Ethics and Pandemics

A Statement of the IACB on Integrating Ethical Approaches to Clinical Care and Public Health

William F. Sullivan, John Heng, Jason T. Eberl, Gill Goulding, Christine Jamieson, Cory-Andrew Labrecque, Alexandre A. Martins, Ursula Scottong, Paulina Taboada, Bernadette Tobin, Jos V. M. Welie

Introduction

a. This statement summarizes main insights from presentations and discussions of a webinar series on "Ethics and Pandemics," which was organized in 2021 by the International Association of Catholic Bioethics (IACB).

b. On January 20, 2020, the World Health Organization (WHO) declared the coronavirus disease of 2019 (COVID-19) to be a "public health emergency of international concern," and on March 11, 2020, a pandemic.[1] This has been one of

1. There are debates among bioethicists and global health experts surrounding the WHO's description of what a pandemic is and how it determines that one has occurred. See Thana C. De Campos, "The Traditional Definition of Pandemics, Its Moral Conflations, and Its Practical Implications: A Defense of Conceptual Clarity in Global Health Laws

the most significant pandemics in history because of the high incidence of deaths and serious, sometimes prolonged, illnesses that are caused by COVID-19.[2] It has also caused indirect (so-called "syndemic") negative effects on pre-existing health conditions and on socio-economic and ecological determinants of health on a global scale.[3] We write this statement in solidarity with all who have fallen ill or suffered losses due to COVID-19. We acknowledge that the full impact of this pandemic and the ethical questions evoked by it will become clearer in years to come.

c. Our planet is likely entering an era in which pandemics will become increasingly prevalent.[4] Learning from both positive and negative experiences and responses to this pandemic is vital for understanding its complex implications for preventing and preparing for future pandemics. An important aspect of this understanding is ethical in nature. Bioethics, however, has tended to emphasize the ethics of individual clinical care. Ethical reflections on public health matters, which pertain to the health and well-being of communities and population groups, are comparatively recent, less developed, and seldom integrated with the ethics of individual clinical care.[5]

d. Part One of this statement aims to stimulate and contribute to developing an *integrated approach* to clinical care and public health care by offering an ethical framework that affirms their mutually supportive roles even during pandemics. Although this framework is rooted in moral insights from the Jewish and Christian

and Policies," *Cambridge Quarterly of Healthcare Ethics* 29.2 (April 2020): 205–217, doi: 10.1017/S0963180119001002.

2. As of July 2022, over 6,300,000 reported deaths have resulted from COVID-19, according to the Center for Systems Science and Engineering (CSSE), "COVID-19 Dashboard," Coronavirus Resource Center, John Hopkins University and Medicine, accessed July 19, 2022, https://coronavirus.jhu.edu/map.html. The World Health Organization (WHO) estimated in May 2022 that there have been 15,000,000 deaths if one also includes those indirectly associated with the pandemic, such as from disrupted health systems unable to meet other health needs: "The True Death Toll of COVID-19: Estimating Global Excess Mortality," Data Stories, WHO, accessed May 2022, https://www.who.int/data/stories/the-true-death-toll-of-covid-19-estimating-global-excess-mortality.
3. Richard Horton, "Offline: COVID-19 Is Not a Pandemic," *Lancet* 396.10255 (September 26, 2020): 874, doi: 10.1016/S0140-6736(20)32000-6.
4. David M. Morens and Anthony S. Fauci, "Emerging Pandemic Diseases: How We Got to COVID-19," *Cell* 182.5 (September 3, 2020): 1077–1092, doi: 10.1016/j.cell.2020.08.021, erratum in *Cell* 183.3 (October 29, 2020): 837, doi: 10.1016/j.cell.2020.10.022.
5. The WHO has defined *public health* as "the science and art of preventing disease, prolonging life and promoting health, through the organized efforts of society. It has a population rather than an individual focus and involves mobilizing local, regional, national and international resources to ensure the conditions in which people can be healthy." Sara Allin et al., *Making Decisions on Public Health: A Review of Eight Countries* (Brussels: WHO Regional Office for Europe, European Observatory on Health Systems and Policies, 2004), 11. Understood in this way, public health is an integral part of providing all health care. Nevertheless, in most countries, clinical care systems and public health systems operate as distinct entities when they should be integrated.

scriptures and teaching, we believe it can accommodate complementary insights from other religions and non-theologically-grounded ethical reasoning.

e. Part Two reflects on and analyzes key issues of ethical concern pertaining to the current pandemic that were identified and discussed in the IACB webinars.

f. Part Three links these reflections to recommended next steps regarding integrating ethical approaches to clinical care and public health care during and beyond pandemics. Members of the public, Christian bioethicists, healthcare providers, those responsible for health systems, researchers, and economic and political leaders are invited to consider and act on these recommendations.

