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Four Ways to Approach Equity and the Opening to Justice – Part One

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***Editor's Note**: This is the first of a two-part article about "Four Ways to Approach Equity and the Opening to Justice" by Darren M. Henson, Ph.D., STL. The second part of the article will appear in the summer 2021 issue of* HCEUSA. *Dr. Henson served as system vice president of mission and discernment at Presence Health and subsequently at AMITA Health in Chicago. Most recently, he was director at the American Hospital Association's Institute for Diversity and Health Equity.*

As the coronavirus pandemic ripped across the U.S. in spring 2020, the nation saw gut-wrenching inequities in infection and mortality rates. Initial outbreaks exposed inequities among black and brown populations in metropolitan areas, followed by inequities among the rural, immigrant, Hispanic, and Native American communities. As these jarring realities ripped across national headlines, and flooded ICUs and tent morgues, a different pandemic took hold. Black women and men were fatal victims of shootings in the early months of 2020: Ahmaud Arbery in Glynn County, GA; Breonna Taylor in Louisville, KY; and George Floyd in Minneapolis, MN. A second pandemic of systemic racism and violence

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collided with the coronavirus. Together, they impacted the health, well-being, and lives of historically marginalized populations. The deadly mixture motivated hospitals, health systems, and their partner organizations like the Catholic Health Association (CHA) and the American Hospital Association (AHA) to publicly respond.

This essay uses the statements by the two national associations to exemplify a range of moral analysis among contemporary ethical currents. Each of four traditional modes of moral reasoning will be reviewed following Brian O'Toole's assessment and application of them in his 1998 *Health Progress* article. I will show how these modes of moral reasoning appear in the CHA and AHA statements. This essay posits that all four modes have value in the current discourse of health equity strategies by health systems today. An analysis will reflect

the contribution of each method. Then, the essay will posit that the current spotlight on equity provides an opportunity to accelerate and solidify an enduring shift in health care ethics grounded in the virtue of justice.

FOUR APPROACHES TO MORAL DECISION MAKING

CHA's statement on May 29, 2020 calling for racial justice and reconciliation opens by affirming a central principle: "that each person is sacred and worthy of our deepest reverence."[1] The AHA's statement on June 1, 2020, opens with a contrasting tone: "The senseless killing of an unarmed black man in Minneapolis and the protests that are occurring in cities across the country have shaken our nation to its core."[2] The AHA statement is an example of the moral sentiment approach to moral reasoning. After these opening lines, both the CHA and AHA statements included elements of moral reasoning from the other two approaches, namely consequential and virtue. To better understand each of these four traditional approaches to moral argument, I turn to Brian O'Toole's application of these four methodologies to a health care setting.[3] These distinct approaches to moral reasoning can provide helpful insight to the chorus of pleas for equity. Each sheds a unique light on the disproportionate inequities in health outcomes experienced by black, brown, indigenous, and other historically marginalized populations.

In the **Principle Approach**, decisions are made according to a principle, law, or regulation. A classic example is the 'Golden Rule' to treat others as you would want to be treated. Today, this is often replaced by the 'Platinum Rule' to treat others as they want to be treated.

Many parts of health care operate by rules that delineate a process. Thus, the principle approach may be the most familiar. Laws and regulations spell out requirements to uphold our American ideal that all people are created equal. This echoes the Catholic principle that all human life enjoys an intrinsic and inviolable dignity. As O'Toole notes, "a principle is a general normative standard of conduct, holding that a particular decision or action is true or right or good for all people in all times and in all places… Everyone should sometimes use the principle approach to ethical decision making; without principles, decision makers have no parameters limiting what they will or will not do."[4]

The CHA statement, as noted above, opened with a principled argument. The AHA statement also included references to principles. It expressed how speaking out against injustice, an appeal to the principle of free speech, "is an essential part of our democracy." O'Toole explains how references to obligations or duty, as well as cautions signaled by the word "never," point toward a principle approach. The AHA statement echoes the CHA's principle of human dignity when the former envisions how all individuals ought to have the means to reach their highest potential for health.

Second, the **Consequence Approach** also appears frequently in health care settings. Here, decisions are made according to their likely outcome. This approach anticipates the results of action or inaction. Dashboards and scorecards, for example, from quality, finance and other departments guide decisions toward a desired endpoint. When outcomes fall short of stated goals, leaders make changes so that the next reports hopefully show improvements,

or better consequences. O'Toole notices the consequential approach when people pose questions such as: "What effect will this have? What good will that bring about? And will this help in the long run? In the consequence approach, the decision maker weighs several possible results and arrives at the decision likely to produce the best result. The problem is that not everyone weighs and evaluates possible results in the same way."[5] A further problem O'Toole omits is that the outcome becomes primary and the means to achieving it is secondary, if scrutinized at all. It is quite possible, and not uncommon, to gloss over principles for the sake of achieving the desired outcome. Such situations end up in the dangerous rationalization of "the ends justify the means." People who favor the principle or virtue approach may sparingly apply the consequential approach. When they do, they will likely ensure that the means to the desired ends honors fundamental values.

Unsurprisingly, the CHA statement sparingly references a consequential argument when it identifies an end to racism and violence as markers for the fruit of their work. Conversely, the statement by the nonsectarian AHA provides several examples of consequential argumentation for embracing and pursing equity strategies. It cites disproportionate effects on diverse communities. The message implies that the efforts of health systems ought to change outcomes clinically and economically.

The third is the **Moral Sentiment Approach**. O'Toole rightly observes how people experience strong and powerful feelings of approval or disapproval. As he points out, the difficulty in a direct correlation between one's feelings and moral decision making is precisely the subjective nature of those feelings. O'Toole writes, "No appeal to principles, weighing of consequences, or reliance on personal integrity is involved. For the person guided by moral sentiment, something either feels right or it does not feel right."[6] The feeling that an action is right for one person or feels uncomfortable for another poses a difficulty. The subjective nature of the feeling makes it impossible to apply universally – the very quest of the principled approach. O'Toole suggests those using the moral sentiment approach may find themselves disadvantaged from others. Yet, his article predated philosopher Martha Nussbaum's compelling arguments on emotion as a centerpiece to moral and ethical discourse.[7] She confronts philosophy's history of dismissing emotions and detaching them from intelligence and discernment, and she rebuts critiques that bifurcate emotion from one's integrity. Instead, Nussbaum builds an ethics methodology that takes seriously the power and influence of emotion amidst the complexity of human reasoning.

The CHA statement appeals to emotion immediately following the opening sentence. It references feeling "appalled by the recent killings of African Americans" and acknowledges "deep grief and anger." The AHA statement, as noted above, is striking in that it opens with an acknowledgement of emotion, signaled by descriptors of "senseless killing" and a nation shaken to its core. It continues by recognizing "deep-seated frustration and hurt," and anger. Both statements unambiguously arise from a place of emotional distress palpably present not just in individuals but within society.

The fourth and final approach is **Virtue**. O'Toole identifies it as making decisions according to one's responsibilities. The virtue approach bears similarities to the principle approach, in that both apply "moral oughts" to situations. The difference is that virtue is not applied universally, but rather to a particular person, role, group or organization. The virtue approach focuses on the character, or the virtue of a physician, nurse, or therapist for example. It probes ideals such as, what type of health care system or hospital do we want to be? O'Toole observes "'Integrity' and 'walking the walk' are very important to people who use the virtue/character approach."[8]

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The CHA statement appeals to virtue arguments when it suggests that one must not respond with violence, but rather be a people who commit to justice and peace. The end of CHA's statement posits that our nation ought to pursue the virtue of justice, specifically racial justice and reconciliation. It describes a desired characteristic. The statement does not posit these virtue generally the way a principle approach would. Rather, it is more specific to its member organizations and to this nation.

This personalization of the desired characteristic is seen in the AHA statement. It specifies that "hospitals have an important role to play in the well-being of their communities." Even more, the AHA statement questions the very integrity and character of our nation when it suggests taking a moment to "hold up the mirror and honestly look at ourselves." This is precisely the virtue/character approach to moral argumentation in action. ✣

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ENDNOTES

1. The Catholic Health Association, "A Call for Racial Justice and Reconciliation," News Release, May 29, 2020. https://www.chausa.org/newsroom/news-releases/2020/05/29/a-call-for-racial-justice-and-reconciliation
2. The American Hospital Association, "Statement on George Floyd's Death and Unrest in America," News Release, June 1, 2020. https://www.aha.org/press-releases/2020-06-01-statement-george-floyds-death-and-unrest-america
3. O'Toole, Brian, "Four Ways People Approach Ethics," *Health Progress*, Vol. 75.6, Nov.-Dec. 1998, 38-43.
4. Ibid., 40.
5. Ibid., 41.
6. Ibid., 43.
7. Nussbaum, Martha, *Upheavals of Thought: The Intelligence of Emotions,* (New York: Cambridge University Press) 2001. Nussbaum expands upon this seminal work in several other books. Themes include shame and disgust in law and politics in *Hiding from Humanity* (2006) and then *From Disgust to Humanity* (2010). In more recent years her work takes up topics of anger, forgiveness, resentment, generosity, justice, fear, and love.
8. O'Toole, 41.

Reflection Questions

1. Which of these four ethical approaches do you use most often?
2. Which of these approaches do you believe your colleagues use most often?
3. How does knowing these approaches help you to discuss ethical matters with your team? With your patients or residents?

The Vocation of the Healthcare Ethicist

Archbishop Anthony Fisher, OP, Ph.D.

Editor's Note: *This article is based on a presentation by Archbishop Anthony Fisher, OP, Ph.D., of Sydney, Australia, at CHA's Theology and Ethics Colloquium, March 10, 2021.*

Thank you and greetings from Sydney, Australia. Let us consider the vocation of the healthcare ethicist by first examining current dilemmas of health ethics and various perspectives on healthcare ethics from secular, Jewish and Christian traditions. We will also examine viewpoints on the role and need for ethicists in the context of contemporary health care and moral principles of the Catholic Church.

