from a norms perspective, to demand that the person acting maintain a status quo (and one that violates legal rights) and to punish him or her for actively intervening."[39]

In an earlier version of her text, Hoven also wrote that there could be no doubt that refraining from doing something is always the lesser wrong compared to actively doing something. In response, we can say that refraining from ventilating due to the lack of a ventilator is not a lesser wrong but rather no wrong at all; removing a ventilator in spite of medical indication, resulting in death, on the other hand, is not to let someone die but rather to kill them—that is, it is to actively do something that must be refrained from. This obligation to refrain always takes priority over the obligation to even help the newly admitted patient. If the new patient can only be helped by a breach of law and of trust against the first patient, then one must refrain from helping thus. The obligation to refrain takes precedence over the obligation to act; it is not unconditional in the same way that the obligation to help is.

Therefore, in the context of the difficulties of triage, the distinction between acting and refraining from acting does not lose any of its normative character.[40] There is "fundamental difference" between refraining from ventilating in triage *ex ante* and refraining from continuing to ventilate in triage *ex post*.[41] If the moral quality of actions depended solely "on their suitability as means for achieving the goal of optimization," there would be no immoral actions *eo ipso*. The

saying "The ends justify the means," which long has been considered an expression of reprehensible convictions, would lose its reprehensibility.[42]

Fifth Misstep: Guilt Is Inevitable

The distinction between triage *ex ante* and triage *ex post* is also challenged in the position on triage taken by the bishop of Essen, Franz-Joseph Overbeck, and his coauthors. Although terminating intensive care in a triage situation is "rather difficult to justify … from a Christian viewpoint," there are "good reasons not to make a fundamental distinction between initiation triage and termination triage." The authors try to resolve this contradiction with the thesis that guilt is inevitable. There are "tragic decisions that—speaking from the Catholic tradition—are burdened with guilt," regardless of "whatever decision one makes in such situations." In response, we can say that there is no such thing as a compulsion to incur guilt. If a doctor cannot help a patient because he lacks the necessary resources or because these resources can only be secured by a breach of law and of trust, then he does not become guilty if he does not help. The impossibility of preventing all patients from dying in an emergency may cause pain, but it is not guilt as long as there are no deficiencies in the hospital planning or emergency services for which the doctor (as opposed to the owner of the hospital or emergency services) is responsible. The authors are clearly not quite comfortable with the thesis that guilt is inevitable. They claim that "the nature of such situations in which one must make a decision" defies "the norms of human morality"; it requires "a transcendental view," and for this reason "a conclusive value judgment cannot be formulated."[43] Surely a "transcendental view" is always recommended, but their suggestion here for a transcendental view comes across as an attempt to avoid the effort to employ reason.

The extent to which the episcopal position appeals to the "Catholic tradition" remains unclear. No documents are mentioned. The talk of the inevitability of guilt in a dilemma is more at home in Reformed theology or Greek tragedy. The Catholic Church has never shared the thesis that guilt is inevitable. Its response is found in the *Catechism*: "The circumstances, including the consequences, are secondary elements of a moral act. They contribute to increasing or diminishing the moral goodness or evil of human acts.… They also can diminish or increase the agent's responsibility.… Circumstances of themselves cannot change the moral quality of acts themselves; they can make neither good nor right an action that is in itself evil."[44] The "Catholic tradition" (i.e., the teaching of the Catholic Church) thus permits no doubt that removing a ventilator from a patient with a

shorter life expectancy in favor of one with a longer life expectancy would be to actively do something, hence to kill, and therefore an immoral act.

Notes

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1. Christine Arentz/Frank Wild, Vergleich europäischer Gesundheitssysteme in der Covid-19-Pandemie, WIP-Analyse 3/2020, Köln 2020, S.4.