Part One: Ethical Framework

1. Above all, promote wise and responsible moral agency.

a. Ethical thinking and deciding advances by individuals and communities striving constantly to learn from moral successes and failures. The goal of becoming wise and morally responsible agents, individually and collectively, is gradually attained by deliberating, deciding, and acting in better ways. This cumulative process calls for attentive learning, reflecting, apprehending what is truly good, and developing personal and communal capabilities for making and implementing decisions well. Advances in ethics also entails supportive communities that will foster education, investigations, discussions, communications, and available spiritual supports on ethical matters—all of which should be oriented to seeking and affirming instances of truth and goodness wherever they can be discovered and striving to overcome negative personal and group biases.

b. Christians believe that God is present and active in our world and in our times, even during pandemics and the suffering that they generate. God does not cause pandemics as punishment for human wrongdoing, as some people have stated during this pandemic. Rather, God's providential care is manifested whenever humans respond to natural evils, such as pandemics, by working through problems persistently to arrive at wise decisions, personally and communally, and being moved to act responsibly and out of self-giving love.

c. We reject the view that clinical care and public health care are *radically* distinct and separate forms of health care.[6] They are mutually supportive forms of health care. Moreover, the same structure of ethical deliberating and deciding described in (a) above, and the same imperatives for wise and responsible moral agency, apply to *both* clinical *and* public health care. In making and implementing wise decisions, we are called:

- to be open and attentive to all relevant data and questions;
- to be intelligent in understanding health needs and possible solutions;
- to be reasonable in making judgments of fact;

6. For an example of this view, see R. E. G. Upshur, "Principles for the Justification of Public Health Intervention," *Canadian Journal of Public Health* 93.2 (March 2002):101–103, doi: 10.1007/BF03404547.

- to form goals that are truly worthwhile and to be responsible in weighing, for actual or possible circumstances, the benefits, risks, and burdens of policies and interventions to align with those goals; and
- to follow through by acting on our decisions.[7]

2. Seek both to respect human dignity and show solidarity in promoting the common good in health care.

a. Every human has inherent dignity.[8] Theologically, we hold that all humans have been created by God and are called to friendship with God. Each human has the capacity and free will to seek and respond to what is truly good.[9] In clinical and public health care, therefore, providers and policy makers ought always to recognize, respect, and promote inherent human dignity.

b. The COVID-19 pandemic has revealed the importance of social bonds and cooperation in promoting, protecting, and restoring overall health and well-being. This cooperation reflects the reality that humans are relational beings and mutually dependent. Christians can affirm, on biblical and theological grounds, that humans are created in the image and likeness of God who, being one God, is not solitary but subsists in a loving communion of three equal persons.[10]

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7. See also Patrick Daly, "A Concise Guide to Clinical Reasoning," *Journal of Evaluation in Clinical Practice* 24.5 (October 2018): 966–972, doi: 10.1111/jep.12940; and Eivind Engebretsen et al., "Uncertainty and Objectivity in Clinical Decision Making: A Clinical Case in Emergency Medicine," *Medicine, Health Care and Philosophy* 19.4 (2016): 595–603, doi: 10.1007/s11019-016-9714-5.
8. Daniel P. Sulmasy has distinguished among three notions of *human dignity* in Western philosophy that often get muddled in discussions in ethics. These notions are the following. *Intrinsic human dignity,* which is the understanding of "human dignity" emphasized in this statement, is the dignity that humans have simply as humans. Intrinsic dignity is not based on "any social standing, ability to evoke admiration, or any particular set of talents, skills, or powers" (473). *Attributed human dignity* is the dignity that humans confer upon individuals because of their qualities or accomplishments. *Inflorescent human dignity* presupposes the intrinsic dignity of all humans but relates to the flourishing of human lives. For an elaboration on these three notions of human dignity, see Sulmasy, "Dignity and Bioethics: History, Theory, and Selected Applications," in *Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics* (Washington, DC: President's Council on Bioethics, 2018), 469–501, https://repository.library.georgetown.edu/bitstream/handle/10822/559351/human_dignity_and_bioethics.pdf. The United Nations General Assembly, *Universal Declaration of Human Rights* (December 10, 1948), https://www.un.org/en/about-us/universal-declaration-of-human-rights, begins with a preamble recognizing that all members of the human family have inherent (or intrinsic) dignity and equal and inalienable rights.
9. Vatican Council II, *Gaudium et spes* (December 7, 1965), *Acta Apostolicae Sedis* 58 (1966), nn. 19 and 26.
10. *Fides Damasi*, in Heinrich Denzinger and Adolph Schönmetzer, eds., *Enchiridion symbolorum, definitionum et declarationum de rebus fidei et morum* (1965), n. 71, cited in the *Catechism of the Catholic Church*, 2nd ed. (Vatican City: Libreria Editrice Vaticana, 1997) n. 254; see also Pontifical Council for Justice and Peace, *Compendium*

