An Opportunity to Re-Think Healthcare Ethics: Commentary on the PAV's *Global Pandemic & Universal Brotherhood*

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Introduction

'All humanity is being put to the test' says the Vatican's bioethics think-tank, the Pontifical Academy for Life (PAV), in *Global Pandemic and Universal Brotherhood: Note on the Covid-19 Emergency*. **[1]** 'The COVID-19 pandemic puts us in a situation of unprecedented, dramatic and global difficulty', threatens to destabilise our life-plans and 'calls into question aspects of our way of life that we have been taking for granted'. **[2]**

Yet such 'existential destabilisation' **[3]** or disruption is an opportunity for retreat, reflection, conversion and witness. The PAV Note does not pretend to be an exhaustive contribution to the bioethics of emergency. **[4]** Rather, it offers some reflections about four questions in particular:

- In the face of pandemic, how are we to think of human persons: as powerful, autonomous agents or as free but vulnerable and needy beings?
- In the face of pandemic, how are we to think of the human community: as an arena of threat and security or as a place for giving and receiving in solidarity?
- In the face of pandemic, how are we to think of healthcare: with technocratic thinking or a more 'humanistic' ethic?
- In the face of pandemic, how are we to act: dismissal of the problem like some populists, the 'panic porn' of the media or the self-protective behaviour of panic-buyers, or with the Christian witness of charity and prayer?

In what follows, I will therefore seek to interrogate and build upon the document's thoughts on these four matters.

1) Human Beings in a Pandemic: Agency or Need?

Global Pandemic and Universal Brotherhood notes that modernity is marked by a 'technological and managerial euphoria' that inclines us to the self-deception 'that we are invulnerable or that we can find a technical solution for everything' **[5]**. This left us physically, culturally and politically ill-prepared for the present pandemic. Yet, try as we might to resist it, we bump up against 'the precariousness that radically characterises our human condition', 'the limits of our understanding' and the painful realisation that we are not entirely 'masters of our own fate'. **[6]**

Related to the myth of invulnerability is modernity's valuing of people only for their agency or self-sufficiency. The authors of the PAV Note **[7]** join Alasdair MacIntyre, Stanley Hauerwas and others who have long challenged liberalism's view of the human person as a self-sufficient, powerful agent, proposing instead that we are free but

vulnerable beings, always needing help from others, and sometimes very dependent indeed. **[8]**

The turn of contemporary medicine away from thinking of the patient as a passive sufferer of disease and recipient of treatment to a consumer of chosen services was supposed to promote greater responsibility for self-care and decision-making, and greater respect for this by professionals. But where words like patient were essentially moral ones – redolent of certain attitudes to suffering, endurance, trust and receptivity – words like consumer only indicate a kind of financial power. Seeing the sick as powerful contracting agents, rather than vulnerable others due special protection and care, may reduce not only overweening paternalism but also proper protectiveness; it may help us get what we want but not what we most need. **[9]**

Even those who take a rather sanguine view of patient autonomy recognise that there are situations in which carers, family or guardians can exercise a 'good paternalism'. In less fraught circumstances the healing relationship must be one of trust and there is often a kind of 'guided' or 'shared' decision-making. **[10]** Situations of compromised competence call for judgements by others as to what is in a patient's best interests. Instead of see-sawing between paternalism and consumerism in medicine, we need approaches that recognise the particularities of those involved and the fact that this is a joint project. The risk in this present 'state of exception' is that public health authorities and politicians will resume the pre-liberal 'doctor knows best' approach, and apply it to whole populations not just individual patients. As commentators such as Giorgio Agamben have argued, emergency powers easily become 'the new normal'. **[11]**

2) Human Community: Isolation or Solidarity?