CURRENT HEALTH DILEMMAS: WHICH ETHIC APPLIES?

- A young man dies in the ER after a car accident; his widow wants his sperm collected immediately so she can have his children. The emergency team is unsure of their options and responsibilities. What do you advise?[1]
- An elderly lady from an aged care facility who has been febrile for days and is now short of breath, coughing, and tachycardiac. She has hypertension and early dementia, and has previously been treated for pneumonia, but is otherwise relatively healthy. There is dispute over what is medically indicated, what the patient wanted, and what her family is demanding. You are contacted by the director of nursing. What do you advise?[2]
- A ten-year-old biological male diagnosed with Asperger's Syndrome and gender dysphoria is referred by a GP to your hospital for assessment and prescription of 'puberty blockers' followed by other 'gender affirming' pharmacological and surgical interventions. The child is already dressing as a girl and the child's parents, teachers and psychologist are divided on how to respond. The matter is referred to the hospital ethics committee and the members all turn to you. What do you advise?[3]

These cases are examples of the thousands of enquiries referred each year to medical associations, healthcare institutions and ethicists for advice. Thousands more people access the codes and online ethical resources of these bodies[4] or go trawling the net and the blogsphere for counsel. Others get their ideas from such reliable sources as *General Hospital, Grey's Anatomy* or one of the 73 American TV series so far, all set in medical or hospital settings and combining soap opera and ethical consult.[5] For every one of these cases in the professional literature or the pop media, there are thousands more real life examples that you and your colleagues could add to the catalogue of human experience.

The COVID-19 pandemic has multiplied people's ethical dilemmas, and there is already a burgeoning literature around these.[6] Issues have included the limitation of public freedoms, access to tests and treatments, sharing of test results with civil authorities, principles of triage for overwhelmed systems, and maintaining family integrity amidst quarantine and social distancing. While many have put their hope in vaccines, these too have raised questions regarding the use of fetal cell-lines, the testing and effectiveness of vaccines, priority of access to vaccines, whether there is a strong duty to be vaccinated and what encouragement or coercion is appropriate, and the responsibilities of 'big pharma' and the richer nations towards poorer countries under COVID. For many people the pandemic has forced a re-examination of the meaning of life, their own priorities, ethics in a time of crisis, and their attitude to healthcare.[7]

Addressing the coronavirus crisis, the Vatican has offered several reflections upon our common vulnerability and interconnectedness along with some principles for responding to such an emergency.[8] These documents have also challenged the reduction of the ethics of healthcare to certain 'neuralgic issues' as John Glaser has pointed out, and we can become fixated on a narrow range of 'moral' concerns while ignoring issues of access, equity, waste and the like that touch on the lives of many more people, often more drastically.[9]

Which is not to trivialize for a moment the seriousness for people's personal lives, and for the character and mission of practitioners and institutions, of controversies over care at the beginning or end of life,[10] sterilizing or 'gender-affirming' interventions, the conscience rights of practitioners and institutions;[11] nor to minimize the anxiety many feel about the direction of government policy in recent years or in the years to come.[12] The theological anthropology, Gospel of life, and freedoms of religion proclaimed in the Catholic tradition are surely non-negotiables for any Catholic ethicist, practitioner or institution, but it will take courage and prudence to hold fast to these things at a time when they are increasingly counter-cultural.

Into these myriad issues the bioethicist "enters where angels fear to tread." What are the rules of engagement? In a world with multiple, rival, fragmented moralities, and where some think there's no more to ethics than personal preferences, loyalty groups, and power games, which way do we go for the inspiration, even vocation, of the ethical adviser in Catholic healthcare?

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WISDOM TRADITIONS ON HEALTH ETHICS

'Secular' Wisdom on Health Ethics

One obvious place to start is the Hippocratic tradition, which evolved from the fifth century BC onwards,[13] and was long regarded as the model of medical conduct. Suffice it here to say that the 'Hippocratic Oath' is topped and tailed with a vow and prayer to the gods of health; it briefly articulates the intrinsic goals of medicine and character proper to its practitioners; and it lists some dos and don'ts which give a sense of how those vows, goals, and character might play out in practice. There's no hint here, however, of the need for ethics expertise: moral philosophy, like medicine, was in its infancy in the Hippocratic era and the doctor still knew best.

I won't trace here the evolution and influence of the Hippocratic tradition thereafter. Much of it survived in the 1948 *Declaration of Geneva* and subsequent declarations of the World Medical Association (WMA). Here, the medical profession worldwide, recovering from the catastrophic malpractice of the Nazi era, sought to recover and translate the oath for modernity.[14] Though more coy about god language, Geneva joined Athens (and Jerusalem) with talk of a "solemn pledge", "consecrating my life" to service, maintaining "utmost respect" for human life from conception, and being ready "even in the face of threats" to observe "the higher laws of humanity". In just a few verses, the WMA commended *pietas* toward teachers and profession, a dignified professionalism and good conscience, and strict observance of patient confidentiality, non-discrimination and non-maleficence.

The Hippocratic tradition suggests that bioethics can be grounded in the internal logic of the practice of medicine and a morality 'natural' or 'common' to humanity. It marks a deeply humane and spiritual concern at the heart of good medicine. But in modernity, medicine can be market-driven and even cynical: how is the best of the Hippocratic tradition to be recovered and advanced?

Jewish Wisdom on Health Ethics

What does biblical wisdom offer? In the 38th chapter of the *Book of Ecclesiasticus* in the Catholic and Orthodox bibles, we have the nearest ancient Jewish parallel to the ethics of Hippocrates. Written by a Hellenistic Jew, Ben Sirach from Seleucid-occupied Jerusalem in the second century BCE (it opens by telling the sick to honor the physician and the pharmacist as well). Why? For his knowledge of medicinal herbs and his service of humanity; for diagnosing accurately, preserving life, prescribing the right medicine; and for healing effectively and relieving pain (vv. 1-8,14). The physician can hold his head high, knowing he is a credit to God and a contributor to the world (vv. 3,6,8). But he must also acknowledge that his hands and learning are God-given gifts, and so pray to the God from whom all healing comes (vv. 1-2,4-7,12,14).

The 'patient', for her part, must be patient rather than defiant, cleanse body and soul, pray and sacrifice for a cure, and "then let the doctor take over" (vv. 9-12). As if an advertisement for the American Medical Association (AMA), *Ben Sirach* declares that no sensible person will reject the physician's advice, and that life and health may depend on it! (vv. 4,12-14) But then, as if to counter-balance the praise of doctors, Ben Sirach quotes a popular aphorism of the ancient

world: "Let the wicked fall into the hands of a physician"! (v. 15)

Christian Wisdom on Health Ethics

The parable of the Good Samaritan in Chapter 10 of the *Gospel of Luke* is the text that most influenced Christian healthcare and health ethics. Suffice it here to say it is the story of a 'carer' cradling a wounded man, binding up his wounds, pouring lineament, giving pain relief, and ensuring institutional care and funding for as long as needed. Here we find themes of:

- Compassion and active mercy
- An ethic of rescue (save-heal-care), without discrimination, calculus, blaming
- Charge to "Go and do likewise".

Jesus' own healing ministry, his self-description as a physician of bodies and souls, and this story with its concluding mandate, were springboards for Christian healthcare, pastoral care of the sick, and health ethics. Thereafter, came a sacrament of the sick and rites for the dying; monastic pharmacies and hospices for pilgrims and the infirm; hospitaller orders of religious men and nursing orders of religious women; hospitals, orphanages, clinics and other Church-sponsored care services; and centers for training physicians and nurses. In the process, the Catholic Church became the oldest and largest healthcare provider in the world!

WHY DO WE NEED HEALTH ETHICISTS?

Despite tell-all interviews with Oprah Winfrey, Americans may be mystified regarding the role of the monarch in the Westminster system. The queen clearly has great symbolic authority and some surviving royal prerogatives as the parliament, executive and judiciary all act 'in her name'. But the British monarch does not make the decisions. When she acts, she acts on the advice of her government. She does, however, have three rights vis-à-vis her government: to be consulted, to encourage, and to warn.[15] You might say that the role of the ethical adviser in healthcare is rather similar. But why have them at all? Why not just leave it to the republic of common sense and its fine citizens, health professionals and patients?

'Secular' Wisdom On the Need for Health Ethicists

The latest AMA *Code of Ethics* (2016) claims continuity with the Hippocratic tradition and insists that health professionals must not only be technically competent but ethically principled in their practice (1.2, 1.3, 3.1.6). This includes being professional (1.1, 3.1), trustworthy (1.5), patient-focused (2.1.1 etc.), confidential (2.2), and respectful of patient dignity, rights, and boundaries (1.5, 2.1.1, 2.1.5, 3.1.8, etc.).[16] Amongst those with whom the Code envisages health professionals collaborating are ethics committees and consultants.

The AMA conceives of these as:

- Supporting informed, deliberative decision-making by patients, families, and the healthcare team
- Offering assistance in addressing ethical issues that arise in individual cases, clarifying issues and values, and facilitating sound and respectful decisions
- Facilitating discussion that promotes respect for the values, needs, and interests of all participants, especially when there is disagreement or uncertainty

- Providing ethics-related educational programming and policy development within their institutions.[17]

These are important tasks, but they have their risks and need to be contextualized with their goals and substance carefully articulated.

Jewish Wisdom On the Need for Health Ethicists

In a previous section, I noted that in *Ecclesiasticus* Chapter 38 we have the nearest thing in the Old Testament to a healthcare ethic. There, we find advice both for health professionals and for patients, about the calling and inspiration of medicine, its goals, the spiritual attitudes proper to the participants, and the conclusion that we should follow our physician's advice. In the very next chapter of *Ecclesiasticus,* we are told to seek the advice also of the philosopher or wise person. She is one who meditates on the Law of the Lord, researches the wisdom of the ancients, ponders the meaning of stories and proverbs, and is upright and grateful. She also explores less familiar territory, sifts good from evil, and prayerfully contemplates divine wisdom as much as human (*Sir* 39:1-14).

