

CONTRIBUTIONS FROM THE CATHOLIC ETHICAL TRADITION IN TIME OF PANDEMIC

Rev Joseph Parkinson



CATHOLIC HEALTH
Australia

Caregivers in Catholic health and aged care services have been challenged to review and potentially modify normal clinical practice in the face of the COVID-19 pandemic. In this article I reflect on some differences between the 'normal' context of care and a 'crisis' situation requiring practice of triage, and explore how the Catholic ethical tradition (including moral theology, bioethics and social ethics) continues to provide guidance in such a 'crisis' situation. The aim is to help care givers adjust to these new challenges while preserving their commitment to Catholic ethical principles.

PANDEMIC: FROM 'NORMAL' TO 'CRISIS' MODE

Catholic bioethical principles are predicated on a 'normal' model of care in which the primary focus of a medical relationship is the health of the individual patient. This reflects the historical origins of bioethics in the West, as well as the Christian principle of the dignity of every human being.¹

In this model the patient's role in decision-making is to request and consent (or not) to treatment: the patient is offered a menu of treatment options, from which he/she may choose or refuse one or all.

The goal of clinical practice in this model of care is the best health outcome for the individual patient.

Respect for the dignity of the patient is promoted by his/her active engagement in the decision-making process even in the event of losing legal competence. Today's 'Goals of Care' documents and statutory instruments for appointing Enduring Guardians are more than simply mechanisms for resolving issues in end-of-life care.

Behind this model – from a system perspective – lies an assumption that there is a manageable number of patient presentations and adequate resources (including consumable, capacity, personnel and financial resources) to achieve the goals of care. This will be the case in most instances of medical care in a wealthy western country like Australia.

A major practical challenge in the pandemic setting, however, is that medical staff may tend to continue to work according to the 'normal' model when in fact the assumptions underlying it no longer apply: the number of presentations increases dramatically, patients present with a highly contagious infection complicating often complex comorbidities, and both of these create time pressures and therefore increase stress on unchanged personnel, consumable, and capacity resources.²

Clinical practice must shift gears to adjust to this new urgency without abandoning the ethical foundations of health care provision. For example in a pandemic environment Goals-of-Care instruments and the like are likely to assume even greater importance in sometimes urgent end-of-life decision-making. And in the use of triage, setting the goals of clinical practice must expand to take greater account of at least another two related factors: the public health dimensions of care, and practical challenges around best use of scarce health care resources. The challenge might be summarised as: how to provide the best care for each patient and for the greatest number of patients while minimising the risk of inefficiencies in the disposition of personnel, material or financial resources.²

For the Catholic health or aged care provider, this translates as: how do we maintain our traditional ethic of care in a radically changed operating environment?

¹ For an account of the origins of health care as a Christian ministry: <https://www.thetablet.co.uk/features/2/17880/how-the-sick-became-precious>

² I resist here the common formulation 'the greatest good for the greatest number' which in my view does not focus adequately on the legitimate needs of both the individual and the wider community. In the Catholic ethical tradition appropriate attention must always be paid to both, as discussed below.



A CATHOLIC VISION OF THE HUMAN PERSON IN TIME OF TRIAGE

A great deal of current commentary around both of these issues has focused on ethical principles to guide prioritising one patient over another.³ The underlying assumption seems to be that patients are individual entities in competition with one another for those resources, and so some kind of ethical calculus must be undertaken to choose which patient shall take priority.

Such conflicts inevitably arise in the radically autonomous view of the human person that underpins most of secular western medical ethics.

This emerged in its most well-known form from the United States of America of the late 1970s, a time when popular rhetoric in that country was preoccupied with asserting the rights of individuals over against the institutions of the state: think protests against the Vietnam war, think Watergate.⁴ The famous 'four pillars' of bioethics (autonomy, beneficence, non-maleficence, justice) naturally came to be dominated not just by autonomy, but by the particular American version of autonomy in which the rights of the individual too easily morph into moral absolutes to be defended absolutely over against the claims of other individuals or of social institutions.⁵

The Catholic ethical tradition, on the other hand, always sees every human being as an individual member of a larger social body or 'common whole' for whom the greatest possibilities of individual flourishing exist only when optimum conditions for flourishing of the 'common whole' also exist.⁶ This truth lies at the heart of all Catholic theologies of the human person: we are created in relationships, and for relationships, and only in our relational nature do we find the real meaning of human autonomy. It is a view not of radical but of relational autonomy, captured succinctly by Pope Benedict XVI:



³ See for example Swiss Academy of Medical Sciences (2020), 'COVID-19 pandemic: triage for intensive care treatment under resource scarcity.' Swiss Med Weekly. 2020;150:w20229. Online at <https://www.ncbi.nlm.nih.gov/pubmed/32208495> ; Sydney Health Ethics (2020), An Ethics Framework for Making Resource Allocation Decisions within Clinical Care: Responding to COVID 19. Version 1. Online at <https://www.sydney.edu.au/content/dam/corporate/documents/faculty-of-medicine-and-health/research/centres-institutes-groups/she.-clinical-ethics.-resource-allocation-framework.-version-1.-2-april-2020.pdf>

⁴ Numerous authors have commented on the significance of bioethics' modern origins in the United States of America in the last quarter of the Twentieth Century, among them Daniel Callahan, *The Roots of Bioethics* (New York: OUP 2012); Albert R Jonsen, *The Birth of Bioethics* (New York: OUP 1998); and Jennifer K Walter and Eran P Klein, eds., *The Story of Bioethics* (Washington: Georgetown University Press 2003).

⁵ Tom L Beauchamp and James F Childress recognise the challenges of an overly individualistic notion of autonomy and evidence considerable development in their thinking between the earlier and later editions (1979-2013) of their monumental *Principles of Biomedical Ethics*. Another thoughtful reflection is Regine Kather, "Autonomy: as Self-determination against, or as Self-transcendence to Others? Anthropological Reflections on the Background of Bioethics" in Bogdan Olaru (ed), *Autonomy, Responsibility, and Health Care: Critical Reflections*. (Bucharest: Zeta Books 2008).

⁶ This formulation protects both of the central tenets of the Catholic social tradition: the dignity of the human person (considering the good of the human person as an individual being) and the common good (considering the good of human society, or the human person as a social being).

[A human being] is not a 'monad', an isolated being who lives only for himself and must have life for himself alone. On the contrary we live with others, we were created with others and only in being with others, in giving ourselves to others, do we find life.⁷

In this perspective questions about allocation of scarce health resources are not well conceived if one person's needs are set 'over against' another's needs. In the Catholic ethical view, and in the setting of a pandemic in which there may be many future infections, each patient's individual needs have to be viewed in the context of the (likely) needs of the whole population. This ensures an appropriately balanced focus on the health needs of the individual patient as he or she really is: an individual member of a larger community whose health needs must also be kept in mind. The notion of 'relational autonomy' is a more solid ethical foundation for the practice of triage.



THE PRACTICE OF TRIAGE

The principles of triage were developed to manage large numbers of sudden casualties in time of war or other disaster.⁸ Triage requires rapid and accurate assessment of patients according to the likely achievable effect of treatment for the individual in the context of the needs of the total population of injured or infected persons, and in the face of limited resources (bearing in mind that 'limited available resources' is a natural corollary of 'sudden high demand').

Typically in trauma events patients are 'triaged' into various categories:⁹

1. requiring immediate care ('treat right now'), or
2. able to await delayed care ('treat as soon as the patient's condition deteriorates or resources become available'), or
3. requiring minimal care ('able to wait longer for treatment'), or
4. too compromised to receive any effective care ('unable to be helped in these circumstances'), or
5. deceased.

Successful implementation of the triage process requires a conscious and intentional switch of mindset, from 'the most effective intervention in view of the needs of the individual alone', to 'the most effective intervention for this patient considered in context of the likely needs of the total affected population'. Successful triage in a pandemic setting depends on very rapid simultaneous assessment of both individual and community health needs.

The legitimate aim of triage decision-making is to optimise all actually available resources to achieve the best outcome for both individual patients and for as many people as possible, which may lead to some unfamiliar and unwelcome outcomes. Sometimes, perhaps because of time pressures, patients may be over or under treated ('under-triaged' or 'over-triaged' respectively).¹⁰

This means that in rare cases a patient in the 'crisis model' may not receive the same level of care he/she would have received under the 'normal model'. Both of these possibilities increase the likelihood that care givers will experience elevated levels of moral stress, and even grief, at their inability under extreme pressure to provide 'care as usual'.

⁷ Benedict XVI, Homily in Rome's Prison for Minors 'Casale del Marmo'. 18 March 2007.

