



A Catholic Perspective: Triage Principles and Moral Distress in Pandemic Scarcity

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Abstract

Striving to be faithful to the moral core of medicine and to spiritual, moral, and social teaching of the church, Catholic physicians see their role as an extension of the healing ministry of Jesus. When faced with a situation in which a large number of gravely ill people are seeking care, but optimal treatment such as ventilation in intensive care unit cannot be offered to all because of scarcity of resources, Catholic physicians recognize the need to consider the common good and to assign a priority to patients for whom such treatments would be most probably lifesaving. Making these evaluations, physicians will use only objective medical criteria regarding the benefits and risks to patients and will be mindful that all persons deserve equal respect for their dignity. Discrimination or prejudicial treatment against patients based on factors such as age, disability, race, gender, quality of life, and possible long-term survival cannot be morally justified. Triage process should incorporate respect for autonomy of both the patient and the professional and opportunity for an appeal of a triage decision. Other principles and values that will affect how a triage protocol is developed and applied are proportionality, equity, reciprocity, solidarity, subsidiarity, and transparency. The current coronavirus pandemic can provide valuable lessons and stimulus for reforms and renewal.

Summary: Catholic physicians strive to continue the healing ministry of Jesus Christ and be faithful to the moral core of medicine. In situations such as pandemic, the scarcity of personnel and technological resources create serious challenges and even moral distress. Church teachings on dignity, the common good and protection of the vulnerable help guide decisions based on public medical criteria and shared decision-making.

Keywords

Bioethics, Catholic identity in health care, Catholic social teaching, Dignity of the human person, Health policy, Intensive care, Medical decision-making, Pandemics, Triage protocol

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Jesus went about all the cities and villages, teaching in their synagogues, proclaiming the good news of the kingdom, and curing every disease and sickness.

Matt (9:35)

This reflection from Catholic doctors in Canada is written in the midst of the COVID-19 pandemic. Clarifying physician duty in medical scarcity became an urgent issue with the apparent lack of both transparency and adequate consultation in certain jurisdictions in Canada as reported by the media (Hauen 2020). However, it also has much broader and deeper ramifications for medicine and society. As practitioners, we are well aware that personal and communal health crises present profound challenges to beliefs and values. Global crises, such as pandemics, raise these challenges for all of humanity. Our faith calls us to prayerful discernment and prophetic action which can inform public policy.

In this pandemic, there is a new appreciation of doctors and other healthcare professionals' selflessness in the care of the sick. Doctors profess a duty to care for the sick and accept its risks. They are committed to saving a life. We now have heart-wrenching stories from Rome (Giuffrida 2020), Spain (Kassam 2020), and New York (de Puy Kamp, Devine, and Griffin 2020), among other cities, of weeping doctors and nurses who have had to limit access to scarce potentially lifesaving care and technology. We have seen the tragic suicide of emergency physicians and medics who were overwhelmed by a sense of failure. Recognizing the spiritual trauma and moral distress of doctors, nurses, and other healthcare personnel is crucial.

This reflection has three goals. First is the affirmation of the ethical, moral, and spiritual foundations of care of the sick and dying for Catholic doctors and healthcare professionals. Second is the articulation of specific recommendations regarding the principles and practice of clinical triage in scarcity of resources arising from those foundations that should guide the development or implementation of any triage protocol. Third is the identification of the lessons learned for more just and caring postpandemic medicine and health care in the inevitability of more pandemics to come.

The Moral Core of Medicine

The moral core of allopathic medicine emerges with the Hippocratic tradition which melds the Aesculapian (priestly) and scientific roots of medicine. For centuries, in a public oath, the doctor committed,

"I will use regimens for the benefit of the ill in accordance with my ability and my judgment, but from (what is) to their harm or injustice, I will keep (them)" (Miles 2004, p xiii). The focus is on altruistic commitment to individual patient benefit and scientific integrity and also includes issues of civic responsibility and public health.