God blesses her with wisdom, but she doesn't hoard it for herself: she counsels the great and the good, appears before the authorities, and pours forth words of wisdom for all (vv. 4,6,9). "Many shall praise this one's wisdom," the text continues, "and it shall never be forgotten. The memory of the wise shall not fade away, and their wisdom shall be honored" from generation to generation, in the nation and the Church (vv. 12-14). Though Ben Sirach doesn't say explicitly that this advice is as important for moral and spiritual health as medical advice is for physical health, he declares the faithful should meditate on this sage's advice (v. 16).

The positioning of these two chapters of *Ecclesiasticus* – about the advice of the physician and the advice of the philosopher – right up against each other, invites reflection on the intersection between medicine and ethics, and the possibility of someone being a wise counsellor when it comes to healthcare decisions.

When the great Jewish philosopher-physician Moses Maimonides (1135-1204) offered his medieval ideas on the medical arts and ethics, such sentiments were omnipresent. After the model of *Ben Sirach,* he presented the philosopher-physician as a wisdom figure and friend of humanity, a lover of science and of neighbor, without avarice or vanity.[18] But does the wise physician really need ethical advisers?

The words the Bible uses for 'advise' or 'counsel' – in Hebrew יעץ (*ya'ats*) and עצה (*'etsah*), in Greek βουλή (*boule*), συμβουλεύω (*symbouleuo*) and γνώμη (*gnome*) – have some interesting qualities. Advice in the Bible is never merely feeling or opinion: it is expected to be well-considered and taken from a reliable source. It is usually very practical, advising on plans, strategies, what is to be done. And it is never neutral. To give counsel is not just to outline a range of options. Rather, it is to commend *the right* course of action, and so it implies guidance and obligation.

There are many *advisers* and much *advice* given in the Bible – the terms יעץ and עצה appear 168 times. God is, of course, the best of advisers

and the most prudent choice is that which conforms to his plan;[19] indeed God's revealed plan ***is*** His counsel.[20] The Prophets confirm that right counsel comes from the Lord, or the Spirit of the Lord.[21] The Psalms and Wisdom literature personify Wisdom as a divine adviser.[22] In this tradition, Christ is presented as the 'Wonderful Counselor',[23] wisdom incarnate[24] and wiser than Solomon,[25] and the Holy Spirit as 'the Counselor'.[26] Throughout the Old Testament, patriarchs and kings had regular advisers,[27] and the Wisdom literature recommends that people more generally take broad advice, from one of more quality advisers and heed that advice.[28] So Christians are taught to seek the wisdom 'from above' and give and take counsel from each other.[29] To be a wise bioethicist in the Biblical sense, therefore, would be to be one who is in tune with the wisdom of God and who assists others with the practical application of that wisdom.

Christian Wisdom On the Need for Health Ethicists

This brings me to Christian attitudes on the idea of a health ethicist. With the gradual development of Catholic healthcare and pastoral care of the sick, there developed parallel traditions of thought about the ethics of life and death, sickness and health, self-care and health-care, professions, institutions and systems. This stretched from the Gospel generation, the fathers and scholastics, through the casuists and manualists, to the Catholic 'medico-morals' texts and secular bioethics of modernity.[30] One could easily identify some key influencers and monuments of that evolution: Augustine, Aquinas, Alphonsus, the neo-Thomists, Pius XII, John Paul II in *Evangelium Vitae,* Elio Sgreccia and his Pontifical Academy for Life, Paul Ramsey, Beauchamp and Childress, Edmund Pellegrino, Ashley and O'Rourke, the *Ethical and Religious Directives* to name a few.[31]

One monument along that winding path was the publication in 1994 of the *Charter for Health Care Workers* by the Pontifical Council for Pastoral Assistance to Health Care Workers. It was revised and reissued in 2016,[32] just before that council was absorbed into the Dicastery for Promoting Integral Human Development. The original charter elaborated an ethic for healthcare workers, beginning with a description of their vocation as "Ministers of Life" and elaborating their duties, especially with respect to procreation, life and death.

The *New Charter* follows the same structure but now includes some key magisterial pronouncements of the past two decades, and some reflection upon advances in technology, professional practice, healthcare law and ethics in the meantime. There is a rather 'Franciscan' emphasis on social justice in the new text.[33] Another difference is the addition of a section on *ethics committees and clinical ethics counseling.*[34] Here at last, we have a magisterial document that recognizes the existence of the hospital, system ethicist and ethics committees, and favors these because they can:

- *Supply* for deficits in the experience and sensitivity of the individual health worker faced with an ethical dilemma
- *Articulate* the values and principles at stake
- *Assist* where there are areas of conflict or ethical doubts on the part of clinicians, patients and relatives, as well as policy-makers, managers, insurers and the like

- *Enable* more reasonable clinical decision-making "within the framework proper to medicine and ethics".

The *Charter,* like the secular, Jewish and Christian bioethics of the two and a half millennia before it, presents healthcare as a calling and self-gift; ethical advisers share in that vocation by *supplying, articulating, assisting* and *enabling* in the ways identified. Ethicists are wise advisors, teachers and mentors, who help form the consciences of health practitioners and managers, always challenging them to more and better. As even the AMA recognizes with respect to ethics committees that serve faith-based or mission-driven heath care institutions, these are expected to "uphold the principles to which the institution is committed" and "make clear to patients, physicians, and other stakeholders that the institution's defining principles will inform the committee's recommendations".[35]

NOT-SO-GOOD REASONS FOR HEALTH ETHICISTS

Having explored some of the good reasons in the philosophical, biblical and magisterial traditions for having ethics advisers, consults and committees, we might consider some of the risks of these 'experts' and practices.

First, modernity tends to bifurcate the medical and ethical, as the know-how of two distinct groups. It takes years of specialized studies to master a discipline, and so those engaged in the one have only limited knowledge of the other. The upside is that there is rigorous research, academic discipline, debate and progress in each field; the downside is that the two disciplines float further and further apart. Then the ethicist may think, teach and advise from a position so theoretical as to be ill-informed, irrelevant or unintelligible, and the practitioner may pay lip-service to professional ethics, but in fact be guided by personal preference, professional fashion, civil law, and/or income maximization, and not much more.

Secondly, there is a danger of individuals or whole institutions outsourcing conscience and moral decision-making to some expert or committee of experts whose 'job it is' to deal with ethical matters.[36] This has several related but distinct risks: that the ethicist, who scores higher on 'moral reasoning' – whatever that means[37]– becomes the ethical know-all in the minds of others or in her own mind; that patients and families are disabled in favor of the 'expert' opinion of the ethicist; and that medical professionals abrogate their own personal moral responsibility, especially in the face of vexing issues.[38] As the late, great Jewish ethicist, Lord Jonathan Sacks, observed in his Templeton acceptance speech:

> You can't outsource conscience. You can't delegate moral responsibility away. When you do, you raise expectations that cannot be met. And when, inevitably, they are not met, society becomes freighted with disappointment, anger, fear, resentment and blame.[39]

Thirdly, at the other end of the spectrum, are those ethicists who, avoiding shouldering such grave responsibilities, become so vague or evasive as to be unhelpful. Interviews with a number of clinical neuroscientists over a seven-month period revealed the perception of a boundary between the 'real' work of practitioners and the 'ideal' work of ethicists.[40]

As one participant put it: "I've been to conferences where there was a talk on bioethics It's too philosophical what they say, not tangible, and they all talk and talk, and by the end of it, you don't remember anything."[41] Well, that might tell you more about the inattention of that particular practitioner than the quality of the talk itself. But it is clear in the three traditions I have explored today that ethical advisers are expected not to offer grand theories, or speculate about the range of options, but to guide choices and actions. Bioethicists must assist in good healthcare decision-making and in the sound education of professional or institutional consciences, rather than confusing everyone, making them unconfident about the way forward, or unconcerned about the ethical implications of their choices.

Fourthly, some imagine that a person might gain expertise as a bioethicist by doing a course or conference here and there, but with no serious grounding in one or more of the relevant disciplines of moral philosophy, moral theology, biology, healthcare or pastoral theology.[42] If people are free to erect a shingle announcing themselves as a health ethicist without serious credentials, so too individual practitioners may imagine themselves well formed in ethical matters after very little formal study of ethics or formation in the application of ethics to their behavior. Asking medical and nursing students to undertake some classes in principlism so that they can recite the Georgetown mantra, or requiring healthcare managers to read and sign onto the *Ethical and Religious Directives*, is just not enough.

A fifth danger of which bioethicists and those who seek their advice must be aware is that consciously or not the ethicist can be 'tamed' by their institution. We all want to get along with our comrades at arms in a healthcare setting; to be a team player, not a naysayer who gets in the way of technical progress, fiscal responsibility or current practice. We don't want to be branded as a 'hard-liner' or a 'difficult person'. The risk here is that the ethicist's desire to get along with or within the institution blunts her willingness to ask hard questions and press for limits. In such a case, the ethicist loses purpose or, worse, ends up as window-dressing for ethically dubious decisions. Here the Vatican's *New Charter* is right to warn that ethics committees can become 'merely administrative supervision' ticking various boxes when it comes to research or clinical practice for legal or professional purposes, but not addressing the ethical values at stake.[43]

Finally, if ethicists risk being tamed by their institutional affiliation, they must be equally watchful of their surrounding culture. Some aspects of the contemporary West are supportive of sound ethics, but we can also experience pressures to secularize and accommodate, or to so elevate medicine that it colonizes the whole of reality. Like the anathemas against witch-doctors in the Old Testament and against the pharmacists in the New,[44] ethicists as practitioners of true religion must always be ready to call out unethical behavior or systems, as well as medical idolatry.[45]

PROFESSION AND VOCATION: HOW ETHICISTS SERVE HEALTH CARE AND THE CHURCH

The Profession of Health Ethicists

The three traditions that have informed my

paper today all present health-carers – and by extension health ethics advisers – as engaged in more than a job or career. Some prefer the terms profession and professionals. Leon Kass and Alasdair Macintyre have explained that 'profession' is an *ethical* notion entailing:[46]

- A conviction on the part of practitioners about the importance of their particular service to others and their suitedness to it
- Immersion of newcomers in that practice, calling forth devotion of character and life
- Appropriate apprenticeship or education in knowledge, skills, mission, practical principles and virtues
- Public recognition by the community and public 'profession' by the practitioner of this tradition of practice
- Self-regulation by the practitioners of their own professional standards according to the internal goals of their activity and their inherited but evolving ethic
- Readiness to be public advocates for that professional ethos and for the needs of those they serve.