2. COVID-19 is short for “coronavirus disease 2019.”

3. Deutsche Interdisziplinäre Vereinigung für Intensiv- und Notfallmedizin [German Interdisciplinary Association for Intensive and Emergency Medicine], “Entscheidungen über die Zuteilung von Ressourcen in der Notfall- und Inten-sivmedizin im Kontext der Covid-19-Pandemie, Klinisch-ethische Empfehlungen,” March 24, 2020, § 2.2 (hereafter “DIVI-Empfehlungen”). Cf. Thomas Heinemann, Ingo Proft, Stephan Sahm, and Eberhard Schockenhoff, “Covid-19: Ethische Empfehlungen über Beginn und Fortführung einer intensivmedizinischen Behandlung bei nicht ausreichenden Behandlungskapazitäten” (Vallendar, Germany: working draft, April 1, 2020), 29–30.

4. Reinhard Merkel and Steffen Augsberg, “Die Tragik der Triage: straf- und verfassungsrechtliche Grundlagen und Grenzen,” *JuristenZeitung* 75 (2020): 706.

5. Schweizerische Akademie der Medizinischen Wissenschaften [Swiss Academy of Medical Sciences], “Covid-19-Pandemie: Triage von intensivmedizinischen Behandlungen bei Ressourcenknappheit, Richtlinien,” March 24, 2020, as well as in the updated version of November 4, 2020, § 3; DIVI-Empfehlungen, § 2.2; cf. Heinemann, Proft, Sahm, and Schockenhoff., “COVID-19,” 30.

6. Der Deutsche Ethikrat [German Ethics Council], “Solidarität und Verantwortung in der Corona-Krise. Ad-hoc-Empfehlung,” March 27, 2020, 3.

7. Heinemann, Proft, Sahm, and Schockenhoff, “Covid-19,” 29. Stephan Ast reaches the same conclusion in “Quieta non movere? Ärztliche Auswahlkriterien sowie der Behandlungsabbruch im Fall einer Pflichtenkollision aus strafrechtlicher Sicht,” *Zeitschrift für internationale Strafrechtsdogmatik*, 6 (2020): 271—there is no conflict of obligations in this situation. Armin Engländer und Till Zimmermann, “‘Rettungstötungen’ in der Corona-Krise? Die Covid-19-Pandemie und die Zuteilung von Ressourcen in der Notfall- und Intensivmedizin,” *NJW* (2020), S. 1405, also

consider "keeping ventilators available" to be inadequate justification to get around the crime of negligent homicide.

8. Christiane Woopen argues that priority should be given to the rescuers: "Wenn die Ressourcen knapp werden, stellen sich existentielle Fragen," interview with *Spiegel-online*, March 19, 2020.

9. Jochen Taupitz, "Verteilung medizinischer Ressourcen in der Corona-Krise: Wer darf überleben?" *Zeitschrift für Medizinrecht* 38 (2020): 449.

10. Thus Thomas Ribi, "Triage für Kranke kann Gerecht sein," *Neue Zürcher Zeitung*, November 19, 2020, 14.

11. Udo di Fabio, "An den Grenzen der Verfassung," *Frankfurter Allgemeine Zeitung*, April 6, 2020, 7; Josef Isensee, "Virokratie," *Frankfurter Allgemeine Zeitung*, June 4, 2020, 7; Jürgen Habermas and Klaus Günther, "Lebensschutz oder Freiheit," *Die Zeit*, May 7, 2020, 43–44. On the public-health measures to contain the coronavirus pandemic as well as returning society to normal, cf. the three ad hoc statements released by the Leopoldina National Academy of Sciences on March 21, April 3, and April 13, 2020.

12. Deutscher Ethikrat, "Solidarität und Verantwortung," 2. A similar argument is made in the paper of the Deutsche Bischofskonferenz [German Council of Bishops], "Triage: Medizinische Allokationsprobleme angesichts der Covid-19-Pandemie in ethischer Beurteilung," April 8, 2020, § 6. Cf. Katja Gelinski, "Was regeln in einem Triage-Gesetz? Zur Zuteilung von Überlebenschancen bei unzureichenden medizinischen Ressourcen" (working paper of the Konrad Adenauer Foundation, April 21, 2020), 5–6; Heinemann, Proft, Sahm, and Schockenhoff, "Covid-19," 14, 17, 35; and Merkel and Augsberg, "Tragik der Triage," 705.