As this tradition encountered early Christianity, the ethics recognized patient vulnerability and focused intently on the character of the doctor as a moral agent and the virtues of medicine: fidelity to trust, compassion, *phronesis* (prudence or practical wisdom), justice, fortitude, temperance, integrity, and self-effacement (Pellegrino and Thomasma 1993). However, by the end of the seventeenth century, the sick experienced rampant entrepreneurial medicine as a crisis of trust. Modern professionalism was developed with Codes of Ethics again identifying the core elements of scientific competence and an altruistic commitment to the patient's interest. It clearly articulated medicine as a public trust with other obligations to society (Pellegrino and Thomasma 1988). The 2018 Canadian Medical Association (2018) Code of Ethics is in continuity with this tradition. It emphasizes the centrality of trust in the patient–doctor relationship and identifies core duties and responsibilities. Key duties identified in the Code that are under challenge in the condition of scarcity of resources and in situations of crisis include:

- "Consider first the well-being of the patient" (p. 1). In a severe scarcity of medical resources, the primary duty to the individual patient remains but may be balanced by the health systems' duty for the stewardship of shared resources and attention to prevention and population health. This requires a protocol that will protect the trust essential to the patient–physician relationship as far as possible while discharging responsibilities to the population at large.
- "Recommend evidence-informed options; recognize that inappropriate use or overuse of treatments or resources can lead to ineffective, and at times, harmful patient care and seek to avoid or mitigate this" (p. 6). Offering only "evidence-informed options" is central to ensuring that objective medical criteria regarding benefit and risk of the proposed intervention are used in recommending access to resources.
- "In the process of shared decision-making: Empower the patient to make informed

decisions regarding their health” (p. 11). The modern focus on shared decision-making and respect for patient’s values and wishes directly expressed and in advance care directives may be constrained by choices available during scarcity.

The last and most undeveloped responsibility, even though it is central to medicine as a public trust, requires doctors to “Support the profession’s responsibility to promote equitable access to health care resources” (p. 43).

In the late nineteenth and early twentieth centuries, public health made a positive impact on the health of communities and populations as it focused on issues of poverty, sanitation, and disease prevention. However, as modern medicine developed from the late nineteenth century, it progressively focused on scientific and technological advances to individual patients (Kenny 2010). Medical ethics was largely replaced by principle-based bioethics dominated by respect for autonomy (Beauchamp and Childress 2001). Public health ethics became separate and distinct focusing on social justice (Powers and Faden 2006).

Catholic Physicians and the Ministry of Healing

A leper came to him and pleaded on his knees: “If you want to” he said, “you can cure me.” Feeling sorry for him, Jesus stretched out his hand and touched him. “Of course, I want to!” he said, “Be cured! (Mark 1, 29:40–41)

Spiritual

Caring for the sick is a privilege and an expression of faith and of love and respect for Jesus himself. Caregivers can experience the presence of God in new ways that are transforming, encouraging, and powerfully supportive. But care and compassion can also be exhausting, challenging, and risky.

For Catholics, medicine and the health professions continue the healing ministry of Jesus, the Great Physician (Sulmasy 1997). Jesus’s cures involved physical care, healing of the whole person—body, mind, and spirit—and restoration to the community for the sick, suffering, chronically ill and disabled, the dying, and the bereaved. So, the Church has accompanied the sick and dying in pandemic from the Black Death, through the Middle Ages, to

pandemics in this century. In a simpler time, with limited medical options, death came quickly to most persons. The Christian imagination shared a vision of a *good death* in the death of Saint Joseph. This “righteous man” is comforted and cared for by his loved ones, Mary and Jesus, as he breathes his last. In medieval times, Christians addressed the challenges of living in preparation for dying through the *art of dying* which depended upon two features of the culture: shared faith in the birth, death, and resurrection of Jesus, and the importance of families and community in care for the seriously ill and the dying (Kenny 2017). That said, the modern context is secular, professionalized, institutionalized, and dominated by technology. Hospice and palliative care developed in this new context to support those who could not be cured (Kenny 2017).

Moral Teaching

There is a long and strong Catholic moral tradition of decision-making in illness and dying that can support patients and physicians in the assessment of the benefits and risks of proposed medical interventions (Ashley and O’Rourke 1997). Some key teachings include the following:

“Life and physical health are precious gifts entrusted to us by God. We must take reasonable care of them, *taking into account the needs of others and the common good*” (Catechism of the Catholic Church, 2288). Generally speaking, “reasonable care” would include interventions that are readily available, effective, and not excessively burdensome.

“If morality requires respect for the life of the body, it doesn’t make it an absolute value” (Catechism of the Catholic Church, 2289). Right interventions are those valued by the person; they allow the person to pursue spiritual goods and life goals (e.g., relationship with others and union with God). The Church has never required individuals or doctors to “do everything” to prolong biological life or for patients to accept interventions that they experience as overwhelming or too burdensome even if such therapies would be effective.