As an example of this last matter, the COVID-19 pandemic has served to highlight the inequities in access to tests, treatments and preventative measures within our communities and between countries. There are some big questions here about the allocation of social resources, and especially healthcare resources, and widening gaps between haves and have-nots in healthcare. Here, health ethics and social ethics intersect and the Christian preferential option for the poor and powerless will play out not just in willingness to do the unprofitable but charitable thing, but in public advocacy for social change.

If the idea of a medical or nursing 'profession' is itself an ethical notion, then the 'profession' of the bioethicist (at least in part) is to support his or her medical colleagues in being faithful to their 'profession'. When patients, relatives, colleagues, insurers or others press the health worker to act contrary to sound ethics and professional conscience, the ethics adviser can both support them in their resolve and advance education and discussion with those promoting a contrary agenda.

The Vocation of Christian Healthcare and Health Ethics

For Christian carers and those who advise them, however, talk of being 'professionals' – while better than talk of job or career – still limps somewhat. They reach for a word like 'calling' or 'vocation' to describe their sense of a transcendent mission to save, heal and care for or to assist others to do so. Hence the use of religious language in the Hippocratic, Jewish and Christian traditions of health ethics, and of a kind of sacred seriousness even in the contemporary codes and declarations of the WMA and the AMA. The Vatican *Charter* characterizes the activity of health-carers and their colleagues as guardians and servants of human life, health and dignity.[47] They serve human beings respectfully at their most fragile, and thereby contribute to the common good of their community, and give witness to moral norms and the spiritual life.[48] They know their task to be one of Christian witness and mission, 'a response to a transcendent call that takes shape in the suffering face of the other', a prolongation of the charity of

Christ the Physician, and a reflection of his 'Good Samaritan'.[49] Theirs is a participation in the pastoral and evangelizing activity of the Church.[50]

Beyond the moral elements of profession for healthcare and health ethics, there are spiritual dimensions of vocation, that include:

- A sense of divine calling, building upon any natural suitedness, so that one expects to find purpose, fulfilment, even sanctity, through the appropriate pursuit of that activity
- Willingness to cultivate character and mores not only through professional studies and immersion, but also through personal prayer, study of the sacred word, and reception of the sacraments
- Desire to pursue the goods of this vocation even if this will not maximize income or kudos[51]
- Public profession of that willingness, if not in religious vows, then by attachment and fidelity to a Church institution, its magisterium and directives such as the *ERDs*
- Integration of the role of bioethicist with other elements of one's personal and spiritual life, e.g., the service of one's family and the worship of one's God. Thus, one would expect a Catholic health ethicist to be a faithful Mass-goer, not out of tribalism or legalism, but because she finds inspiration and sustenance for her vocation there
- Prophetic willingness to call out cultural, economic or political forces that press practitioners (or even ethicists themselves) to conform to the values 'of this world' rather than of the kingdom of God
- Involvement in a Christian "community of concern" that assists the ethicist with discernment and supports them through challenging times.[52]

Conceiving of bioethicists as missionaries to their institutions, systems and surrounding cultures does not mean adopting a posture of imagined superiority or permanent opposition. Christians are called to be instruments of peace, and health ethicists can be so in a polarized Church and society, or when patients, family members and carers have opposing views. Even in the face of intractable issues like abortion, euthanasia, sterilization, sex-change or vaccine hesitancy, bioethicists can share with people to a broader historical, cultural, and spiritual vision and invite them into a conversation that is at once candid about basic norms yet respectful of those who think differently. As

Christians are called to be instruments of peace, and health ethicists can be so in a polarized Church and society, or when patients, family members and carers have opposing views.

Ron Hamel argued, ethicists "should also seek to form communities of moral discourse, places where ethical issues are acknowledged and taken seriously, where conversations can take place about ethical concerns and issues, and where ethical discernment can take place."[53]

CONCLUSION

There are today some powerful pressures to abandon the three streams of sound health ethics that I have followed today, or to diminish the senses in which health-carers and their advisers are engaged in an ethical profession, even a God-given vocation, or to disallow Catholic institutions to be different in some ways. Buzz words like 'compliance', 'efficiency' and 'transparency'; 'discrimination', 'anti-discrimination', 'homophobia' and 'transphobia'; 'reproductive health' and 'the full range of services'; 'separation of Church and state' and more – have been weaponized, as have some laws and policies addressing these matters. People are dismissed, de-platformed, trolled and otherwise threatened with ruin if they do not conform. In turbulent times like these, as several CHA ethicists have pointed out, ethics is critical to preserving the identity and integrity of Catholic healthcare, in assisting people in dealing with ethically complex matters, in challenging some individual behavior and organizational culture, and in engaging in the ongoing formation of leaders and staff.[54]

In this paper I began by identifying some examples of contemporary ethical issues, including ones raised by the COVID-19 pandemic, that call for sound ethics and reliable ethical advisers. I asked *which* healthcare ethic should inform our practice, and proposed as authoritative the 'secular' wisdom of the Hippocratic tradition through to the WMA declarations, the Jewish wisdom of Ben Sirach through Maimonides and since, and the Christian wisdom beginning with Jesus' *Good Samaritan* via great theologians and health practitioners through to the contemporary magisterium and theological reflection. I then probed *why* health ethicists, consults and committees are desirable, and identified some good reasons in the three traditions, as well as some dangers. Finally, I considered the *how* of the service of health ethicists and proposed that it is more than a career, or even profession, and more like a religious vocation, and I identified some of the marks of ethics advisers so understood. I suggested that in times such as these the missionary or evangelical role of the bioethicist comes to the fore but is also very challenging.

And so I leave the last word to that Biblical wisdom with which I began this talk. "In an abundance of counselors there is safety" (*Prov* 11:14; 24:6), so "Listen to advice and accept instruction, that you may gain wisdom for the future" (*Prov* 19:20). But as "All counselors think highly of their own counsel" but not always deservedly (*Sir* 37:7-11), esteem most highly the counsel that is most like "consulting the oracle of God" (*2Sam* 16:23). God bless health ethicists! ✠

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ENDNOTES

1. Adapted from Daniel Sokol, 'Meeting the ethical needs of doctors: We need clinical ethicists in addition to other measures', *British Medical Journal* 330(7694) (Apr 2005) 741-2, at p. 742.
2. Adapted from case reworks one offered in David Fleming, 'Responding to ethical dilemmas in nursing homes: Do we always need an ethicist?' *HEC Forum* 19(3) (2007) 245-59, at p. 245.
3. Adapted from Annie Pullen et al., 'The experiences of gender diverse and trans children and youth considering and initiating medical intervention', *International Journal of Transgenderism* 20(4) (2019) 371-87.