Global Pandemic and Universal Brotherhood acknowledges the 'painful paradox' of quarantine (which would also apply to 'self-isolation' and 'social distancing'): that to survive we must live apart and yet we cannot live apart **[12]**. The disruption of the present crisis is an opportunity for deeper appreciation that 'we are part of humanity and humanity is part of us' **[13]**. Some have been resistant to any compromise of personal liberties, especially freedoms to assemble and worship, however temporary. **[14]** But Thomas Joseph White O.P. and others have demonstrated that the tradition has always allowed, even required, such temporary sacrifice for the common good, especially where necessary for survival of the group or protection of the weakest members. **[15]** The Pontifical Academy agrees: 'Reckless or foolish behaviour, which seemingly affects only ourselves, becomes a threat to all who are exposed to the risk of contagion, perhaps without even affecting the actor… There is no right that does not have a corresponding duty'. **[16]**

The document promotes a shift from a merely accidental or 'de facto interconnection' to a more intentional or 'chosen solidarity'. **[17]** Instead of thinking of ourselves as competing atoms struggling to achieve personal security and fulfil our preferences, many contemporary philosophies, **[18]** as well as traditional and Christian anthropology and sociology, recognise that our freedoms and happiness are 'intertwined and overlapping'. **[19]** Where panic might incline us to think of the other as 'an infectious threat from which to distance ourselves', we must recognise that alongside

self-preservation there are other, more relational goods that are equally important. **[20]** In the Biblical tradition human beings are fundamentally weak and needy, social and interdependent beings, entrusted to each other's care. The *Catechism of the Catholic Church* observes that:

> *On coming into the world, man is not equipped with everything he needs for developing his bodily and spiritual life. He needs others. Differences appear tied to age, physical abilities, intellectual or moral aptitudes, the benefits derived from social commerce, and the distribution of wealth. These 'talents' are not distributed equally. These differences belong to God's plan, who wills that each receive what he needs from others, and that those endowed with particular 'talents' share the benefits with those who need them. These differences encourage and often oblige persons to practise generosity, kindness and sharing of goods; they foster mutual enrichment*. **[21]**

Images of health professionals devoting themselves to the care of COVID-19 patients, at considerable risk to their own life or health, have been celebrated as showing the work of latter-day Good Samaritans. Alongside this we think of those isolated in hospitals, nursing homes or domestic settings, those practising responsible social distancing, and those accepting that much of ordinary life must be put on hold, all for the sake of keeping themselves and others safe, are doing so not as an expression of liberal autonomy but rather as a matter of justice and care for others. The PAV Note proposes this caring relationship as 'the fundamental paradigm' not just of healthcare ethics but of all human existence – each is, indeed, their brother's keeper. And this makes healthcare far more than a mere 'transaction' or service for a fee. **[22]**

In the Christian tradition healthcare is treated more as an entitlement in justice than a free market commodity. **[23]** The Second Vatican Council and all the modern popes have asserted that there is a universal right to healthcare. **[24]** In proposing that healthcare be regarded as a public good rather than being privatised as a commodity for exchange and consumption, Bruce Jennings and Mark Hanson argue that some works:

> *… establish relationships among individuals that are not transactional or consumptive, but involve a cooperative and participatory effort to produce something of common value. This value is not appropriated exclusively by one of the parties to its creation, no one is simply a 'provider' or a 'consumer', and the value is realised by communities as much as by individuals*. **[25]**

Conceiving of healthcare as a vocation and profession, as a social good and responsibility, and even as a kind of communion, challenges the 'pharmacological, medical and surgical consumerism' so commonplace in modernity. In the PAV Note's most memorable phrase, it is suggested that in the face of tendencies to self-protection and panic it is only 'the antibodies of solidarity' **[26]** that will enable sound action – decisions that integrate clinical policies with 'a broad and deep search for the common good' and resist direct partiality towards the privileged and powerful or indirect discrimination against the frail elderly, poor and dying. **[27]**

3) Healthcare Ethics in a Pandemic: Technocratic or Humanistic?