“The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but

only foreseen and tolerated as inevitable” (Catechism of the Catholic Church, 2279). It is clear that when used appropriately and therapeutically, opioids do not hasten death.

Church teaching that “Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick or dying persons. It is morally unacceptable. Thus, an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person . . .” (Catechism of the Catholic Church, 2277). In countries such as Canada that have legalized euthanasia and assisted suicide, there is grave concern about pressure on patients (Herx, Cottle, and Scott 2020).

Speaking directly to pandemic scarcity, the Pontifical Academy for Life (2020) has said,

It should always be borne in mind that decisions cannot be based on differences in the value of a human life and the dignity of every person, which are always equal and priceless. The decision concerns rather the use of treatments in the best possible way on the basis of the needs of the patient, that is, the severity of his or her disease and the need for care, and the evaluation of the clinical benefits that treatment can produce, based on his or her prognosis. Age cannot be considered the only, and automatic criterion governing choice . . . particular attention should be paid to those who are most fragile, and we are thinking especially of the elderly and people with special needs.

Social Teaching

While the spiritual and moral tradition highlights duties to individual patients, with brief attention to the public responsibility of doctors, the Church’s social teaching is a source of wisdom for balancing these duties with the common good (Merkle 2014). Dignity is an inherent quality of the children of God, not an attribute lost in illness and dependence because, “The dignity of man (*sic*) rests above all on the fact that he is called to communion with God” (Catechism of the Catholic Church, 27).

The Church’s social teaching balances the dignity of each person and fair access to necessities of life

including health care. These are elements of the *common good*, which is “. . . the sum total of all those conditions of social life which enable individuals, families and organizations to achieve complete and effective fulfilment” (Vatican Council 1965, 74). Moreover, the “preferential option for the poor” (Catechism of the Catholic Church, 2444, 2448) requires that the protocol to minimize structural discrimination in accessing resources especially for persons with chronic medical and psychiatric conditions, disabilities, refugees, prisoners, and non-white or poor communities. The principles of solidarity, stewardship of resources, and subsidiarity can assist in difficult decisions as well.

The Process of Clinical Triage in Scarcity

When patients present for emergency care under ordinary circumstances, they will be assigned a level of priority corresponding to their medical condition, but with expectation that they will receive the treatment most appropriate for their condition in a timely manner and that the waiting for care will not seriously affect their health status. Even patients whose condition is so grave that survival seems unlikely are given (with their consent or consent of a surrogate) trials of aggressive interventions that could possibly rescue them.

However, when truly massive numbers of sick people are seeking emergency care, a healthcare facility may be overwhelmed, and such ordinary prioritization of care becomes unworkable. Such a predicament occurred in past influenza pandemics and was one of the reasons why nations engaged in pandemic planning (Kotalik 2006). This has been the situation in the current COVID-19 pandemic, when many patients present with severe pneumonia that can be rapidly lethal if not supported by mechanical ventilation and expert care in an intensive care unit (ICU). If the local capacity for such care is exhausted, the first response to this situation must be to move people to other facilities in the region, province, or state where the resources are available or to bring these resources to where sick people are. If all possibilities of transportation were exhausted, it will be necessary to resort to a process of assigning patients to resources (e.g., ventilators, ICU beds) that in this article we call “clinical triage.” Declaration of need for triage should always be a temporary response, activated as a last resort in crisis and deactivated as soon as possible.

The triage process recognizes that all human lives are of equal worth, and this would not be served if an

opportunity to save the life of one person would be lost because of a nonurgent or likely futile treatment of another person. The triage process recognizes that in the situation of extreme scarcity, the different care needs of patients must be understood in conjunction with the common good, taking into account estimated opportunities for lifesaving and recovery. Triage decisions are always difficult, and no physician should be placed in a position of assigning patients to suboptimal care without guidance of a protocol or policy and support of a care team (Pacholczyk 2020).

The protocol for triaging patients who meet inclusion criteria for aggressive lifesaving therapy will typically consist of three steps: (1) application of exclusion criteria, (2) assessment of mortality risk, and (3) periodic clinical assessments to reassess the best care.