4. BBC News, 'Doctors make ethical plea', 2 December 2003, http://news.bbc.co.uk/2/hi/health/3253786.stm
5. 'List of medical drama television programs', *Wikipedia* https://en.wikipedia.org/wiki/List_of_medical_drama_television_programs.
6. For example: E. Azoulay and N. Kentish-Barnes, 'A 5-point strategy for improved connection with relatives of critically ill patients with COVID-19', *Lancet Respiratory Medicine* 8(6) (2020); Ezekiel Emanuel et al., 'Fair allocation of scarce medical resources in the time of Covid-19', *New England Journal of Medicine* 382(21) 2049-55; T. Farrell et al., 'AGS Position Statement: Resource Allocation Strategies and Age-Related Considerations in the COVID-19 era and beyond', *Journal of the American Geriatric Society* 68 (2020) 1136-42; T. Farrell & L. Francis, 'Rationing limited healthcare resources in the COVID-19 era and beyond: Ethical considerations regarding older adults', *Journal of the American Geriatrics Society* 68 (2020) 1143-49; Joanna Hart et al., 'Family-centered care during the COVID-19 era', *Journal of Pain and Symptom Management* 60(2) (2020); J. Lai et al., 'Factors associated with mental health outcomes among health care workers exposed to coronavirus disease', *JAMA Netw Open* 2 March 2020; R.C. Maves et al., 'Triage of scarce critical care resources in COVID-19', *Chest* 11 April 2020; Franklin Miller, "Why I support age-related rationing of ventilators for Covid-19 patients", *Hastings Centre Bioethics Forum*, 9 April 2020; Rene Robert et al., 'Ethical dilemmas due to the Covid-19 pandemic', *Annals of Intensive Care* 10(84) (2020); L. Rosenbaum, 'Facing COVID-19 in Italy – Ethics, logistics, and therapeutics on the epidemic's front line', *New England Journal of Medicine* 382(20) (2020) 1873-75; R.D. Truog et al., 'The toughest triage: allocating ventilators in a pandemic', *New England Journal of Medicine* 382 (2020) 1973–5; M. Vergano et al., 'Clinical ethics recommendations for the allocations of intensive care treatments, in exceptional, resource-limited circumstances', Critical Care 24(1) (2020) 165; D.B. White & B. Lo, 'A framework for rationing ventilators and critical care beds during the COVID-19 pandemic', *Journal of the American Medical Association* 323(18) (2020) 1773-4.
7. Seren Boyd, "Doctors Wrestle with Ethics of Clinical Decisions," *British Medical Association News*, 9 December 2020 https://www.bma.org.uk/news-and-opinion/doctors-wrestle-with-ethics-of-clinical-decisions
8. E.g. Pope Francis, *Fratelli Tutti: Encyclical on Fraternity and Social Friendship* (2020) 7, 32-6, 54, 168; *Meditation in a Time of Pandemic,* 27 March 2020; Address to the Banco Farmaceutico Foundation, 19 September 2020; *Message to the 75th Meeting of the United Nations General Assembly,* 25 September 2020; *Message for the 54th World Day of Peace,* 1 January 2021; Congregation for the Doctrine of the Faith, *Note on the Morality of Some Anti-COVID19 Vaccines* (2020); Dicastery for Promoting Integral Human Development, *Message in Time of Coronavirus* (2020); Dicastery for the Laity, Family and Life, *In Loneliness the Coronavirus Kills More*, 7 April 2020; Pontifical Academy for Life, *Pandemic and Universal Brotherhood* (2020) and *'Humana communitas' in the Age of Pandemic* (2020); Pontifical Academy for Life and the Dicastery for Integral Human Development, *Old Age = Our Future: the Elderly after the Pandemic* (2021); Pontifical Academy of Social Sciences, *Responding to the Pandemic (*2020).
9. John Glaser et al., 'Reflections on the role of ethicists in the Catholic health ministry', *Health Care Ethics USA,* Spring 2010, 8-18.
10. For my thoughts on some of these matters see: A. Fisher, *Catholic Bioethics for a New Millennium* (CUP, 2012).
11. For my thoughts on this matter, A. Fisher, 'Freedom of conscience and institutional integrity', in Helen Alvaré (ed.), *The Conscience of the Institution* (South Bend: St Augustine's Press, 2014), 1-28.
12. See the National Catholic Bioethics Center's Bioethics Public Policy reports of recent weeks: https://www.ncbcenter.org/bioethics-public-policy-reports.
13. See Helen Askitopoulou & Antonios Vgontzas, 'The relevance of the Hippocratic Oath', *European Spine Journal* 27(2) (2018) 1481-90; T.A. Cavanagh, *Hippocrates' Oath and Asclepius' Snake: The Birth of the Medical Profession* (OUP, 2017); Robin Fox, *The Invention of Medicine: From Homer to Hippocrates* (Basic Books, 2020); Raphael Hulkower, 'The history of the Hippocratic Oath; Outdated, inauthentic, and yet still relevant', *Einstein Journal of Biology and Medicine* 25 (2010) 41-44; Leon Kass, *Toward a More Natural Science* (Simon & Schuster, 2008); Howard Markel, *'I swear by Apollo* – On taking the Hippocratic Oath', *New England Journal of medicine* 350(20) (2004) 2026-9; Steven Miles, *The Hippocratic Oath and the Ethics of Medicine* (OUP, 2005).
14. World Medical Association, *Declaration of Geneva – The Modern Hippocratic Oath* (1948, as revised 1968, 1983, 1994, 2005 and 2006): https://www.wma.net/what-we-do/medical-ethics/declaration-of-geneva/
15. Walter Bagehot, *The English Constitution* (1867), ed. Paul Smith (CUP, 2001), p. 75
16. American Medical Association, *AMA Code of Ethics* 2004, as revised 2006 and 2016.
17. AMA, *Ethics Committees in Health Care Institutions: Code of Medical Ethics Opinion 10.7* https://www.ama-assn.org/delivering-care/ethics/ethics-committees-health-care-institutions and *Ethics Consultations: Code of Medical Ethics Opinion 10.7.1* https://www.ama-assn.org/delivering-care/ethics/ethics-consultations. See also *AMA Journal of Ethics,* May 2016, special issue devoted to health care ethics consultation.

18. E.g. in *The Guide to the Perplexed* and in the *Oath of Maimonides*. See Abraham Heschel, *Maimonides* (Farrar, Straus & Giroux, 1984); Moshe Halbertal, *Maimonides: Life and Thought* (Princeton University Press, 2015); Corey Miller, *In Search of the Good Life: Aristotle, Maimonides and Aquinas* (Pickwick, 2019); Fred Rosner, 'The life of Moses Maimonides – a prominent medieval physician', *Einstein Q J Biol Med* 19(3) (2002), 125-8; Kenneth Seeskin (ed), *The Cambridge Companion to Maimonides* (Cambridge University Press, 2005).

19. *Ex* 18:19; Dt 32:18-20,28-29; *1Kings* ch.12; *Pss* 5:10; 81:12; 107:10-14; *Jer* ch. 24; Prov 21:30.

20. *Exod* 18:19; *Num* 24:14; *1Kings* 1:12; 12:6; *1Chr* 26:14; 27:33; *2Chr* 20:21; 30:23; *Isa* 8:10; 19:11; 28:29; *Jer* 32:19; *Ezra* 7:28; *Ps* 33:10; 119:24; *Job* 3:14; *Prov* 8:14; *Mt* 26:4; *Lk* 7:30; 23:51; *Jn* 18:14; *Acts* 2:23; 4:28; 5:38; 13:36; 20:27; 27:12; 42: *1Cor* 4:5; *Eph* 1:11; *Heb* 6:17

21. *Isa* 11:2; 28:29; 40:13-14; *Jer* 32:19.

22. e.g. *Ps* 16:7; 19:20-21; 32:8-11; 33:8-11; 73:24; 106:13; 107:11; 119:24; *Prov* 1:25,30; 8:14; *Wis* 8:9; 9:13-17; *Sir* 24:29; 42:21; *Job* 12:13; 26:1-4; 38:1-7; 42:1-6.

23. *Isa* 9:6.

24. *Mt* 7:24; 13:54; *Mk* 6:2; *Lk* 2:40,52; *Jn* 1:1-18; *1Cor* 1:18-31; *Col* 2:3; *Rev* 5:12.

25. *Mt* 12:42.

26. *Jn* 14:16,26; 15:26; 16:7; cf. *Mt* 17:5; *Jn.* 3:16-17;

27. Amongst those with regular or at least occasional advisers are Abimelech (*Gen* 26:26), Pharaoh (e.g. *Gen* 41:14-45; *Ex* 6:28; 10:7 etc.; *Isa* 19:11), Moses (Ex 18:17-19,24), David (*2Sam* 15:12,31; 16:9-12,23; *1Kings* 12:13-14; *1Chr* 26:14; 27:32-3), Absalom (*2Sam* 15:34; 16:15,20-23; 17:4-23), Rehoboam (1Kings 12:6,13; *2Chr* 10:6-8,13-14), Jeroboam (*1Kings* 12:28), Jehoshaphat (*2Chr* 20:21), Ahaziah (*2Chr* 22:3-5), Amaziah (*2Chr* 25:16-17), Hezekiah (*2Chr* 30:2), Zedekiah (*Jer* 38:4), Shecaniah (*Ezra* 10:2), Haman (*Esther* 5:14; 6:13), Artaxerxes (*Ezra* 7:14-15,28; 8:25), Ahasuerus (*Esther* 1:21; 3:13), Nebuchadnezzar (*Dan* 3:2-3,91-4; 4:27,36; 6:7) and others (e.g. *Jud* 20:7; *2Kings* 6:8; *1Chr* 12:19; 26:14; Judith 14:1; *Jer* 18:18; 49:7). Herod, too, assembled the chief priests and scribes to advise him: *Mt* 2:3-6.

28. *Job* 38:2; 42:3; *Prov* 1:5; 8:6,10; 11:14; 12:15,20,26; 13:10; 15:22,31-33; 19:20; 20:5,18; 24:6; 27:9; *Eccles* 4:13; *Sir* 6:6; 21:13; 37:7; 40:25; 44:3-4; *Tob* 4:18-19; *1Macc* 2:65.

29. *Mt* 18:15-17; 23:3; *cf. Mt* 5:38; 7:7-8; *Gal* 5:22-23; 6:1-2; *1Cor* 15:33; *1Thess* 5:21; *Col* 3:16-17; *Jas* 1:5; 3:17; *cf. 2Tim* 3:16-17.

30. Robert Baker, *Before Bioethics: A History of American Medical Ethics from the Colonial Period to the Bioethics Revolution* (OUP, 2013); Jeffrey Bishop, *The Anticipatory Corpse: Medicine, Power, and the Care of the Dying* (University of Notre Dame Press, 2011); John Evans, *The History and Future of Bioethics: A Sociological View* (OUP, 2014); Nancy Jecker, *Bioethics: An Introduction to the History, Methods and Practice* (3rd edn, Jones & Bartlett, 2011); Albert Jonsen, *A Short History of Medical Ethics (*OUP, 2008); Christopher Kaczor, *Defense of Dignity: Creating life, Destroying Life, and Protecting the Rights of Conscience* (University of Notre Dame Press, 2013); Sana Loue, *Case Studies in Society, Religion and Bioethics* (Springer, 2020).

31. On the history of Christian/Catholic bioethics see: Stanley Hauerwas, 'How Christian ethics became medical ethics: the case of Paul Ramsey', *Christian Bioethics* 1(1) (March 1995) 11-28; Dianne Irving, 'Quid Est Bioethics?' https://www.catholicculture.org/culture/library/view.cfm?recnum=3320; Louise Mitchell, 'A brief history of Catholic bioethics', *Ethics & Medics* 41(7) (2016) 3-4; Kevin O'Rourke et al, 'A brief history of the development of the *Ethical and Religious Directives for Catholic Health Care Services*', *Health Progress* 82(6) (2001), 18-21; Kevin O'Rourke & Philip Boyle, *Medical Ethics: Sources of Catholic Teachings* (3rd edn, Georgetown University Press ,1999); Edmund Pellegrino & Martin D'Arcy, 'The Catholic physician in an era of secular bioethics', *Linacre Quarterly* 78(1) (2011) 13-28.