c. A central principle of Catholic social teaching, applicable to all health care, is concern for the common good. Recognizing our equal dignity and interdependency, we are called to participate in and contribute to the common good of our communities.[11] The common good should not be regarded as the sum of benefits (e.g., liberties, opportunities, or rights) that individuals seek only for themselves.[12] Nor should the common good be regarded as a set of mere outcomes that benefit most people in a community.[13] We should, instead, understand the common good to be the social order that best supports and promotes conditions for each and every member of a community to flourish and be fulfilled.[14]

d. We affirm that the good of individuals and the common good are inextricably inter-related aspects of the human good. We reject, therefore, any approach, whether in clinical care for individuals or public health care for communities, that opposes concern for the good of individuals over and against concern for the community, and vice versa. We also oppose any approach that regards individuals as mere means to attaining the common good in health and health-related systems,[15] and the controlling and manipulating of such systems to benefit privileged individuals and groups only.[16]

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of the Social Doctrine of the Church (Vatican City: Libreria Editrice Vaticana, 2005), n. 34.

11. Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, n. 167.
12. An example of this notion of the "common good" is found in forms of libertarian ethics in which society's role is to protect each individual's exercise of liberty. A subtler version underlies certain arguments for an egalitarian approach to allocating limited resources during pandemics (such as flipping a coin or a lottery). In such an approach, society's ethical obligation is to develop a process of rationing that would not undermine individuals' equal interest in surviving. See, as an example, Alex James Miller Tate, "Rethinking the Ethics of Pandemic Rationing: Egalitarianism and Avoiding Wrongs," *Cambridge Quarterly of Healthcare Ethics* 31.2 (April 2022): 247–255, doi: 10.1017/S0963180121000633, PMID: 35243977.
13. This notion of the "common good" is defended by utilitarian ethicists. See, as an example, Julian Savulescu, Ingmar Persson, and Dominic Wilkinson, "Utilitarianism and the Pandemic," *Bioethics* 34.6 (July 2020): 620–632, doi: 10.1111/bioe.12771.
14. Vatican Council II, *Gaudium et spes*, n. 26, defines the "common good" as "the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfilment more fully and more easily." A succinct discussion of a Catholic understanding of the common good as applied to responses to the COVID-19 pandemic can be found in Daniel P. Sulmasy, "The Virus and the Common Good," *The Tablet* 274.9348, April 18, 2020, 8–10.
15. See, as an example of this kind of ethical reasoning, James Cameron, Bridget Williams, Romain Ragonnet, Ben Marais, James Trauer, and Julian Savulescu, "Ethics of Selective Restriction of Liberty in a Pandemic," *Journal of Medical Ethics* 47.8 (August 2021): 553–562, e-pub May 31, 2021, doi: 10.1136/medethics-2020-107104, PMID: 34059520, PMCID: PMC8327318.
16. For example, it could be argued that controlling patents or hoarding COVID-19 vaccines are practices that privilege certain commercial or national interests and undermine global solidarity and concern for the common good during the pandemic.

e. Clinical and ethical deliberations, decisions, and actions regarding the care of patients should be made within health and health-related systems that have oversight of, and policies that are based on, a sound understanding of the common good as described above. What results from clinical decisions will invariably have an impact not only on individual patients but also on other members of their community. Responsible moral agency, on the level of patients, caregivers, and healthcare providers, entails solidarity with others in their community. Clinical care should not be guided solely, or above all, by over-inflating the principle of respect for individual autonomy and the rights of individuals to the extent of excluding concern for the common good.

f. Included in the common good of a community, however, are conditions for promoting and supporting responsible moral agency in patients, caregivers, and healthcare providers. This follows from respecting their inherent dignity and worth, which is fundamental to a flourishing society. It also applies the principle of subsidiarity from Catholic social teaching in health care, according to which "a community of a higher order should not interfere in the internal life of a community of a lower order, depriving the latter of its functions, but rather should support it in case of need and help to coordinate its activity with the activities of the rest of society, always with a view to the common good."[17] Within communities, we should always support the moral education and development of patients, caregivers, and healthcare providers, promote their decision-making capabilities, and seek to provide adequate resources for them to make and implement wise and responsible decisions regarding their health and health care. We reject, therefore, the position that it is ethically justified for communities, during a pandemic or other health emergency, to suspend, circumvent or undermine—even temporarily—the wise and responsible moral agency of individual members.