Global Pandemic and Universal Brotherhood identifies the present pandemic as a challenge not just to our conceptions of the human person and community, but also to our ethics. Alongside any technological and bureaucratic thinking, we need 'greater depth of vision', humility regarding our limits, 'responsible reflection about the meaning and values of humanism', an alliance or integration of science and ethics. **[28]** In critiquing perfectionist, reductionist and individualist accounts of the human person and community, the Note proposes a more relational ethic that acknowledges our interdependence and entrustment to each other's care, the responsibilities that come with our rights and sovereignty, and our particular duties to the poor and powerless. **[29]**

When people today talk of 'emergency ethics', 'pandemic ethics' or 'the ethics of triage' this often amounts to the adoption of a fairly un-nuanced utilitarianism or the abandonment of ethics altogether. Faced with great needs and limited resources, healthcare managers and professionals on the ground may be tempted to prefer the young over the old, the productive over those whose social contribution is less, or those who can fund their own care over those who cannot. In what is the first Vatican document to directly address the puzzles of healthcare allocation, the Note argues that rationing between patients or patient groups should only be entertained once all alternatives have been explored and exhausted, such as greater resourcing of healthcare, seeking alternative treatments, and attempting creative responses such as sharing ventilators. **[30]**

When healthcare rationing is necessary, the document continues, it must occur in a way that values human lives equally and respects the dignity of every person. Limited healthcare should be allocated 'on the basis of the needs of the patient, that is, the severity of his or her disease and need for care, and the evaluation of the clinical benefits that treatment can produce, based on his or her prognosis'. **[31]** Age may sometimes be a rough guide to some of this, but it cannot be the decisive criterion: sometimes the older patient will have the more urgent need, or the better prognosis after receiving the care, than the younger patient. Always favouring the young 'could lead to a discriminatory attitude toward the elderly and the very weak'. And even when there is nothing more to be done by way of therapy or when not every patient can be offered the kind of care we would like, 'we must never abandon the sick person… palliative care, pain management and personal accompaniment are never to be omitted'. **[32 / 33]**

At this point the Christian 'preferential option for the poor' will act as a corrective to any purely philosophical account of healthcare ethics, especially one focussed purely on 'quality of life', number of years of 'quality' life gained and maximising 'bang for the healthcare buck' assessed in these terms. The sympathy and solicitude that Christ proposes that his followers should have 'for the least of these' (Mt 24:40-45) speaks especially to our attitudes towards the poor, elderly and dying, and refugees and immigrants in healthcare as elsewhere. **[34]** And this in turn raises questions about the self-conception of the health professions: Is there a logic proper to healthcare or is it merely what its individual

practitioners, professional societies, funders and regulators make it? What (if any) are the ends or goals internal to medicine and nursing? What alternative conceptions or uses of healthcare should be resisted? As Christians, we can try to respond to these questions in the light of our Gospel faith.

4) Behaviour in a Pandemic: Self-Protection or Charitable Witness?

A time of pandemic is not only a trial for humanity, it is also a trial for Gospel faith. **[35]** As Christ identifies with the weak, including the sick, the Church comes to the aid of 'the least of these my brethren'. **[36]** And every corporal work of mercy, 'every form of solicitude, every expression of benevolence is a victory of the Resurrected Jesus'. **[37]** At the beginning of the Christian era waves of what was probably Smallpox claimed perhaps 10 million lives in the Antonine Plague (165-80 AD) and the Plague of Cyprian (249-70 AD). The 'public health response' of the imperial authorities was panic and flight, but Christians distinguished themselves by staying and caring for the victims. Why was that?