    Key texts include: Benedict Ashley, Jean deBlois and Kevin O'Rourke, *Health Care Ethics; A Catholic Theological Analysis* (5th edn, Georgetown University Press, 2006); Nicanor Austriaco, *Bioemedicine and beatitude: An Introduction to Catholic Bioethics* (Catholic University of America press, 2010); W.J. Eijk et al, *Manual of Catholic Medical Ethics* (Connor Court, 2014); William E. May, *Catholic Bioethics and the Gift of Human Life* (3rd edn, Our Sunday Visitor, 2013); Edmund Pellegrino and David Thomasma, *Helping and Healing: Religious Commitment in Health Care* (Georgetown University Press, 1997); Elio Sgreccia, *Personalist Bioethics: Foundations and Applications* (National Catholic Bioethics Center, 2012); Nicholas Tonti-Filippini, *About Bioethics*, 5 vols (Connor Court, 2011-17), US Conference of Catholic Bishops and CHA, *Ethical and Religious Directives for Catholic Health Care Services* (6th edn, 2018) https://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf.

32. Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* (1st edn, 1994; 2nd edn, 2016). The first edition is available at https://www.vatican.va/roman_curia/pontifical_councils/hlthwork/documents/rc_pc_hlthwork_doc_19950101_charter_en.html. The *New Charter for Health Care Workers* was translated into English and published in Philadelphia by the National Catholic Bioethics Center in 2017 and is available online at https://www.scribd.com/document/431501363/The-New-Charter-for-Health-Care-Workers#from_embed. The Council ceased operation in 2017 and its responsibilities were transferred to the new Dicastery for Promoting Integral Human Development.

33. See Cathleen Kaveny, 'Pope Francis and Catholic healthcare ethics', *Theological Studies* 80(1) (2019) 186-201.

34. *New Charter* §140.

35. AMA, *Ethics Committees in Health Care Institutions: Code of Medical Ethics Opinion 10.7* https://www.ama-assn.org/delivering-care/ethics/ethics-committees-health-care-institutions

36. *Cf.* Sokol, 'Meeting the ethical needs of doctors'. AMA, *Ethics Consultations: Code of Medical Ethics Opinion 10.7.1* https://www.ama-assn.org/delivering-care/ethics/ethics-consultations notes that "Whether they serve independently or through an institutional ethics committee or similar mechanism, physicians who provide ethics consultation services should… serve as advisors and educators rather than decision makers. Patients, physicians, and other members of the care team, health care administrators, and other stakeholders should not be required to accept the consultant's recommendations. Physicians and other institutional stakeholders should explain their reasoning when they choose not to follow the consultant's recommendations in an individual case."

37. D. Self, J Skeel & N. Jecker, 'A comparison of the moral reasoning of physicians and clinical medical ethicists' *Academic Medicine* 68 (11) (1993) 852-5.

38. Thus AMA, *Ethics Committees in Healthcare Institutions*, observes that "To be effective in providing the intended support and guidance in any of these capacities, ethics committees should: (a) Serve as advisors and educators rather than decision makers. Patients, physicians and other health care professionals, health care administrators, and other stakeholders should not be required to accept committee recommendations. Physicians and other institutional stakeholders should explain their reasoning when they choose not to follow the committee's recommendations in an individual case."

39. Jonathan Sacks, 'Acceptance speech for Templeton Prize', *Templeton Foundation,* 26 May, 2016 https://www.templetonprize.org/laureate-sub/sacks-acceptance-address/

40. Caragh Brosnan and Alan Cribb, 'Between the bench, the bedside, and the office: The need to build bridges between working neuroscientists and ethicists', *Clinical Ethics* 9(4) ((2014) 113-19.

41. Brosnan and Cribb, 'Between the bench, the bedside, and the office', p. 115.

42. Thus AMA, *Ethics Consultations: Code of Medical Ethics Opinion 10.7.1* notes that "Whether they serve independently or through an institutional ethics committee or similar mechanism, physicians who provide ethics consultation services should… have appropriate expertise or training—for example, familiarity with the relevant professional literature, training in clinical/philosophical ethics, or competence in conflict resolution—and relevant experience to fulfill their role effectively."

43. Pontifical Council for Health Workers, *New Charter,* 140, para 2.

44. *Lev* 20:27; *Dt* 18:10-14; *1Chr* 10:13-14; *Acts* 13:6-12; *Rev* 21:8; 22:15.

45. *cf.* Hauerwas 1985; Meilaender 1995., see

46. Kass, *Toward a More Natural Science;* Alasdair MacIntyre, *After Virtue: A Study in Moral Theory* (3rd ed., University of Notre Dame Press, 2007).

47. Pontifical Council for Health Workers, *New Charter*, 1.

48. Pontifical Council for Health Workers, *New Charter*, 2-6.

49. See: John Paul II, *Evangelium vitae* (1995), 27; Pontifical Council for Health Workers, New Charter, 8; J.A. Di Noia, "The virtues of the Good Samaritan: Health care ethics in the perspective of a renewed moral theology", *Dolentium Hominum* 31 (1996), 211-14.

50. *New Charter,* 9. See also Congregation for the Doctrine of the Faith, *Samaritanus Bonus: On the Care of Persons in the Critical and Terminal Phases of Life* (2020).

51. Alan Astrow, Is medicine a spiritual vocation?' *Society*, 50(2) (2013), 101-105; Philip Bochanski, 'Professing faith, professing medicine: Physicians and the call to evangelize', *Linacre Quarterly,* 81(1) (2014), 1-11; R.A. González, 'The vocation to serve: Cornerstone of healthcare', *MEDICC Review*, 14(2) (2012); Germain Grisez, 'Healthcare as part of a Christian's vocation', in Luke Gormally (ed.), *Issues for a Catholic Bioethic* (London: Linacre Centre, 1999), 151-58; S. Hinohara, 'Medicine and religion: the spiritual dimension of health care', *Humane Health Care* 1(2) (2001), E2; Margaret Mohrmann, *Medicine as Ministry: Reflections on Suffering, Ethics and Hope* (Cleveland: Pilgrim Press, 1995); Daniel Sulmasy, *The Healer's Calling: A Spirituality for Physicians and Other Healthcare Professionals* (New York: St Paul, 1997) and *A Balm for Gilead: Meditations on Spirituality and the Healing Arts* (Georgetown University Press, 2006); etc..

52. Glaser, 'Reflections on the role of ethicists', p. 20.
53. Ron Hamel, 'Strengthening the role of ethics in turbulent times', *Health Progress* May-June 2010, 60-61, at p. 60.
54. See the several articles collected together in CHA, *The Ethics Role in Catholic Health Care* https://www.chausa.org/docs/default-source/general-files/cha_ethicsrole-pdf.pdf?sfvrsn=2.

Reflection Questions

1. If you are an ethicist, how do you see your part in the ministry as a peacekeeper?
2. Everyone has a vocation, a calling. Where have you seen yourself called this past year?
3. The Archbishop sees ethics as a part of Catholic identity. How do you see our moral teaching shaping the way we provide care in today's world?

Legal Lens

Students from the Saint Louis University School of Law Center for Health Law Studies contributed the following items to this column. Amy N. Sanders, associate director, supervised contributions by Jessie Bekker (J.D., M.H.A. anticipated 2023) and Darian Diepholz M.B.A., M.P.H., (J.D. anticipated 2022).

HOW RICH HOSPITALS PROFIT FROM PATIENTS IN CAR CRASHES

Hospitals nationwide are placing liens on accident settlements as a method of obtaining reimbursements for caring for patients after a car injury. Reporters from *The New York Times* followed Monica Smith, a 45-year-old woman who visited Parkview Regional Medical Center in Fort Wayne, Indiana following a car injury. Although Medicaid could have covered her costly care, the hospital opted to put a lien for five times the Medicaid reimbursement amount on her accident settlement, a practice that remains legal under hospital lien laws. By collecting under a lien, the hospital profits from money which would otherwise go to patients as pain and suffering compensation and amounts to charging a Medicaid patient as an uninsured patient at full price. In most states, hospital lien laws were written in the early 20th century, prior to widespread health insurance coverage among the general population to allow hospitals to provide care without the uncertainty of reimbursement. These laws are now mostly invoked in instances like Smith's, though some cap the lien amount or restrict collections to nonprofit hospitals. However, in states without such restrictions, hospital lien laws are generally invoked by the wealthiest institutions. Patients end up suffering from lowered credit scores and are left without the means to pay for follow-up care. In an attempt to tackle the problem, Indiana passed a bill requiring hospitals to bill a patient's insurer prior to pursuing a lien. The law did not specify Medicaid, however, and Parkview Regional Medical Center continued its lien practices, fending off at least nine lawsuits on the issue since the law was passed. It argues Medicaid does not qualify as health insurance, and instead, is government assistance. The hospital declined an interview, but said in a written statement that the hospital has discontinued this practice and that "Parkview has always taken a conservative and fair approach to collections."

Sarah Kliff and Jessica Silver-Greenberg, *The New York Times*, Feb. 1, 2021
https://www.nytimes.com/2021/02/01/upshot/rich-hospitals-profit-poor.html

MCKINSEY SETTLES FOR NEARLY $600 MILLION OVER ROLE IN OPIOID CRISIS

A $573 million settlement was reached in February between McKinsey & Company, a consulting firm, and 47 states. The settlement was reached after documents in the lawsuit revealed McKinsey drove sales of Purdue Pharma's OxyContin during the opioid crisis, leading to more than 450,000 deaths over

the past two decades. One of McKinsey's acts included advising Purdue to sell high-dose pills. This is a rare instance in which a party that profited from the opioid epidemic is being held accountable. McKinsey did not admit wrongdoing but agreed to court-ordered restrictions on its work with some addictive narcotics and agreed to publish thousands of documents related to its opioid work on a public database. While this settlement is worth more than McKinsey received for their work over the years, they were held to a higher role of accountability because McKinsey not only offered management advice, but two senior partners led the firm in implementing the plans to drive sales. This settlement may not be the end, as local governments in some jurisdictions have also filed suits. The Biden administration also could act.