3. Support holistic health and well-being.

a. Humans are more than material beings and more than the sum of their parts. It would be inconsistent to hold that humans ought to exercise responsible moral agency, in view of their own needs and of the common good, while at the same time reducing humans simply to their biological aspects. The COVID-19 pandemic has revealed once more the human reality that biological, psychological, social, moral, and spiritual well-being are essential and interacting aspects of human flourishing.

b. As Christians, we affirm that a human being is a material and spiritual unity. We are called to be responsible stewards of our life and health, and to live in harmonious relationships with one another, with the rest of creation, and ultimately, with God.

c. Clinical care of individuals and public health care, therefore, should jointly strive towards *holistic* health and well-being of individuals and communities. We propose that a conception of biologically-focused health care is incomplete and inadequate if it restricts itself only to goals of managing illnesses or preventing infections,

17. John Paul II, *Centesimus annus* (May 1, 1991), n. 48, para. 4, cited in *Catechism of the Catholic Church*, n. 1883. See also the article by Michael Wee in this special issue, "Solidarity and Subsidiarity as Principles for Public Health Ethics," *National Catholic Bioethics Quarterly* 22.2 (Summer 2022): 221–229.

serious illnesses, and deaths. While it is understandable, during pandemics, that these biological goals may need to be prioritized, other health goals should not be set aside entirely. Examples of these other goals are building resilience by sustaining healthy habits and diminishing unhealthy ones, promoting rehabilitation and other forms of long-term recovery from illnesses, and preventing and addressing distress and trauma through a combination of medical, psycho-social, and spiritual supports as needed. These are essential aspects of holistic health care that can play a key role in a more robust conception of clinical and public health care in responding to this pandemic and preventing and preparing for future ones.

d. It is important in both clinical and public health care to be guided by the reality that, as embodied beings, all humans are mortal. While affirming the fundamental value of life, the preservation of life should not trump all other values. Although battling infections and preventing untimely deaths are worthwhile goals, clinical and public health care should not be focused on prolonging human life at all costs through every available medical and technological means, as if denying the reality that humans are limited and finite.

4. Attend especially to those who are marginalized and excluded from the benefits of health systems.

a. Because "each one of us is a part of all of us,"[18] we have a moral responsibility, personally and collectively, to strive to ensure that no one is isolated, marginalized, excluded or subject to neglect or discrimination in our communities and in our healthcare-related systems. Our communities flourish when each and every member has the opportunity to benefit from the common good.

b. Catholic social teaching upholds a "preferential option for the poor"[19] and for those who are vulnerable because they are relegated to the edges of a community or excluded altogether from participating in it. As Christians, we hold that we ought to see Christ in everyone,[20] and especially those members of our communities who are neglected and harmed because they are wrongfully judged to have "less worth" or to "contribute less" to the community than others.

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18. This is a phrase coined by Victor, a young Canadian man with intellectual and developmental disabilities. A complementary notion is that of *ubuntu*, a term from the Nguni languages of Zulu and Xhosa in southern Africa. *Ubuntu* is usually translated as "compassion" or "humanity." It entails the notion that "I am only because we are." It "envisions the ideal society as one in which members relate to each other in a manner of deep friendship and respect." James E. Sabin, "Cross-Cultural Bioethics: Lessons from the Sub-Saharan African Philosophy of Ubuntu," *Theoretical Medicine and Bioethics* 42.1–2 (April 2021): 61, doi: 10.1007/s11017-021-09547-y.
19. Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church* (June 29, 2004), e.g., nn. 3, 182–184, 449. For an extended discussion of the preferential option for the poor and bioethics, see, in this issue, Alexandre A. Martins, "Theological Bioethics and Public Health from the Margins: Epistemology and Latin American Liberation Theology in Bioethics," *National Catholic Bioethics Quarterly* 22.2 (Summer 2022), 239–255.
20. Matt. 25:40 (NRSV): "Just as you did it to one of the least of these who are members of my family, you did it to me." See also Francis, *Fratelli tutti* (October 3, 2020), n. 85.

c. We reject, therefore, the position that certain people should bear a greater burden of the pandemic or of public health interventions and policies for the sake of others out of a mistaken understanding of the "common good."

5. Address large-scale and long-term negative impacts of healthcare decisions, policies, and interventions.

a. As noted above, humans are relational beings and mutually dependent. This is true on the level of one's local community, e.g., one's family, clan, or country. But it is also true that people around the world are increasingly connected and dependent on one another as one global community. Additionally, we are discovering that humans are participants in a broader planetary ecosystem. Human health and well-being, therefore, are inextricably linked to the well-being of this ecosystem.

b. As Christians, we are called to live what Pope Francis has called "social friendship" and universal fraternity and sorority.[21] We affirm also that all creation has inherent goodness, which goes beyond its usefulness in serving human needs. That is, creation is not merely a set of commodities for humans.[22] Entrusted by God to be carers of all creation, humans have a moral responsibility to discern what will best bring about the health and well-being of all life forms.

c. Every healthcare decision, whether in clinical or public health care, has ecological implications, positive or negative, currently and in the future. Our moral responsibility to promote conditions for all to flourish extends to promoting future conditions for such flourishing, according to our knowledge and capabilities. While knowledge of the future is limited, we have a moral responsibility, personally and communally, to seek such knowledge and to decide and act on what we judge to be reasonable and in alignment with our commitment to the common good. This responsibility includes seeking, deliberating, and deciding on the best knowledge we can gain regarding large-scale and long-term negative environmental effects of clinical care and public health goals and weighing benefits, risks, and burdens of interventions in this light. It also entails interrogating and advocating to change certain medical, social, economic, and political approaches and arrangements, as well as inauthentic expressions of cultures and religions, that undermine the common good regarding health care. These harms render some groups in our world more vulnerable than others to poor health and diminished well-being during and beyond pandemics.