⁸ For a good summary of the way triage works in the trauma situation, see E R Frykberg, Triage: Principles and Practice. Online at <https://journals.sagepub.com/doi/pdf/10.1177/145749690509400405>

⁹ See Frykberg, 273-274.

¹⁰ These are discussed in Frykberg at 274ff.

These are not desirable outcomes, but they may be unavoidable. Deleterious effects on caregivers are an additional ethical concern for provider organisations, who will need to provide additional support for care givers at all levels.

Triage requires the best use of scarce medical resources. What specific guidance can we find among Catholic bioethical principles, specifically in the Code of Ethical Standards for Catholic Health and Aged Care 2001?¹¹

A CATHOLIC ETHICAL PRINCIPLE TO ASSIST TRIAGE

Catholic bioethical principles, too, have been shaped against the backdrop of the 'normal' model of clinical practice: the concepts of care and compassion, fair access to treatment, and distribution of resources have all been framed in order to guide normal models of care in 'normal' situations.

One important operative principle is the Principle of the Morally Disproportionate Means of Medical Treatment.¹² Also called the Principle of Ordinary and Extraordinary Means [POEM], this establishes three conditions under which a patient might judge a proposed treatment to be morally disproportionate and so ethically refuse to accept it (or have it withdrawn):

- The treatment is not likely to be reasonably therapeutically beneficial; or
- it is not reasonably available; or
- it is likely, in the patient's view, to impose an unreasonable burden.

The principle addresses the patient's ethical right to refusal or withdrawal of treatment, it does not establish a right to demand a treatment. In this way it avoids some of the conflictual potential inherent in the radical model of autonomy.

However note also that while it is framed in terms of the patient's ethical right, POEM can also inform the physician's decisions: the doctor may decide not to offer a particular treatment option because (for example) it would not seem to offer this patient sufficient therapeutic benefit, or because it would be likely to impose too high an economic burden on the patient.¹³

For the clinician or medical facility, then, POEM could be conceived as a three-step framework capable of grounding triage decisions on a more or less objective basis: under triage conditions, treatments should not be offered if they are likely to fail any one of these conditions, and should only be offered if they are likely to meet all three of these conditions.

Importantly the Code indicates that assessment of 'unreasonable burden', while primarily focused on burdens for the patient, can extend to consideration of burdens which the proposed treatment may impose upon others:

The burdens of treatment to be properly taken into account may include pain, discomfort, loss of lucidity, breathlessness, extreme agitation, alienation, repugnance and cost to the patient. In some cases, the burdens of treatment may also include excessive demands on family, carers or healthcare resources.¹⁴

So the Catholic ethical tradition, even operating in 'normal mode', accepts that the third condition could apply if the treatment constitutes an 'unreasonable burden' on the patient's family or available healthcare resources. In referencing the good of persons other than the patient, and with an explicit eye on resource use, this condition allows the assessment of burden to include the likely needs of the wider population.

¹¹ Catholic Health Australia, Canberra, 2001.

¹² Code 1.13-1.14 & 5.9-5.18.

¹³ The Code appears to encompass this possibility in 5.16.

¹⁴ Code 1.14.

In practical terms, this suggests that the conditions for POEM in time of pandemic could be used in a sequential and cumulative manner, each condition constituting a 'hurdle' to be passed before the next condition is considered. In the following example, a COVID-19 patient is being assessed to receive aggressive intervention such as mechanical ventilation.

- The first condition 'not reasonably therapeutically beneficial' should always be grounded in the immediate condition of the individual patient. If in view of the patient's complex condition and comorbidities it seems that mechanical ventilation would not be therapeutically beneficial – that is, it would not make an appreciable difference to the patient's health outcome – then the patient might be prioritised for other kinds of care (eg non-invasive ventilation support or bipap) or for 'standard' and palliative care while undergoing regular reassessment. However, if ventilation for this patient promises to be therapeutically beneficial, we move to the second condition.
- 'Not reasonably available' would obviously apply when medical and personnel resources are unavailable due to high demand during the pandemic crisis. No-one can be bound to do that which is impossible, including conjuring up resources where none exist. However, if mechanical ventilation and the required personnel support are available, we move to the third condition.
- The concept of an 'unreasonable burden' should be assessed against the needs of the individual and of the wider community. Next to assessment of immediate burden on the patient, what capacity to cope does the patient, their family or health system have if the patient were to survive only with a very poor prognosis and likely to require ongoing or repeated aggressive intervention? At what point does a treatment outcome cease to be 'saving life' and become 'delaying death'? If the burden on the patient, their family, health carers, or healthcare resources is considered too great, the patient could instead be prioritised for standard and palliative care.