Michael Forsythe and Walt Bogdanich, The New York Times, Feb. 3, 2021, https://www.nytimes.com/2021/02/03/business/mckinsey-opioids-settlement.html?action=click&module=Top%20Stories&pgtype=Homepage

'INCREDIBLY CONCERNING' LAWSUIT THREATENS NO-CHARGE PREVENTIVE CARE FOR MILLIONS

The Affordable Care Act is again being challenged, and this time, preventative care services are on the chopping block. A Texas federal judge seems poised to rule in favor of eliminating preventative services on religious and free-market grounds. The case, *Kelley v. Azar*, is a class action suit, in which the plaintiffs argue that those deciding which preventative services must be offered for free are not appointed by the president and confirmed by the Senate, and therefore those decisions cannot be binding. The plaintiffs also argue that "Congress cannot delegate responsibility to executive branch agencies to make binding regulatory decisions without providing clear guidance." Under the ACA, most plans must cover certain preventative services, including cancer screenings, vaccines, and contraceptives. The requirement has made such benefits more accessible to Americans, which, if ended, "would mean a lot of people would forgo preventive services and end up with much worse medical problems," according to Tim Jost, a retired Washington & Lee University law professor, in an interview with *Kaiser Health News*. If the Texas federal judge issues a preliminary injunction blocking access to preventative services, the Biden administration is likely to appeal to the Fifth Circuit, also a conservative court. Meanwhile, the Supreme Court will likely issue its ruling in *California v. Texas* soon. Though health has improved as a result of access to preventative services like cancer screening, including an increase in early-stage colon cancer diagnoses, it is unclear if insurers would continue coverage for these services without a mandate. Legal experts expect the case to make its way to the Supreme Court.

Harris Meyer, *Kaiser Health News*, March 26, 2021, https://khn.org/news/article/lawsuit-targets-health-law-no-charge-coverage-of-preventive-exams-like-mammograms/

'VACCINE PASSPORTS' ARE ON THE WAY, BUT DEVELOPING THEM WON'T BE EASY

With President Biden's pledge to start regaining some sense of normalcy this summer, "vaccine passports" have become a new topic for standardizing proof of vaccinations as businesses begin to reopen. The public can apply for passports on their phone and free of charge, possibly display a scanned code like airport boarding passes. The European Union is racing to develop similar digital certificates as summer begins and the public gets the urge to travel. Issues remain to be addressed regarding data privacy and health-care equity. There is a balance between ensuring everyone has access to receive credentials while also creating a passport that cannot be hacked or counterfeited. Another issue is the number of passport designs already underway, with at least 17 passport projects identified so far from the World Health Organization to IBM's, which is being tested in New York. Federal officials in the U.S. defended the project, asserting the Administration is moving carefully to ensure it is built well. The Biden administration must balance encouraging shots with not becoming a government mandate that could turn bad quickly. There is also the issue of determining how to handle those who cannot be vaccinated. While the passport could potentially motivate skeptics to get vaccinated so they could more easily visit family, take vacations, and resume everyday life, there are still many details to address before the Biden administration rolls out vaccine passports. Brian Anderson, a physician at Mitre, said the goal of passports to "[c]reat[e] an environment for those vulnerable populations to get back to work safely — and to know that the people coming back to their business are 'safe,' and vaccinated — would be a great scenario."

Dan Diamond, Lena H. Sun, and Isaac Stanley-Becker, *Washington Post*, March 28, 2021, https://www.washingtonpost.com/health/2021/03/28/vaccine-passports-for-work/

BIDEN SEEKS TO BOLSTER HOME HEALTH CARE IN INFRASTRUCTURE PLAN

President Biden has proposed a $400 billion bill which would fund home and community-based care, including long-term care coverage under Medicaid. The bill would raise wages for home-care workers and reduce home care Medicaid waiting lists. Including Medicaid, the U.S. spent nearly $380 billion on long-term care services and support in 2018, and demand is increasing. Still, wages lag behind at about $12.15 hourly for home-health aides. Meanwhile, about 820,000 people nationwide, most with disabilities, remain on community-based care waiting lists. By making home support and care services mandatory for Medicaid, and funding the requirement, the wait lists could shorten.

Alex Ruoff, *Bloomberg News*, March 31, 2021, https://www.bloomberglaw.com/product/blaw/bloomberglawnews/health-law-and-business/XCLIVMQS000000?bc=W1siU2VhcmNoICYgQnJvd3NIIiwiaHR0cHM6Ly93d3cuYmxvb21iZXJnbGF3LmNvbS9wcm9kdWN0L2JsYXcvc2VhcmNoL3Jlc3VsdHMvMjY0ZjBhZTQ2YzlkY2FlZmVmZTlhZDVmNDE2OTY2NzgiXV0--24dae282d1fc060494dd0d1659dfd6385dbfed56&bna_news_filter=health-law-and-business&criteria_id=264f0ae46c9dcaefefe9ad5f41696678

JUDGE RULES PURDUE MUST ANSWER QUESTIONS ABOUT DOCUMENTS SHOWING ANY LINK BETWEEN OXYCONTIN, BIRTH DEFECTS

In 2014, about 32,000 babies were born with neonatal abstinence syndrome (NAS), which dramatically increased from ten years before. NAS is "a group of conditions caused when the baby withdraws from certain drugs while exposed in the womb." NAS causes birth defects and long-term problems in heart defects, spina bifida, cleft palates, and more. The syndrome has commonly been linked to opioid use while pregnant, specifically OxyContin. Purdue Pharma filed for reorganization in bankruptcy court in response to lawsuits that the company downplayed the risks of its painkillers and encouraged doctors to prescribe large amounts. Attorneys for 3,000 NAS children are attempting to obtain animal toxicology studies from Purdue that would link OxyContin to NAS. Based on information received from other companies affiliated with Purdue, lawyers assert that Purdue still has other documents to provide, including findings on studies done. According to the NAS attorneys, the judge has directed them to review all obtained documents and then would allow deposition of the records custodian. The lawyers are looking for toxicology reports, including those not submitted to the FDA, to prove the linkage between OxyContin and NAS.

Ed Silverman, Statnews.com, April 7, 2021, https://www.statnews.com/pharmalot/2021/04/07/purdue-oxycontin-birth-defects-sackler/

FEDERAL-STATE HEALTH WAIVER TALKS ARE LESS INDULGENT, MORE OPEN

President Biden is starting strong in his tenure by being open with the public about rolling back Medicaid waivers. The U.S. Department of Health and Human Services recently provided notice to some states that it is rolling back the must-work rule for adults on Medicaid. This process aligns with administrative law playbooks, giving notice and the opportunity for a hearing in front of an HHS review board, decreasing the likelihood of litigation down the road. This is very different from past administrations whose Medicaid pilot programs involved backroom discussions and secret deals. This all changed with the passage of the Affordable Care Act in 2010, which introduced notice-and-comment requirements to waiver programs. Letters were sent out in March and April to alert four states that HHS was rolling back prior approval of the pilot programs under Section 1115 of the Social Security Act. Every waiver has a provision for the federal government to change the terms or conditions, but it has not been used until now. Work requirements led to 18,000 people being dropped from Medicaid in Arkansas within seven months. HHS stated it is ill-advised to require poor adults to work to receive health care during the pandemic.

Christopher Brown, Bloomberglawnews.com. April 20, 2021, https://www.bloomberglaw.com/bloomberglawnews/health-law-and-business/XDFQI5U0000000?bna_news_filter=health-law-and-business#jcite

ANOTHER SODA TAX BILL DIES. ANOTHER WIN FOR BIG SODA

Efforts to implement taxes on sugary drinks remain unsuccessful in many states and locales – most recently, California – as soft drink companies pour millions of dollars into lobbying efforts. A California bill that died in April would have undone a 2018 law that bars California cities from instituting their own sugary drink tax until 2031. Soft drink companies spent $5.9 million on lobbying in California in the last four years, dining with public officials and donating to their campaigns and charities in exchange for support against a sugary drink tax. Lobbyists tend to be people well connected to lawmakers, who know how legislatures operate from the inside. Public health officials argue that successful lobbying has tampered efforts to cut down on sugary drink consumption, which can contribute to diabetes and obesity. Four California cities with sugary drink taxes were grandfathered into the 2018 law. Other places with soda taxes include Boulder, Colorado; Philadelphia, Seattle, and the Navajo Nation. Those taxes contribute to public health department funds.

Samantha Young, Kaiser Health News, April 21, 2021, https://khn.org/news/article/another-soda-tax-bill-dies-another-win-for-big-soda/

Literature Review:
A World in Quarantine: A Step Towards Removing Stigma

Valerie De Wandel, J.D.

Often, an individual dealing with loneliness and depression may be afraid to seek the help of a psychiatrist because of what others might perceive. In 2020 however, that same individual might realize that they are not the only ones dealing with isolation. Isolation has become the norm due to the worldwide pandemic. The individual is not alone, and a stigma that has been so pervasive, has been diminished. Why did it take a pandemic to cause this positive shift?

The year 2020 will forever be known as the year that brought on the COVID-19 pandemic. The pandemic has affected every aspect of day-to-day life around the world. Not only has the pandemic brought about hundreds of thousands of cases and deaths from its physical symptoms, but the pandemic has also affected discussions about mental health. According to Professor Hadi Tehrani, it has become a psycho-social stigma attacking the dignity of the affected.[1] In fact, the uniqueness of COVID-19 is that its adverse effects have exposed concerns of mental health that may have always been present but are now being manifested abundantly.