Part Two: Some Ethical Issues of Concern

This section presents insights discussed in the IACB series of webinars on "Ethics and Pandemics." We do not intend to offer a comprehensive ethical analysis of all issues concerning pandemics, but to illustrate how our integrated framework for clinical and public health care, elaborated above, can be applied to stimulate reflection, education, and discussion on the following key practical and ethical issues.

21. Francis, *Fratelli tutti* , n. 101.
22. Francis, *Laudato si'* (May 24, 2015), n. 69.

1. Science, ethics, and religious faith

a. During the COVID-19 pandemic, we witnessed varying degrees of scepticism and mistrust among some people regarding the scientific basis of public health policies and interventions. Among them were Christians who expressed such scepticism and mistrust, allegedly on the grounds of their religious commitments. Claims proliferated purporting to be factual that scientists described as "pseudo-science" and "misinformation." Scientists urged policy makers and the public, instead, to "follow the science" in responding to this pandemic. We affirm the importance of scientific inquiry and learning in developing public health responses. However, we reject the idea that scientific information, by itself, is a sufficient basis for determining public health policies and interventions.

b. All knowledge in both clinical and public health care advances according to a cumulative, self-correcting process. Data need to be interpreted, critically assessed, and affirmed. There can often be a legitimate range of insights and judgments. Scientific and medical conclusions that are reached after such a review process, in which relevant questions are addressed, competing interests declared, and the limits of studies identified, can be relied upon to be reasonable and trustworthy. Such facts are necessary to inform clinical care for individuals and public health care for communities.

d. Factual information alone, however, is insufficient for making wise and responsible decisions regarding healthcare interventions and policies. Such decisions also entail identifying and evaluating goals (which are guided by values, i.e., commitments regarding what is truly good and responsible), and the weighing of benefits, risks, and burdens of proposed policies and interventions in light of these goals. These decisions also depend on the moral dispositions and moral development of the agents making them. Ethics, religious faith, and theological reflection can guide and support people in these other aspects of healthcare decision-making. Christians can, in good conscience, support scientists and clinicians who envision goals of health care that are holistic and address the health needs of individuals, while also taking into account a social order that promotes conditions for the health and well-being of all.

e. Decisions regarding clinical and public health care often deal with complex scientific and ethical questions, which require integrating a range of areas of human knowing and learning. Simplistic approaches to such questions that reduce relevant grounds for decisions to one or a few areas are incapable of yielding adequate solutions. Trust in science and ethics, whether theologically-grounded or not, demands of its practitioners a responsibility to incorporate relevant investigations, insights, and perspectives regarding the full range of interdependent factors that are integral to human health and well-being. This should be the case in both clinical care and public health care.

f. There should be approaches in all areas of knowledge relevant to both clinical and public health care that are adaptable and responsive to developing knowledge and circumstances. We should all promote conditions that optimize developing knowledge (such as free, creative, and critical inquiry, discussions, and cooperation) and minimize personal, group, and systemic biases that undermine such developments of knowledge (e.g., rashly accepting and communicating premature

conclusions, hoarding knowledge, commercial greed that compromises the integrity of investigations, reductionist or distorted views of human health or well-being, prejudice based on socio-economic status, nationality, race, gender, age, creed, health status or disability that might lead, for example, to under-monitoring and under-reporting of the effects of the pandemic and of public health responses on vulnerable groups in the community). Authentic religious faith can support the overcoming of such biases by strengthening natural human intellectual and moral virtues and assisting humans to act out of enduring hope and self-giving love.

g. Preparedness for health emergencies like pandemics includes ethical and spiritual preparedness. But such preparations begin with fostering a culture in health care that recognizes the continuity and need for integrating clinical care for individuals and public health care, during and beyond pandemics. Patients, caregivers, healthcare providers, and policy makers should be prepared and helped in all healthcare contexts to make decisions with adequate ethical and spiritual supports, counselling, mentoring, and other resources as needed.

2. Vaccines and treatments

a. During the current pandemic, global cooperation among various sectors in society resulted in developing a number of safe COVID-19 vaccines at unprecedented speed and levels of effectiveness against emerging variants. In many countries in the world, especially low- and middle-income ones, however, COVID-19 vaccines were and still are not readily available or accessible, for various reasons.[23] At the same time, many people around the world where COVID-19 vaccines are available hesitated or refused to be vaccinated for various reasons.

b. An integrated ethical framework for clinical and public health care emphasizes that the health and well-being of individuals is connected to the well-being of the communities in which they are embedded. The responsibility of individuals to care for their life and health includes considering the needs of others in their local community and the wider human community. The community, in turn, has a responsibility to adopt policies and interventions that strive to promote conditions for the health and well-being of each and every individual.

c. Public health policies regarding vaccinations should be guided by sound scientific-medical information. For individuals and families, the way of deliberating about whether available interventions are proportionate for certain patients in clinical care can also guide deliberations regarding vaccination. Such deliberations require weighing and comparing, for each person's circumstances, the known or likely benefits, risks, and burdens of a range of public health measures in light of the goals of protecting one's health and overall well-being as well as those of others in the community.