13. Schweizerische Akademie der Medizinische Wissenschaften, "Covid-19-Pandemie," § 4.3. Cf. Bettina Schöne-Seifert, "Wen soll man leben lassen?," *Frankfurter Allgemeine Zeitung*, March 31, 2020, 11.

14. Elisa Hoven, "Die 'Triage'-Situation als Herausforderung für die Strafrechtswissenschaft," *JuristenZeitung* 75 (September 2020): 451.

15. Bettina Schöne-Seifert and Hugo van Aken, "Worauf es jetzt ankommt: Der Tod an einer Lungenentzündung in hohem Alter muss nicht in jedem Fall bekämpft werden," *Frankfurter Allgemeine Zeitung*, April 14, 2020, 11.

16. "Stellungnahme zu Entscheidungen über die Verteilung notfall- und intensivmedizinischer Ressourcen in der Corona-Krise des Bischofs von Essen, des Rates für Gesundheit und Medizinethik des Bistum Essen und der Katholischen Akademie Die Wolfsburg," April 6, 2020, § 2.

17. Schöne-Seifer and van Aken, “Worauf es jetzt ankommt,” 11.
18. “COVID-19 Toolkit,” Compassion & Choices, https://compassionandchoices.org/end-of-life-planning/covid-19-toolkit/; “COVID-19 Advanced Directive Addendum: Documenting Your Preferences,” Compassion & Choices, https://compasion andchoices.org/wp-content/uploads/COVID-19-Addendum.pdf.
19. Nancy Valko, “The Assisted Suicide Lobby Is Taking Advantage of the Pandemic,” *MercatorNet*, June 11, 2020, https://mercatornet. comthe- assisted-suicide -lobby-is-taking-advantage-of-the-pandemic/63689/.
20. Hoven, “Die ‘Triage’-Situation,” 452.
21. Ulrich Schuler, Axel R. Heller, and Barbara Schubert, “Rückhalt für die Ärzte: Wie weit ist leben und sterben lassen auf der Intensivstation eine Frage des Rechts? Drei Kliniker skizzieren, wie Katastrophen zu minimieren sind,” *Frankfurter Allgemeine Zeitung*, April 15, 2020, N2.
22. Schweizerische Akademie der Medizinischen Wissenschaften, “Covid-19-Pandemie,” § 4.3.
23. Österreichische Gesellschaft für Anästhesiologie, Reanimation und Intensivtherapie [Austrian Association for Anesthesiology, Resuscitation, and Intensive Medicine], “Allokation intensivmedizinischer Ressourcen aus Anlass der Covid-19-Pandemie, Klinisch-ethische Empfehlungen,” March 17, 2020, § 6.
24. Schuler, Heller, and Schubert, “Rückhalt für die Ärzte,” N2.
25. Deutsche Bischofskonferenz, “Triage,” § 6; Konstantin Kuchenbauer, “Irrweg Utilitarismus: Das Triage-Problem und die Würde des Menschen,” *Zeitschrift für Lebensrecht* 29., no. 4 (2020).
26. Decisions of the Federal Constitutional Court (BVerfGE), 115 (2005–2006), 118 (2007–2008), available at https://www.bundesverfassungsgericht.de/DE/Entscheidungen/Liste/110ff/liste_node.html;jsessionid=53B158E01A5B80CE9D7B22676726CE7A.1_cid377. 115, 118.
27. Karsten Gaede, Michael Kubiciel, Frank Saliger, and Michael Tsambikakis, “Rechtmäßiges Handeln in der dilemmatischen Triage-Entscheidungssituation,” *medstra-statement* (March 2020), 135.
28. Tonio Walter, “Menschlichkeit oder Darwinismus? Zu Triage-Regeln und ihren Gründen,” *Goltdammers Archiv für Strafrecht*, 2020, 457f.
29. Manfred Spieker, “Sterbehilfe? Selbstbestimmung und Selbsthingabe am Lebensende: Eine katholische Perspektive,” in *Was heißt: In Würde sterben?*, ed. Thomas Sören Hoffmann and Marcus Knaup (Wiesbaden, 2015), 215–45.
30. DIVI-Empfehlungen, § 3.2.2.