The principle of triage is a process driven primarily by clinical concerns, namely foreseeable benefits and treatment availability in view of foreseeable burdens. Non-medical criteria such as age, race, religion, wealth or social position should never apply to this assessment, except as one or other factor might contribute to better or worse therapeutic outcomes. Justice in delivering healthcare begins with affirming the dignity of every individual person and should always proceed on clinical grounds alone.¹⁵

NEGOTIATING THE CASUS PERPLEXUS

A careful clinical focus on actual or foreseeable benefits and burdens will in most cases obviate any need for a 'one patient v another' calculus. When, for example, two or more patients present but only one ventilator is available, it is obvious that the treatment would best be applied where it will have greatest therapeutic benefit while imposing the lowest burden (considered in its wide sense).

But what happens when estimates of therapeutic benefit and patient burden are more or less equal between two or more candidates for treatment, and resources are severely limited? How should we decide which patient to treat immediately (triage level 1) and which patient to waitlist for treatment as resources become available (triage level 2)? When delaying treatment might compromise its chance of success, a time-constrained decision-making process is especially fraught for the clinical teams involved.

The Catholic ethical tradition has long recognised the casus perplexus, the true moral dilemma or 'perplexed case'.¹⁵ On rare occasions an ethical (or medical) decision will present as a genuine dilemma, a complex problem for which there is simply no unequivocally 'right' answer: the choice appears to reduce to either one bad outcome or another equally bad outcome.

¹⁵ Code 1.15: "It is consistent with the principle of the sanctity of human life to recognize that the burdens a life-sustaining treatment may impose on a patient may be such as to make it permissible to omit that treatment."

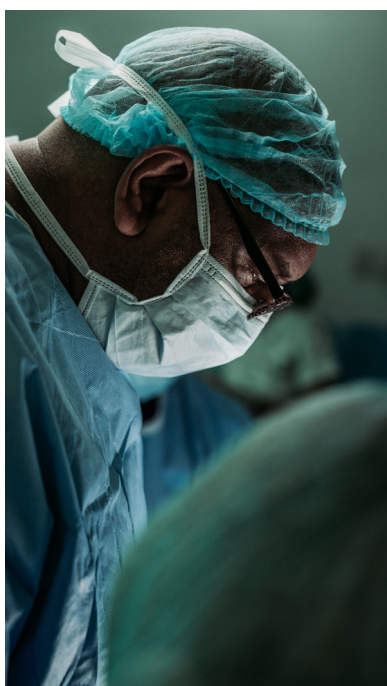
¹⁶ See for example Alfonsus Liguori, *Theologia moralis*, L.1, T.1, C.1, 10; reflected in numerous other manuals including Henry Davis SJ (1959), *Moral and Pastoral Theology* Vol.1, 72.

Academics may debate in the abstract whether a genuine moral dilemma ever really arises, but practicing clinicians and ethicists know that some cases certainly present this way, often due to an unavoidable lack of information necessary to resolve the impasse.

Faced with such a dilemma, what is one to do? First it is important to determine that there are no obvious 'right' or 'good' options: the only achievable outcomes will be bad. Secondly, to choose to do nothing is itself a moral choice, so one cannot escape moral responsibility for what results if one opts to delay or suspend making a choice at all. Thirdly, if one outcome is obviously 'less bad' than the others it should be favoured, since it would be absurd to suggest that one should bring about more rather than less harm.¹⁷

But in the case in question the various options are equally balanced – it is impossible to prioritise one patient over the other on the basis of benefits/burdens – so how should one proceed? The patron saint of moral theologians, Alphonsus Liguori, held that if one is unable to determine which option represents the lesser evil, one may choose either option without incurring formal moral fault.¹⁸

A necessary first step is to recognise a true dilemma when it arises, and to accept that since a choice must be made, the best one can achieve may be to choose – and be seen to choose – as reasonably and objectively as possible. 'Reasonably' here simply means 'ethically defensible' or 'grounded in reason' and able to withstand external scrutiny, recognizing that sometimes other options may be equally ethically defensible. In other words, when there is no obvious good outcome to choose and the only options seem equally bad, at least the process of choosing must be impeccable. The Code offers some guidance on two points.