Applying exclusion criteria in step 1 will identify and exclude patients with the highest probability of mortality regardless of applying lifesaving therapy. In step 2, patients with a moderate degree of mortality but most likely to survive with the particular therapy will be prioritized for treatment. In step 3, clinical assessment is repeated every forty-eight hours to determine whether or not to continue the intervention (New York State Department of Health 2015). We need to keep in mind that published triage protocols, and those being developed for COVID-19, are untested and may possibly have unexpected, unintended consequences, for example, removing so many patients by exclusion criteria that ICU beds remain empty. Therefore, the impact of these protocols must be monitored in real time so that adjustments can rapidly be made.

Standard of care tools for objective clinical assessment (e.g. Sequential Organ Failure Assessment, Glasgow Coma Scale) may be used to make criteria objective and fair for all. Offering only “evidence-informed options” is central to ensuring that objective medical criteria regarding benefit and risk are used in recommending access to resources for patients.

In situations when triage scores two patients with exactly the same level of priority but only one patient can be accommodated, the tie can be broken either by enacting less-ideal criteria such as first come, first served basis or by random choice. Tiebreakers that imply a judgment about the value of different lives, such as age, gender, or disability, should be avoided.

Patients who meet exclusion criteria and will not have access to lifesaving therapies, for example, ventilation, must be offered the most appropriate alternative forms of medical care as clinically indicated. Alternative forms of care may include life-

prolonging or life-sustaining interventions outside an ICU (e.g., oxygen, antibiotics, blood transfusions, fluids) or comfort measures only. Fluid and nutrition should always be provided unless there are medical contraindications. All patients benefit from a palliative approach to care in order to optimize symptom management and quality of life regardless of the focus of care. No patient should be left without care.

All patients presenting with a life-threatening illness that may require lifesaving interventions, and especially those who are either not eligible or choose to forgo such interventions, should be offered spiritual and psychological support corresponding to their religious tradition and worldview (Hilliard 2020). Ministers, priests, counselors, and other personal support staff should be given adequate personal protective equipment so that they may interact with patients at the bedside, and Catholic patients and staff can receive anointment of the sick and other sacraments (Hilliard 2020).

Values and Principles Guiding Triage in Scarcity of Resources

The general goals of clinical triage in scarcity are to minimize death and serious illness. To accomplish this goal, patients for whom intensive care and ventilator therapy would most likely be lifesaving are prioritized. Survival is defined by examining a patient’s short-term likelihood of surviving the acute medical episode with the use of specific medical interventions and not by focusing on a patient’s long-term prognosis related to an underlying chronic medical condition or disability.

Patients with the highest likelihood of survival without medical intervention, along with patients with the smallest likelihood of survival with medical intervention, should have the lowest level of access to lifesaving supports such as ventilator therapy. Thus, patients who are most likely to survive without the ventilator, together with patients who will most likely survive with ventilator therapy, increase the overall number of survivors. This type of approach maximizes the overall benefits and minimizes harms while providing equality of opportunity and justice by treating equals equally and similar cases similarly. However, there are significant limits that have to be placed on decision-making based on this approach, and in a triage protocol, these can be expressed as safeguards.

There is particular concern regarding the safeguards needed for people with disabilities. As recently expressed by representatives of over 200 disability-related organizations in Ontario, it would be improper if persons with disabilities were deprived of the

possibility of intensive care based on their disability alone, because they need support for daily living or because they need some disability-related accommodation (Arch Disability Law Centre 2020). Canadian (University of Toronto Joint Centre for Bioethics 2005; Christian et al. 2006) and American (Emanuel et al. 2020; Gostin, Friedman, and Wetter 2020; Di Camillo 2020; Daley 2020; Petrini 2010) ethicists, among others, have identified values that need to be considered in developing clinical triage criteria. These key values include the following:

Respect for the dignity of all persons: Care must be provided to all in need. Discrimination or prejudicial treatment against patients based on age, health status, race, and gender should not be tolerated in triage protocols. This is very different from acknowledging that some health conditions make certain intensive therapies not appropriate as they are unlikely to help and more likely to cause harm. A value judgment by a healthcare professional based on the assumed patient's quality of life should not be a factor in decisions to provide types of care. Personalist perspective promotes the collective good by safeguarding and giving value to the well-being of every individual (Schiedl 2020).