31. Deutsche Bischofskonferenz, "Triage," § 7; Heinemann, Proft, Sahm, and Schokenhoff, "Covid-19," 32, 39; Peter Schallenberg, "Freiheit, Recht, 'triage' in Zeiten von Corona," *Kirche und Gesellschaft* 469 (2020), 9–10. Schallenberg's argument is questionable, however, when he further says that doctors may end life-sustaining measures when the patient is dying so that these may be administered to a second person who is not dying, if the doctors see no likelihood of the dying patient surviving "long enough." Who wants to draw the line between a survival that is "long enough" and one that is "short enough"?

32. Reinhard Merkel, "Eine Frage von Recht und Ethik," *Frankfurter Allgemeine Zeitung*, April 4, 2020, 11–32. Similarly, see Gelinsky, "Was regeln in einem Triage-Gesetz?," 9; Margaret Sommerville, "Thinking Through the Ethical Challenges of Covid-19," *MercatorNet*, May 6, 2020, https://mercatornet.com/thinking-through-the-ethical-challenges-of-covid-19/62589/.

33. Deutscher Ethikrat, "Solidarität und Verantwortung," 3.

34. Merkel, "Eine Frage von Recht und Ethik," 13.

35. Deutscher Ethikrat, "Solidarität und Verantwortung," 3; Deutsche Bischofskonferenz, "Triage," § 7; Heinemann, Proft, Sahm, and Schockenhoff, "Covid-19," 26; Gelinsky, "Was regeln in einem Triage-Gesetz?," 7; Engländer and Zimmermann, "'Rettungstötungen' in der Corona-Krise," 7.

36. Schuler, Heller, and Schubert, "Rückhalt für die Ärzte," N2.

37. Elisa Hoven, "Es ist ein Unterschied, ob ein 90-Jähriger oder eine 19-Jährige stirbt," *Frankfurter Allgemeine Zeitung-Einspruch* (March 31, 2020); also Gaede, Kubiciel, Saliger, and Tsambikakis, "Rechtmäßiges Handeln," 134–35.

38. Schöne-Seifert, "Wen soll man leben lassen?," 11.

39. Hoven, "Die 'Triage'-Situation," 453. According to Ast, if the doctor terminates ventilation, thus refraining from providing ventilation that is still necessary, this is "to be considered factually an act of neglect." Ast, "Quieta non movere?," 272. Taupitz also believes that ending treatment "in order to save as many as possible in a triage situation is … equivalent to legally permissible neglect." Taupitz, "Verteilung medizinischer Ressourcen in der Corona-Krise," 447.

40. Gelinsky, "Was regeln in einem Triage-Gesetz?" 8–9.

41. Merkel and Augsberg, "Die Tragik der Triage," 711.

42. Robert Spaemann, *Glück und Wohlwollen: Versuch* über *Ethik* (Stuttgart, 1989), 164–65. Cf. *Catechism of the Catholic Church* (Citta del Vaticano: Libreria Editrice Vaticana, 1993), § 1753, https://www.vatican.va/archive/ENG0015/__P5R.HTM.

43. "Stellungnahme zu Entscheidungen über die Verteilung notfall- und intensivmedizinischer Ressourcen in der Corona-Krise des Bischofs von Essen, des Rates für Gesundheit und Medizinethik des Bistum Essen und der Katholischen Akademie Die Wolfsburg," April 6, 2020, § 5. From the same moral-theological perspective, cf. Jochen Sautermeister, "Ultima Ratio: Triage bei Covid-19-Patienten," *Herder-Korrespondenz* 74, no. 5 (2020): 40. Cf. also the journal of the Catholic academy Die Wolfsburg, *Akademie-Akzente* (February 2020): 4, which asserts that decisions for ending intensive care "deserve the highest respect and are not subject to any moral evaluation."

44. *Catechism of the Catholic Church*, § 1754.