In the first place, respect for the dignity of every human being demands that we must never enter into a 'measuring of worth' of one person over against another, because all persons are of equal and inestimable value.¹⁹ Treatment decisions, even in triage situations, must be driven *prima facie* by clinical indications alone, even if the ability to enact those decisions is restricted by limited resources.

In view of limited resources it may be helpful to recall that although one may desire to provide a wide range of care to the patient, practical circumstances may limit that range considerably. In that case it is important to remain focused not on the hypothetical breadth of good one would like to achieve but cannot, but rather on the actual good one can achieve. This is sometimes expressed as, 'focus on the good you can do, not the good you can't.' Fretting over unrealisable options is a classic sign of moral distress. Focusing on the good one can actually achieve is an exercise of prudence, the moral virtue which enables one to determine the most appropriate achievable good. If nothing else this preserves one's psychic energy for dealing with present and future moral distress.

¹⁷ These conditions taken together are sometimes referred to as the 'principle of the lesser evil', a not uncontroversial question in the history of moral theology. Richard McCormick SJ, *Notes on Moral Theology 1965 through 1980* (University Press of America, 1981), at 235, hints that much of the historical controversy revolves around an incapacity to distinguish between the objective and subjective dimensions of moral choices. This view was endorsed by the then Cardinal Joseph Ratzinger (later Pope Benedict XVI) writing as Prefect of the Sacred Congregation for the Doctrine of the Faith: "This subjective situation, while it can never change into something ordered that which is intrinsically disordered, may to a greater or lesser extent modify the responsibility of the person who is acting." SCDF, Note regarding 'The moral norm of 'Humanae vitae' and pastoral duty' 16 February 1989. Online at https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19890216_norma-morale_en.html

¹⁸ *Theologia moralis*, loc. cit. "Without incurring formal moral fault" is significant: the fact that one chooses one option over another does not in itself make that option objectively good – unavoidably the object chosen remains (objectively or materially) bad, even if the process of choosing is (subjectively or formally) faultless.

¹⁹ Code 1.15: 'It is not consistent with the principle of the sanctity of human life to claim that the value or worth of the life of one human being can be measured, or compared with that of another, or to claim that the value or worth of a human life can in any way be reduced by illness or disability.'

Secondly, the process of decision-making must always be transparent. It is especially important that family members and those providing care most directly to the patient are kept well informed.²⁰ Both the decision-making process and the task of communication may be assisted by a clinical ethics consultant if one is available, noting that the ethicist's task is not to replace the clinician's decision but to help ensure that the process of decision-making is as robust as possible in the circumstances. The demands of transparency and accountability also require that accurate notes should be kept on the patient's medical record.²¹

MANAGING THE RISK OF INFECTION

Experience in the COVID-19 pandemic has shown the value of managing the risk of infection by imposing strict visitor regimens in acute and aged care facilities. Some of these restrictions may not sit comfortably in the 'normal' mode of care, but they can be supported in the Catholic ethical tradition.

Both acute and aged care service providers routinely welcome regular and prolonged family contact for patients or residents who are seriously ill or imminently dying. However, when the patient has a highly infectious disease – one requiring mandatory use of personal protective equipment (PPE) and other barrier nursing measures – family members may naturally be distressed to learn that they cannot visit or touch the person. This is especially difficult when death is imminent, and family members – especially younger children – want to 'say goodbye'.²²

Viewed through the lens of 'radical autonomy' any restriction placed on visitors looks like an infringement on the rights of both patient and visitor. However, the perspective of 'relational autonomy' presents another view: since every person is not only individual but relational in nature, we have to pay equal attention to the relational, social or community implications of our moral choices. When the risk of infection carries very serious consequences, the need to reduce that risk assumes a more urgent character. Even younger visitors with lower personal risk of contracting the infection can carry it out of the hospital environment and into the community. In this instance, concern for community health is a natural extension of our traditional Catholic ethic of care for the human person in all his/her dimensions and must be given priority.



Some care providers may be able to make other arrangements for families, such as creating dedicated spaces for families and patients to interact, or the use of electronic or online platforms to enable 'virtual' visits. More creative pastoral care options may also be possible without elevating risks to care givers, to family or friends of the infected patient, or indeed to the wider community.

Likewise, aged care facilities may institute restrictions to normal visiting rules for all residents, such as allowing visits by only one or two persons in each resident's room. Finding the right balance between the 'infection control' value of these restrictions and their psychological effect on residents is a challenge, but their very institution can be seen as an application of our traditional ethic of care.²³

²⁰ Code 1:3, 5:17.