Respect for patient autonomy: Public health emergencies, such as a pandemic, imposes harsh limits on decision-making autonomy for patients. A just scheme must endeavor to support the wishes and values of patients in these circumstances. Existing do-not-resuscitate orders or advance directives that refuse intubation or mechanical ventilation should be taken into account. Patients, or their surrogate decision makers, need to be informed about the initiation of the triage protocol and later about the outcome of the triage as relevant to them. If the triage resulted in the patient being offered lifesaving care such as ventilation, the patient needs to be informed about the potential benefits and risks involved. If the patient is not provided lifesaving interventions, the nature of the care and support to be provided must be explained. Consent to the offered focus of care is to be obtained, if possible after the patient has had an opportunity to communicate with family or other support person. Every patient has a right to reject lifesaving care interventions offered by the triage process,

at the beginning or at any later time, especially in the event of deterioration. If the patient will not be offered lifesaving interventions based on the triage protocol, the position of the patient toward this decision should be ascertained. If the patient expresses a strong preference for receiving lifesaving interventions, the patient situation and position must be reviewed by a hospital committee set up for the purpose of appeal. The committee's decision will be communicated to the patient.

Estimation of medical benefit is frequently the chief operating principle in triage protocols. It requires the development of standardized inclusion and exclusion criteria for resources in limited supply based on evidence-informed, highly predictive clinical tools for assessment of benefit and survival. Examples of inclusion criteria for ventilation in ICU would be severe refractory hypoxemia or severe respiratory acidosis. Examples of exclusion criteria would be cardiac arrest unresponsive to appropriate Advanced Cardiovascular Life Support (ACLS), overwhelming traumatic injuries, massive intracranial bleeds, intractable shock, multisystem organ failure, advanced states of cancer, and so on.

Respect for the autonomy of caregivers that also honors the duties of care and stewardship is a mirror image of the principle of respect for the autonomy of those who receive care (patients). Because patients are generally considered to be in a dependent position and medical professionals in an authoritative position, the physicians' rights to autonomy have not received much attention recently, but the fact is that both patients and physicians are moral agents and deserve equal respect. Any action that involves both parties requires mutual consent. Consequently, patients cannot claim that their autonomy allows them to demand a particular intervention such as intensive care or ventilation, if this would conflict with the professional duties of physicians or with the physicians' rights to freedom of conscience.

It is in this context that we can appreciate the crucial role that trust between doctor and patient forms the basis for a fruitful dialogue on how to balance appropriate and futile interventions. As our Church teaches, "... for such a decision to be made, account will have to be taken of the reasonable wishes of the patient and the patient's family, as also of the advice of the doctors who are specially competent in the matter" (Vatican 1980).

Equity is a concept of fairness that treats persons equally, taking into account relevant differences. Ethically sound responses to a public health emergency must not exacerbate disparities in access to care. An example of the equity principle in practice would be to apply the first come, first served rule for prioritization of people with the same or similar likelihood of benefit when competing for the same resource.

Transparency: Any plan allocating potentially lifesaving resources requires robust efforts to promote transparency, by seeking broad input in the design of the plan and educating the public. Vulnerable groups should be expressly sought out to be part of the development process of triage guidelines. Monitoring of triage with real-time data collection and ongoing reporting to the public is also expected in order to build trust and accountability.

Proportionality requires that necessary and effective interventions should be the least restrictive alternative. This supports an approach in which triage decisions are dependent on the magnitude of demand.

Reciprocity requires support for those health-care professionals and personnel who face a disproportionate burden in caring for the sick and includes the crucially important housekeeping and food preparation staff in hospitals and long-term care facilities, who have no professional duty of care. This includes ensuring adequate staffing, a work environment that mitigates health risks with access to vaccines, antivirals, and protective equipment and provides care for staff who get infected. It may include hazardous duty and overtime pay.

Solidarity and stewardship of shared resources: Governments and healthcare professionals have a responsibility to manage resources during a period of true scarcity. Healthcare professionals may struggle to decide whether an intervention (e.g., blood transfusion, antibiotics, or surgical intervention) is appropriate or justified for a particular patient, given that the quantity of a particular resource is limited. Planning before the crisis is an obligation in order to assist exhausted, overtaxed, front-line healthcare workers, who already bear a disproportionate burden in an emergency. Prevention is crucial.