Healing the sick and suffering was a major focus of Christ's ministry and served, alongside his preaching, to proclaim the coming of God's kingdom. The blind, deaf, mute, haemorrhaging, paralysed, leprous, even deceased, received his healing touch. He compared himself to a physician and a nurse. **[38]** At his invitation, the first Christians saw in every suffering person a brother or sister in need, indeed Christ himself, and sought to serve him in them. **[39]**

The parable of the Good Samaritan has been the text most influential in shaping Christian understandings of healthcare. It presents one person's suffering and another's response. It tells of our common humanity, of the social glues of empathy and mercy, of virtuous character and of the principle of caring for neighbours in need. It is a very practical story: the bashed and forsaken Jew receives essential nursing assistance from the rescuing Samaritan, there is 'referral' to an inn-keeper, and a third-party payment. But this does not reduce the relationship and behaviour to a commodity transaction valued only for its medical efficiency or economic worth. Rather, we witness a story of intervention for the sake of the one rescued: damaged and desperate humanity is saved by God; the suffering body or soul healed by Christ the Physician; the sick, ever since, cared for by Christians responding to Christ's command to 'Go and do likewise'. **[40]** As awareness of needs and ability to assist increases, so do the opportunities for neighbourliness: as the Second Vatican Council suggested, 'today there is an inescapable duty to make ourselves the neighbour of every person, no matter who they are, and if we meet them, to come to their aid in a positive way'. **[41]**

The Cyprian Plague is so-called because St Cyprian of Carthage was its chronicler, reflecting upon the spiritual significance of pestilence and encouraging Christians to redouble their service of the sick and suffering. **[42]** This, he thought, was like the final exams for faith and an opportunity for Christians to shine. Sure enough, in cities with significant Christian populations the death rate was half of that of other cities and many of the survivors were converted by what they saw. **[43]**

Thereafter Christians served the sick, suffering and dying through monastic pharmacies, hospices and eventually large-scale hospitals; through orders of Hospitaller Knights caring for sick pilgrims, of nuns nursing mothers and others, or of religious brothers caring for the mentally ill; through lay faithful dedicated to healthcare as their vocation and trained in Church institutions; through sacramental and other pastoral care for the sick; and through systematic reflection on bioethics. Great Christians such as Saints Edmund and Roch, Elizabeth of Hungary and Catherine of Siena, Charles Borromeo and John of God, Aloysius and Camillus, Louise de Marillac, Damien of Molokai and Pier Giorgio Frassati demonstrated Christian heroism in nursing those with infectious diseases. During the COVID-19 pandemic this long and continuing tradition has been regularly in evidence.

The witness of Christian charity is given in such corporal works of mercy, but also in spiritual alms. After the lockdown in Rome people the world over were edified by images of Pope Francis's pilgrimage on foot through the empty streets to pray before the image of Our Lady of Health. Faith helps people find meaning and solace during pandemic, and to experience the human condition not merely as meaningless suffering but as a passage to God. Intercessory prayer expresses that faith, strengthens fraternal bonds, and motors perseverance in trial. **[44]** Christians learn from Christ 'the way to live suffering as an expression of trust in the Father… an inner strength to exercise [our] commitment… and overcome this evil'. **[45]** The power of prayer, married to the efforts of health professionals, will contain and ultimately eliminate COVID-19; and Christian charity will speak even to those without faith.

Conclusion

In *Global Pandemic and Universal Brotherhood*, the Pontifical Academy for Life addresses far more than our immediate concerns about health and safety. At its heart the document is a call to see the present disruption as a wake-up call like the Baptist's voice crying in the wilderness (Jn 1:23). It can shock us into reconsidering our views of human life and our responsibilities to each other, of the very nature of the healthcare endeavour and the principles that should inform it, and of the particular witness that Christian charity and intercession can provide alongside the best of medicine and public health measures.

Endnotes

[1] Pontifical Academy for Life, *Pandemia e fraternità universale* (30 March 2020). The English translation is *Global Pandemic and Universal Brotherhood: Note on the Covid-19 Emergency*. http://www.academyforlife.va/content/dam/pav/documenti%20pdf/2020/Nota%20Covid19/Note%20on%20the%20Covid-19%20emergency_ENG_.pdf Though the document has no numbering, I refer hereafter to the paragraphs by number.

[2] *Ibid.*, para 1.

[3] *Ibid.*, para 2.