Before COVID-19, reports indicated that approximately one in five adults reported having a mental illness in the past year, with over eleven million having a serious mental illness resulting in functional impairment of normal life activities.[2] According to a new government report conducted by the U.S. Centers for Disease Control and Prevention (CDC), forty-one percent of adults surveyed this past June "reported an adverse mental or behavioral health condition."[3] Compared to 2019, the number of Americans suffering from an anxiety disorder tripled and those dealing with depression practically quadrupled. While much of the reported anxiety and depression may stem from a fear of contracting the coronavirus, a position paper published in the *Lancet Psychiatry* examining changes in adult mental health in the United Kingdom before and during the lockdown noted that the major adverse consequences of the pandemic involved increased social isolation and loneliness. The authors noted, "Many of the anticipated consequences of quarantine and associated social and physical distancing measures are themselves key risk factors for mental health issues." Specifically, the authors described these concerns to include "suicide and self-harm, alcohol and substance misuse, gambling, domestic and child abuse, and psychosocial risks (such as social disconnection, lack of meaning or anomie, entrapment, cyberbullying, feeling a burden, financial stress, bereavement,

loss, unemployment, homelessness, and relationship breakdown)." Moreover, "a major consequence of the COVID-19 pandemic is likely to be increased social isolation and loneliness, which are strongly associated with anxiety, depression, self-harm, and suicide attempts across a lifespan."[4] While the statement above refers to the UK, U.S. data depicts similar concerns.

As mentioned above, the reports of Americans dealing with anxiety and depression increased in 2020 compared to the year prior. Additionally, a report discovered that fifty-three percent of U.S. adults reported that their mental health was adversely impacted as a result of stress and worry from the coronavirus. Other data indicate not only mental health concerns resulting from the stress of the virus itself, but mental health outcomes related to adverse effects such as isolation and job loss.

The important takeaway from these studies is not simply an increase in mental health cases, but the fact that more individuals are reporting their mental health concerns. Part of the rationale for this is that, as indicated by Dr. Michael Dewberry, senior associate medical director of Institute of Living of the Hartford HealthCare Behavioral Health Network, "the stress and anxiety of the pandemic is impacting everyone to some degree. We worry about the long-term effect of financial difficulties, uncertainty, social distancing, and isolation."[5] In other words, everyone, not simply a susceptible group of individuals, is experiencing some sort of lifestyle change or isolation that is most likely impacting their mental health.

Although large numbers of individuals dealt with various mental health concerns prior to the pandemic, adverse consequences from the pandemic directly affect everyone. The worry of contracting the virus, isolation, and other effects are ubiquitous. Similarly, discussion surrounding mental health was present prior to the pandemic, but now these issues seem to pervade daily conversation. To understand why this change has come about, it is important to understand why it had not come about sooner. The issue of mental health has always been relegated to hushed tones and a second-tier due to a stigma surrounding it. In order to best understand this notion of stigma, and how it has been affected by the pandemic, it is essential to understand the meaning of stigma and how it can be interpreted.

According to the World Health Organization (WHO), stigma is defined as "a mark of shame, disgrace, or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society."[6] According to the U.S. Surgeon General's Report on Mental Health, "Stigma erodes confidence that mental disorders are valid, treatable health conditions. It leads people to avoid socializing, employing or working with, or renting to or living near persons who have a mental disorder."[7]

Stigmas associated with mental health stem from misguided views that those with mental health issues are "different". More than marking them as "othered", these issues are part of a "moral failure". Editorial Director of the National Alliance on Mental Illness Austin, Karen Ranus, indicated in an interview that the

difficulty people have understanding mental illness as a health issue is because, "there's still a part of us that sees it as some character flaw or some kind of moral failing of some kind, a personality flaw." She also said that when her daughter was diagnosed with a mental health issue, leading her to a behavioral health unit, she never mentioned it on social media. However, when her mother was diagnosed with a brain tumor, she posted on Facebook.[8] It was as if some kind of shame encompassed her daughter's diagnosis.

The WHO has also emphasized that "stigma deters the public from wanting to pay for care, and thus reduces consumers' access to resources and opportunities for treatment and social services. A consequent inability or failure to obtain treatment reinforces destructive patterns of low self-esteem, isolation and hopelessness. Stigma tragically deprives people of their dignity and interferes with their full participation in society."[9] This is a manifestation of the old idea that humans are more likely to exclude those that they perceive as different.

Now, as everyone has started to experience adverse effects from the pandemic and its associated lockdowns, more and more individuals are experiencing shared emotions. Therefore, due to the diminished difference in experience, it is likely we are seeing a reduction in the stigma surrounding mental health issues. As each person experiences their own negative reactions to the pandemic, it allows us to view similar mental conditions without a sense of moral failure.

Isolation has become the most commonly experienced effect of the pandemic. And so, loneliness has become a leading cause of concern. Some of these effects can be seen through increased social media use generally; however, the unique effects of a ubiquitous loneliness throughout American life are best exemplified by the increase in mental health information distributed on social media sites. While much of social media is used to communicate with others, it has now, more than ever, turned into a greater outlet for voicing mental health concerns. As more and more individuals acknowledge the negative emotional experiences resulting from the pandemic, these concerns have become the norm rather than the exception. An unanticipated effect of this change may be a reduction in the stigma surrounding mental health.

An important caveat to this conclusion is that there may be a retained stigma surrounding mental health issues associated with direct contact with the coronavirus. Communication indicating that one might have symptoms, or has been in contact with an infected individual, is likely kept to a minimum from the fear that COVID-19 classifies those anywhere near the virus as undesirables. According to Canadian sociologist Erving Goffman, this undesirable characteristic is the result of social stigma discrediting an individual due to their classification of the "undesirable other", or the notion of "othering".[10] During pandemics and times of high social crisis, discrimination and blame also arise. This means that while those who are dealing with mental health concerns resulting from involvement in quarantine might have their outspoken concerns received with more empathy than those who are dealing with psychological impact from the perception of

having or knowing someone with the disease. Thus, the latter psychosocial concern is likely to not be communicated as outwardly as concerns stemming from loneliness or job loss due to the pandemic. This is the effect of moral shame, that our society has been so fortunate to have seen beaten back, rearing its ugly head.

Perhaps, one of the positive effects of this pandemic is that it has brought about a shared experience that has led to a diminishing of stigma surrounding mental health. This has led to more individuals being willing to reach out and seek help about their mental health. A lesson we can take from this pandemic, thus, is that such positive effects from discussions on social media, in-person, and other forms should be extended to those we still categorize as "others" without seeking blame of moral failure.

While some would argue that the notion of moral failure leads to shame, which might expose problems, no shame, even without a pandemic should surround mental illness. The pandemic explains the rationale behind that statement, because COVID-19, while presenting an atrocious time for our world, has also exposed the shared mental struggles of humans. Possible effects of mental health stigma have only been aggravated due to the additional concerns of community exclusion, self-isolation, and fear that have come about with COVID-19.[11] The question I pose is: Why does it take a pandemic to allow us to realize that many of those dealing with mental illness, on whatever side of the spectrum, are persons who should not be regarded as less than, or a product of moral failure. While you could argue that there is room for those individuals who do not follow quarantine regulations or ignore the severity of the virus, essential workers who have no choice in the matter should not be shamed for risking their lives to provide for the rest of us. If shame is alleviated concerning the pandemic, more people might be willing to speak out, helping identify potential Covid-19 contact risks. If this is the case, think about how more people would speak out about their mental health, allowing greater opportunity to treat and assist.

In sum, this is an issue that has received heightened attention because of the pandemic. It has appeared on the news, social media, and has arguably become a growing topic of discussion amongst our friends and family members. Truly, we should not need a pandemic to alleviate stigma surrounding mental health. The goal and hope for this article is not solely to encourage all members of society to realize a slight positive effect from the pandemic, but to recognize the necessity of removing the stigma of mental health. Mental health should not be an uncomfortable talking point, but a discussion of solidarity that allows us to recognize an opportunity to educate and provide aid for others without any sense of shame or occurrence of a pandemic.

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ENDNOTES

1. Tehrani H. (2020). Mental health stigma related to novel coronavirus disease (COVID-19) in older adults. *Geriatrics & Gerontologyl*, 20(8), 796–797; Mahase E. (2020). Coronavirus: Covid-19 has killed more people than SARS and MERS combined, despite lower case fatality rate, British Medical Journal Publishing Group.
2. Nirmita Panchal, R., et al. (2020, August 21). The Implications of COVID-19 for Mental Health and Substance Use.
3. Ibid; CDC, National Center for Health Statistics. Indicators of anxiety or depression based on reported frequency of symptoms during the last 7 days. Household Pulse Survey. Atlanta, GA: U.S. Department of Health and Human Services, CDC, National Center for Health Statistics; 2020. https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm.
4. Mahase Elisabeth. Covid-19: Mental health consequences of pandemic need urgent research, paper advises *BMJ* 2020; 369 :m1515.
5. Poll: Here's COVID-19 Toll on Americans' Mental Health. (2020, April 24). Retrieved December 06, 2020, from https://hartfordhealthcare.org/about-us/news-press/news-detail?articleid=25741.
6. WHO (2001). *The World Health Report 2001. Mental Health: New Understanding. New Hope*. Geneva, World Health Organization.
7. Ibid.
8. Stayton, J. (2018, December 31). Some Still See It As 'Character Flaw' Or 'Moral Failing.' What We Don't Get About Mental Illness.
9. WHO (2001). *The World Health Report 2001. Mental Health: New Understanding. New Hope.* Geneva, World Health Organization.
10. Link, Bruce G., and Jo C. Phelan. "Conceptualizing Stigma." Annual Review of Sociology 27 (2001): 363-85. Accessed September 11, 2020. http://www.jstor.org/stable/2678626.
11. Peprah, P., & Gyasi, R. M. (2021). Stigma and COVID-19 crisis: A wake-up call. *The International Journal of Health Planning and Management* 36(1), 215–218.

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