23. As of July 2022, about 66.8% of the world's population have received one dose of a COVID-19 vaccine, whereas 19.4% in low-income countries have. Hannah Ritchie et al., "Coronavirus (COVID-19) Vaccinations," Our World in Data (website), University of Oxford Martin School Program on Global Development and Global Change Data Lab, accessed July 19, 2022, https://ourworldindata.org/covid-vaccinations.

d. For most people, in most circumstances, being vaccinated against COVID-19 can be judged to be a proportionate intervention relative to these goals.[24] There is hope of likely benefits with few, generally minor, risks or burdens. Based on current knowledge, many of the available vaccines have been shown, for most people, to be effective in preventing serious illnesses due to COVID-19 and limiting community transmission of the virus causing COVID-19 for known variants for a period of time. High rates of vaccination within a community can protect both one's health and that of others in the community. In contrast, serious adverse effects of the available vaccines appear to be very rare.

e. Weighing benefits and burdens of vaccination and other public health interventions should include considering large-scale and long-term effects on oneself and on one's community. High rates of vaccination enable communities to decrease and eliminate the burdens on people of restrictive public health measures such as isolating at home, physical distancing, avoiding work, school, travel or essential health and social services, together with the disruptions, hardships, and psycho-social stresses that these measures might cause. Widespread vaccination also decreases the risk of over-burdening health and other systems and sustains their capacity to address needs other than preventing or treating COVID-19. However, varying personal circumstances (e.g., a health condition for which the risk of a life-threatening response to certain vaccines is elevated) or communal circumstances (e.g., the lack of infrastructure to administer vaccines safely) might lead to exceptions to the conclusion that being vaccinated against COVID-19 is generally a proportionate intervention. As in other healthcare contexts, Catholics can justify non-vaccination by invoking a conscientious objection to being vaccinated. However, such an appeal can only be justified after the person has taken heed of the moral advice of the Congregation for the Doctrine of the Faith (CDF). In addition to encouraging Catholics to be vaccinated against COVID-19, the CDF reminded Catholics of their responsibility to avoid becoming vehicles for transmitting the infection.[25]

f. Vaccine mandates can be justified if their aim is to promote a social order in which all can maintain their health and overall well-being in shared community spaces. In general, promoting education and responsible moral agency are acceptable modes of implementing these mandates and preferable to coercion by punishment or inducement with incentives.[26] Effective and enduring efforts to promote the common good in health depend on fostering social harmony and a sense of solidarity among members of a community. This is unlikely without leadership in communities and

24. For an extended discussion, see, in this issue, James McTavish and Jason T. Eberl, "Is COVID-19 Vaccination 'Ordinary' (Morally Obligatory) Treatment?," *National Catholic Bioethics Quarterly* 22.2 (Summer 2022): 319–333.
25. Congregation for the Doctrine of the Faith, *Note on the Morality of Using Some Anti-Covid-19 Vaccines* (December 21, 2020).
26. For a good discussion of reasons for this conclusion, see Susan Pennings and Xavier Symons, "Persuasion, Not Coercion or Incentivisation, Is the Best Means of Promoting COVID-19 Vaccination," *Journal of Medical Ethics* 47.10 (October 2021): 709–711, doi: 10.1136/medethics-2020-107076.

health systems that "pursue the good of the general population through measures of prevention and immunization that also engage citizens so that they can feel involved and responsible, thanks to a clear discussion of the problems and the appropriate means of addressing them."[27]

g. Primary care providers and other community health leaders who know patients well, and are trusted by them, can play a key role in mediating and integrating clinical care and public health care. They can support their patients to make informed, wise, and responsible decisions on health issues that straddle both areas of care, such as those concerning vaccinations and antiviral treatments. Their input and cooperation are also essential for developing and implementing public health plans for the community regarding vaccines and treatments.

h. Vaccines that strengthen protection against infections and severe illnesses, and antiviral treatments, which require testing for early diagnosis of COVID-19, should be readily accessible to anyone who could benefit from them. Promoting the common good entails finding ways to remove economic, political, health-system, and other obstacles to producing and distributing these vaccines and treatments equitably, and to improve cooperation that is necessary to enable this.