[4] Fuller treatments of the Church's bioethic are offered in the *Catechism of the Catholic Church*, Part II, ch. 2, ch. 5; such as was offered, for instance, in St John Paul II's *Evangelium vitae* (1995) or the Pontifical Council for Health Workers, *Charter for Health Care Workers* (1995; 2nd edn, 2017).

[5] *Op. cit.*, *Global Pandemic and Universal Brotherhood*, para's 2,4.

[6] *Ibid.*, para's 4-8.

[7] *Ibid.*, para's 9-11.

[8] Alasdair MacIntyre, *Dependent Rational Animals: Why Human Beings Need the Virtues* (Open Court, 2001); Stanley Hauerwas, 'Reflection on dependency: A response to responses to my essays on disability', *Journal of Religion, Disability and Health* 8 (3 & 4) (2005), 191-97.

[9] I say more about these matters in Anthony Fisher, 'Drive-thru healthcare: Is there more to medicine than supply and demand?' *Bioethics Outlook* Special Edition (2017), 1-16.

[10] John Bruhn, 'The lost art of the covenant: Trust as a commodity in healthcare', *Health Care Manager* 24(4) (2005), 311-19; Michael Calnan and Rosemary Rowe, 'Trust and health care', *Sociology Compass* 1(1) (2007) 283-308; Susan Goold, 'Trust, distrust and trustworthiness', *Journal of General Internal Medicine* 17(1) (2002), 79-81; Helena Legido-Quigley, Martin McKee and Judith Green, 'Trust in health care encounters and systems', Sociology of Health and Illness 36(8) (2014), 1243-58; France Légaré *et al*, 'Interventions for improving the adoption of shared decision making by healthcare professionals', *Cochrane Review*, 12 May 2010; Glyn Elwyn, 'Shared decision making and the concept of equipoise: the competences of involving g patients in healthcare choices', *British Journal of General Practice*, 50 (2000), 892-97; A.M. Stigglebout *et al*, *British Journal of Medicine*, 'Shared decision-making: really putting patients at the centre of healthcare', 344 (2012).

[11] Giorgio Agamben, *State of Exception* (Chicago: Chicago University Press, 2005) and blogposts at *Quodlibet*: https://www.quodlibet.it/una-voce-giorgio-agamben; Giorgio Shani, 'Securitizing "bare life"? Human security and coronavirus', *e-International Relations*, 3 April 2020; Lukas van den Berge, 'Biopolitics and the coronavirus: in defence of Giorgio Agamben', *Montaigne Centrum*: http://blog.montaignecentre.com/index.php/2467/biopoliticsand-the-coronavirus-in-defence-of-giorgio-agamben-2/

[12] *Op. cit.*, *Global Pandemic and Universal Brotherhood*, para 1.

[13] *Ibid.*, para's 2-5, 10.

[14] E.g. R.R. Reno, 'Say "No" to death's dominion', *First Things*, 23 March 2020; and 'Coronavirus reality check', *First Things*, 27 April 2020.

[15] Thomas Joseph White O.P., 'Epidemic danger and Catholic sacraments', *First Things*, 9 April 2020, and 'Reopening the sacramental economy', *First Things*, 30 April 2020; 'Is it ethically defensible for the Church to suspend public Masses?', *Public Discourse*, 29 April 2020. See also Nicanor Austriaco O.P., 'Is striving for herd immunity, regardless of the human "culling" that may be required, ethical?', *Aleteia*, 8 May 2020; and Ross Douthat, 'The pandemic and the will of God', *New York Times*, 12 April 2020.

[16] *Op. cit.*, *Global Pandemic and Universal Brotherhood*, para's 5-10.

[17] *Ibid.*, para's 8-12.

[18] From very different perspectives there are the works of Shlomo Avineri and Avner de-Shalit, Daniel Bell, Alan Bloom, Amitai Etzioni, Jurgen Habermas, Alasdair MacIntyre, Charles McCann, George Rupp, Michael Sandel, Robert Spaemann, Henry Tam, Charles Taylor and Michael Walzer.