²¹ Code 5:18-5:19.

²² For a very sobering account of the dilemma facing clinicians, see https://www.nejm.org/doi/full/10.1056/NEJMp2007781?query=featured_coronavirus

²³ In a community-wide response to pandemic Catholic health and aged care providers may find themselves required to collaborate closely with other, non-Catholic organisations to deliver the most effective and consistent continuum of care across the community as a whole. Sponsor organisations can take comfort that this kind of collaboration will rarely if ever touch upon practices to which the Catholic tradition raises ethical objections, and so traditional difficulties with 'material and formal cooperation' are unlikely to arise.



CARING FOR THOSE WHO CARE

Good care of caregivers will include creating opportunities for them to talk about how they feel entering what is, for most, totally new terrain. A willingness to invest in sustained care for caregivers should be a hallmark of all Catholic health and aged care providers.

Care givers facing pandemic conditions are likely to experience higher than usual levels of stress, uncertainty, and fear – not only the fear of infection, but also the fear of making clinical errors under pressure. Some of these concerns can be mitigated only by increasing resources, for example ensuring a sufficient supply of consumable PPE. Other concerns are more difficult to address, but the Catholic tradition of social ethics promotes several important values of great relevance to these circumstances.

The principle of **participation** calls for open and transparent communication and conversation among all levels of care givers as they prepare to face the pandemic, which recognises the respective contributions each can make to the overall organisational response. On a less formal level, participation of this kind also serves as a 'release valve' for staff to express their concerns and for management to respond appropriately.

The corollary principle of **subsidiarity** ensures that clinical concerns are addressed as and where they arise. For example, triage decisions are made by those clinicians (often ICU consultants) who have the best experience in managing life-threatening situations. The role of a clinical ethicist at this point is not to supplant the clinician but to help the processes of decision-making to be as transparent and ethically defensible as possible. As time constraints and clinical complexity make treatment decisions more challenging, providing access to ethics consultants is one way that health and aged care organisations can support those who bear the brunt of making and enacting those decisions.

The added professional and personal stress of a pandemic crisis is likely to increase the risk of error in clinical decision-making and treatment delivery – as noted previously, this tends to be a feature of urgent triage situations. The principle of **solidarity** will inspire health and aged care organisations to reassure all care givers that they will be supported even if clinical errors do occur. This doesn't represent a lowering of clinical standards, but rather an exercise of justice and compassionate care for care givers working under extreme pressure.

Care givers also need to look after one another through these critical times. In a sense every day will need to be "R.U.O.K." day.

Finally, it is to be expected that the rigours of working through a pandemic crisis will have ongoing psychological repercussions for care givers for months or even years to come. Employee Assistance Programs have their place here, but in themselves cannot substitute for a health or aged care organisation intentionally deepening its ongoing culture of care for care givers likely to be affected by the pandemic.



The principle of solidarity, the need to 'stand with' others, is grounded in compassion. 'Sympathy' refers to an ability to 'feel for' someone else in need, and 'empathy' denotes a capacity to 'feel along with' the other, both words of Greek origin. 'Compassion' on the other hand is derived from Latin words meaning 'to suffer with' the other: not merely a willingness to serve the other and then walk away, but a willingness to enter into the other's experience and 'suffer with' the other very deeply, including a willingness to grieve with the other their loss of health or relationships or even life itself.

Entering another's grief is very much more demanding than merely 'feeling sorry' for them, but it is also the point at which we connect with the other in the depths of our common humanity. That depth of connection may seem to threaten the care giver's own wellbeing, but it also holds the promise of profoundly healing both the patient and the care giver because it connects them at the point where healing is most needed – a point that medicine alone cannot reach. Compassion also includes our willingness not only to regret but genuinely to grieve our inability to do more, which becomes a driver within us to keep striving for improvement.

Good forward planning and high levels of community support for mitigation measures go a long way to managing the individual and community health risks of pandemics such as the COVID-19 crisis, and in the best of worlds they greatly help to reduce pressure on susceptible individuals, health systems and care givers. The Catholic ethical tradition, read through the lens of such a pandemic, has much to offer our health and aged care systems in such challenging times.

Fr Joseph Parkinson STL PhD is a priest of the Archdiocese of Perth, Western Australia. Since 2003 he has been Director of the LJ Goody Bioethics Centre and an ethics consultant to Catholic and State health care providers in WA.