Subsidiarity requires that decisions are made at the lowest level of competence. The principle of subsidiarity assists us in deciding who should be the decision maker or at what societal level a decision should be made. The principle states that only those decisions and tasks that cannot be effectively decided upon or performed by a supported or subsidized lower level authority ought to be relegated to a more central or higher authority (Kotalik 2011). Respecting this principle, clinical triage of patients will ideally involve several levels, each with a well-defined responsibility. Therefore, decisions for individual patients at the hospital level should be shared by the patient's physician who makes the medical assessment and a triage officer or committee who uses this assessment in applying the protocol. In order to maintain a clinician's duty of care and nonabandonment, a patient's attending physician does not determine whether the patient receives (or continues) a specific therapy, for example, ventilation. The physician performs a medical assessment according to clear, preestablished criteria. This information is provided to an independent triage officer or triage committee who then makes the decision.

Appeal process: If a patient will not be offered lifesaving care based on the application of the triage protocol, the position of the patient toward this decision should be ascertained. If the patient expresses a strong preference for receiving lifesaving interventions, the patient is to be informed about the possibility of appeal. If the patient wishes to have the case appealed, then the patient situation will be reviewed by a hospital committee set up for the purpose of appeal. At this committee level, care team members may advocate for their patient. The decision of the committee will be final.

Moral Distress in Emergency Triage

The concept of "moral distress" emerged from nurses' experiences of being ordered to act contrary to their understanding of patient best interest. It now is understood to arise "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton 1984, 6). It is directly related to

restraints on freedom of an informed conscience as well as conscientious objection to what is judged immoral or unethical.

The result of moral distress which has compromised integrity has been called “moral residue” (Webster and Baylis 2000). Sources of moral distress in clinical triage in scarcity lie primarily in the requirement for behavior that contradicts doctors’ primary duty to care for the sick, to save lives where possible, and in applying innovative practices and treatments without rigorous research which can result in harm and delay in effective treatment. It also arises from concerns regarding abandonment of those who are dying and their families when there are limits on pastoral and palliative care because of isolation. Since palliative care, according to Pope Francis, “. . . bears witness that the human person is always precious, even if marked by age and sickness,” every effort must be made to ensure this care to all seriously ill and dying patients, especially if they are excluded from intensive and respiratory care (Gallagher, Passmore, and Baldwin 2020).

Clinical triage in scarcity also causes anguish from the awareness of the significant probability of death or long-term harm to patients. This anguish can also extend to patients who are not able to access treatments or are frightened to go to hospital with symptoms from nonpandemic illnesses, such as acute coronary syndrome or early stroke or patients who have delayed access to investigations or treatment for other conditions such as cancer. Physical and emotional fatigue, and ethical conflicts between duties to the sick, risks to self and risks to family requiring isolation from them, escalate distress. There can be a temptation to abandon prayer and other spiritual supports at a time when they are needed most.

For Catholics, moral distress may be compounded by difficult decisions regarding the use of palliative sedation (International Association of Catholic Bioethicists 2012). It can be morally acceptable under certain conditions but, unfortunately, is often confused with euthanasia. It is important to have a good understanding of the difference between palliative sedation and euthanasia. Palliative sedation is a specialized medical intervention used to address refractory, irreversible symptoms in the last hours or short days of life that have not responded to any other treatments. Sedation is provided and maintained at the lightest possible level to control symptoms and is continued until natural death occurs from the underlying medical condition. When used appropriately, palliative sedation does not hasten death and is distinct from euthanasia (Herx 2021). There can also be spiritual distress in awareness of

patients who may choose or be provided euthanasia because of fears and feelings of abandonment or fear that they may lack access to adequate care during a time of scarcity and be left to suffer.

Postpandemic Considerations

This pandemic, as with others in history, brings challenges to caring for the most vulnerable among us and for just systems of health care and disease prevention. Yet, it has also shown us heroic examples of selfless service and a new spirit of neighborliness. Each prior pandemic resulted in awareness of reform needed in preparation for the next. While some things change, we too soon forget the lessons until we are in crisis again.

Let us instead work and pray for a new commitment to a compassionate, just and healthy global village. We can and must make changes. Things will not and should not “go back to normal.” We must resist the temptations of trauma for self-protection and make choices to become more just and more caring health professionals and systems (Pontifical Academy for Life 2020). Health, social, and economic systems need major reform and renewal.

Thus, says the Lord: I am about to create new heavens and a new earth; former things shall not be remembered or called to mind. Be glad and rejoice forever in what I am creating: for I am about to create Jerusalem as a joy, and its people as a delight. (Isaiah 65: 17–18)

Jesus reassures us,

If anyone is in Christ, there is a new creation; everything old has passed away; see, *everything has become new.* (2 Cor. 5:17–19)


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