[19] *Op. cit.*, *Global Pandemic and Universal Brotherhood*, para 9.

[20] *Ibid.*, para 8.

[21] *Catechism of the Catholic Church*, 1936.

[22] *Op. cit.*, *Global Pandemic and Universal Brotherhood*, para 10.

[23] St John XXIII, *Pacem in Terris* (1963), 11; Vatican Council II, *Gaudium et Spes* (1965) 26; St Paul VI, *Message to the World Health Organization on its 20th Anniversary* (1978) and *Message to the World Health Organization on its 25th Anniversary* (1983); St John Paul II, *Homily at Mass in Recife, Brazil*, 4 August 1980, and Evangelium vitae (1995) 26 etc.; Pope Benedict XVI, *Message to 25th International Conference of the Pontifical Council for Healthcare Workers*, 15 November 2010; Pope Francis, *Address to "Doctors with Africa"*, 7 May 2016; cf. *Message to the 31st International Conference of the Pontifical Council for Healthcare Workers*, 12 November 2016; *Discorso ai Commissione Carità e Salute della Conferenza Episcopale Italiana*, 10 February 2017. Likewise, Pontifical Council for Healthcare Workers, *Charter for Healthcare Workers* 63; United States Catholic Conference, *Health and Healthcare: A Pastoral Letter of the American Bishops* (Washington DC: United States Catholic Conference, 1981), 11.

[24] Bruce Jennings and Mark Hanson, "Commodity or public work? Two perspectives on healthcare", *Bioethics Forum* (Fall 1995), 3-11 at 6-7.

[25] *Op. cit.*, Global Pandemic and Universal Brotherhood, para 14.

[26] *Ibid.*, para's 14-17.

[27] *Ibid.*, para's 2-3, 14.

[28] *Ibid.*, para's 8-20.

[29] *Ibid.*, para 15.

[30] *Ibid*., para 15.

[31] *Ibid*., I have argued more fully for this in: Anthony Fisher and Luke Gormally, *Healthcare Allocation: An Ethical Framework for Public Policy* (London: Linacre Centre, 2001); see also David Albert Jones, 'Resource allocation and ventilators: A statement of Catholic principles', COVID-19 Briefing Paper 1 (Anscombe Bioethics Centre, 8 April 2020).

[32] *Ibid*.

[33] I have argued more fully for this in: Anthony Fisher and Luke Gormally, *Healthcare Allocation: An Ethical Framework for Public Policy* (London: Linacre Centre, 2001); see also David Albert Jones, 'Resource allocation and ventilators: A statement of Catholic principles', COVID-19 Briefing Paper 1 (Anscombe Bioethics Centre, 8 April 2020).

[34] *Ibid.,* para's 19-20.

[35] *Ibid.,* para's 1, 18-20.

[36] *Ibid*., para 19.

[37] *Ibid*., para 20.

[38] Lk 4:17; 5:31; 7:22-23; 10:29-37.

[39] Mt 25:31-40.

[40] Lk 10:25-37.

[41] Vatican Council II, *Gaudium et spes* 27.

[42] St Cyprian of Carthage, *De Mortalitate*; cf. Stark, *The Rise of Christianity*, pp. 81-82.

[43] Sean F. Everton & Robert Schroeder, 'Plagues, pagans, and Christianity: differential survival, social networks, and the rise of Christianity', *Journal for the Scientific Study of Religion*, 58(4) (2019), 775-98; Rodney Stark, *The Rise of Christianity: A Sociologist Reconsiders History* (Princeton: Princeton University Press, 1996), p. 81-86; Lyman Stone, "Christianity has been handling epidemics for 2000 years", *FP* [*Foreign Policy*] 13 March 2020; Sarah Yeomans, 'The Antonine Plague and the spread of Christianity', *Biblical Archaeology Review* 43(2) (2017), 22-24 & 66.

[44] *Op. cit*., *Global Pandemic and Universal Brotherhood*, para 21.

[45] *Ibid*., para 22.

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