3. Vulnerable individuals and groups

a. Policies in healthcare systems should make it clear that clinical decisions regarding allocating limited healthcare resources, at any time, should not be based on a putative assessment of the "worth" of a person's life compared to that of others.

b. Our collective responsibility to attend especially to those who are marginalized and excluded from the benefits of healthcare systems should be the basis of decisions and policies throughout clinical and public health care, during and beyond pandemics. Health *inequities* or *disparities* stem from social, economic, environmental, and organizational factors that can result in "differences in the opportunities groups have to achieve optimal health, leading to unfair and avoidable differences in health outcomes."[28] We should recognize and address health inequities in accessing clinical care that also underpin unequal access to public health care, such as COVID-19 vaccinations or anti-viral treatments. Such inequities are exacerbated during pandemics and render persons on the edge of healthcare systems "more vulnerable to be infected by the coronavirus, to become hospitalized, and to die."[29]

27. Francis, Address to the Members of the Diplomatic Corps Accredited to the Holy See (January 10, 2022).
28. National Academy of Sciences, Engineering, and Medicine et al., *Communities in Action: Pathways to Health Equity*, ed. James N. Weinstein et al. (Washington, DC: National Academies Press, 2017), 100, doi: 10.17226/24624, https://www.ncbi.nlm.nih.gov/books/NBK425848/pdf/Bookshelf_NBK425848.pdf
29. Martins, "Theological Bioethics and Public Health," in this issue; see also Rosemary M. Caron and Amanda Rodrigues Amorim Adegboye, "COVID-19: A Syndemic Requiring an Integrated Approach for Marginalized Populations," *Frontiers in Public Health* 9 (May 11, 2021), e675280, doi: 10.3389/fpubh.2021.675280. For an extended ethical discussion regarding people with intellectual and developmental disabilities as one example of a marginalized group whose health inequities have been exacerbated

c. Health inequities arise not only because of negative bias and discrimination against certain groups. Members of these groups might need adjustments to ways in which clinical and public health interventions are typically organized, communicated, and conducted to benefit from health care. Clinicians and healthcare systems should strive to accommodate these needs during regular times and during pandemics. The presence of a widespread health emergency does not justify failing to make needed adjustments or to offer needed supports in clinical and public health care whenever possible.

d. Addressing health inequities entails not only overcoming barriers and improving access to clinical and public health care for people on the edge of health systems. It includes, first and foremost, recognizing and supporting the capabilities of such persons to make decisions regarding their health care and valuing their participation and input into public health policy decisions.[30]

e. The lack of integrated clinical and public health systems, between and during pandemics, can lead to avoidable gaps in the health care of certain groups. For example, persons with intellectual and developmental disabilities and other cognitive challenges often have poor access to preventive primary care and health-promoting programs adapted to their needs.[31] Also, while equitable access to COVID-19 vaccines is monitored by many public health systems, the gathering of data that is necessary to promote equitable access to antiviral treatments is, by comparison, generally poor.[32]

d. Committing to the common good during pandemics entails that, when there are limited resources, health systems should give priority for vaccinations to those who are at elevated risk of being infected (e.g., residents in shared and congregate housing, health and other care providers who are in close contact with persons

during the COVID-19 pandemic, see William F. Sullivan, Petra Björne, John Heng, and Ruth Northway, "Ethics Framework and Recommendations to Support Capabilities of People with Intellectual and Developmental Disabilities during Pandemics," *Journal of Policy and Practice in Intellectual Disabilities* 19.1 (March 2022): 116–124, doi: 10.1111/jppi.12413.

30. For ethical discussion and guidelines, see William F. Sullivan, John Heng, Christopher DeBono, Christine Jamieson, Cory Labrecque, Paulina Taboada, Bernadette Tobin, Jos Welie, and participants of the Ninth IACB International Colloquium, "Promoting Capabilities to Make Healthcare Decisions: Consensus Statement of the Ninth IACB Intenational Colloquium," in "Perspectives on Disability," ed. Jason Eberl, special issue, *National Catholic Bioethics Quarterly* 20.2 (Summer 2020): 355–371, doi: 10.5840/ncbq202020232.

31. Janet Durbin, Avra Selick, Ian Casson, Laurie Green, Andrea Perry, Megan Abou Chacra, and Yona Lunsky, "Improving the Quality of Primary Care for Adults with Intellectual and Developmental Disabilities: Value of the Periodic Health Examination," *Canadian Family Physician* 65 suppl 1 (April 2019): S66–S72, https://www.cfp.ca/content/65/Suppl_1/S66.

32. Hannah Recht, "Is Paxlovid, the Covid Pill, Reaching Those Who Most Need It? The Government Won't Say," *Medscape*, May 12, 2022, https://www.medscape.com/viewarticle/973906#vp_2.

with COVID-19[33]) and those who are at risk for developing serious illnesses due to COVID-19 (e.g., persons with certain health conditions, especially those who have poor access to health systems).

4. Systems thinking

a. Most emerging diseases that result in pandemics are transmitted from non-human hosts to humans. Deforestation, high-density animal-farming practices, and other environmental harms caused by humans contribute to conditions that favour the emergence of such diseases.[34] Low- and middle-income countries are disproportionally burdened by such diseases. "One health" and similar approaches to health care are examples of "systems thinking."[35] They promote harmony in the interdependent relationships among all participants in the earth's ecosystem. Such approaches can serve to prevent future pandemics.[36] They are also essential for developing preventive and health-promoting interventions that address the whole person and should be incorporated into regular health care of every patient.

b. "One health" and similar approaches, however, depend on commitment and cooperation across different areas of learning and various sectors of society. Such commitment and cooperation should be fostered by all to promote the common good, not only for humans but also other participants of our shared ecosystem.

c. An integrated ethical framework for clinical and public health care entails investigating, identifying, and striving to address and educate about ways in which clinical care and public health interventions can harm our planet and their potential negative, long-term implications for the health and well-being of all its life forms.

Part Three: Recommendations

A Chinese proverb states that a thousand-mile journey begins with a single step. Below, we propose six steps that various community members can consider and take towards integrating ethical approaches to clinical and public health care during and beyond pandemics.

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33. For an ethical discussion on prioritizing healthcare workers for COVID-19 vaccination, see Xavier Symons, Steve Matthews, and Bernadette Tobin, "Why Should HCWs Receive Priority Access to Vaccines in a Pandemic?," *BMC Medical Ethics* 22 (June 27, 2021), article number 79, doi: 10.1186/s12910-021-00650-2.
34. Emma C. Hobbs and Tristan J. Reid, "Animals and SARS-CoV-2: Species Susceptibility and Viral Transmission in Experimental and Natural Conditions, and the Potential Implications for Community Transmission," *Transboundary and Emerging Diseases* 68.4 (July 2021): 1850–1867, doi: 10.1111/tbed.13885.
35. The topic of a "one health" approach to health care was among those discussed at the IACB colloquium on "Ecology, Health, and Bioethics" in Rome from June 26 to 29, 2022.
36. "One Health," Newsroom: Questions and Answers, World Health Organization, September 21, 2017, https://www.who.int/news-room/questions-and-answers/item/one-health; and Catherine Machalaba, Kristine M. Smith, Lina Awada, et al., "One Health Economics to Confront Disease Threats," *Transactions of the Royal Society of Tropical Medicine and Hygiene* 111.6 (June 2017): 235–237, doi: 10.1093/trstmh/trx039.

1. For all

Strive to make the best healthcare decisions possible (including advance care plans), recognizing that care for oneself and concern for the common good are complementary and mutually supportive goals.

2. For Christian bioethicists

Educate yourselves and others regarding the ethical framework proposed above, especially the reasons why certain ethical positions should be accepted and others rejected.

3. For healthcare providers

Recognize your essential role in mediating clinical and public healthcare decisions. Promote informed and responsible moral agency in your patients, and advocate for clinical and public healthcare policies that strive to bring about conditions in which all patients can benefit equitably from health and other systems.

4. For those responsible for health systems

Investigate and monitor the effects of policies on clinical and public health care, as well as care of the environment, with the goal of improving their integration. Address gaps in health care and the indirect negative effects of pandemics that result from lack of such integration, especially for those who are disproportionately affected.

5. For researchers

Promote effective and integrated collaborations across disciplines to address the complex scientific, technological, medical, socio-economic, and ethical issues that are emerging regarding responding to, preparing for, and preventing pandemics.

6. Economic and political leaders

Commit to improving access to good primary health care for all as a condition for promoting public health during and beyond pandemics.

Conclusion

This statement echoes and affirms what Pope Francis succinctly stated in his address to diplomats accredited to the Holy See on January 10, 2022: "Each of us has a responsibility to care for ourself and our health, and this translates into respect for the health of those around us."[37]

We have identified a key dichotomy in the organization of contemporary health care, namely, the general lack of integration between clinical and public healthcare systems. This is reflected in different approaches and areas of focus for investigations, reflections, and discussions in clinical ethics and public health and global ethics. We need an integrated and consistent bioethics framework that spans clinical and public health care. Such a framework is essential to guide all health care during and beyond pandemics.

37 Francis, Address to the Members of the Diplomatic Corps (January 10, 2022).

Acknowledgments

Presenters in the IACB webinar series on Ethics and Pandemics *or videos*: Fr. Rob Allore, SJ (Canada), Jason T. Eberl (U.S.A.), Sr. Nuala Kenny, SC (Canada), Cory-Andrew Labrecque (Canada), Alexandre A. Martins (U.S.A., Brazil), James McManus (U.K.), Fr. James McTavish, FMVD (U.K.), Anna Perkins (Jamaica), Delia Grace Randolph (U.K., Kenya), Sr. Damien Marie Savino, FSE (U.S.A.), Xavier Symons (Australia), Michael Wee (U.K.), Klaus Weil (Germany).

Moderators in the webinars or videos: MaryKate Gaurke (U.S.A.), Pedro Guevara Mann (Canada, Panama), William F. Sullivan (Canada), Bernadette Tobin (Australia), Jessica Vallentin (Canada).

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