AN ETHICAL FRAMEWORK
FOR PANDEMIC PREPAREDNESS
AND DECISION-MAKING DURING A PANDEMIC

Introduction
In a pandemic Influenza or other infectious disease or acute illness outbreak, the demand for effective therapies could exceed the supply of those therapies and related resources. In a worst case scenario, this means that people who otherwise could have been saved will die. Thus, Ascension, its Health Ministries (HMs) and healthcare workers (HCWs) have an obligation to prepare themselves to be able to respond to a pandemic outbreak so as to maximize the number of lives saved and minimize preventable mortality by attending to the very difficult and complex clinical and ethical decisions that will need to be addressed as part of both planning and response efforts. The ethical principles that guide medical practice in normal circumstances still apply to the types of decisions that will be faced during a pandemic outbreak. However, the application of these principles and values shift from a more individual-centered perspective in the context of the physician-patient relationship to a more population-based public health-centered perspective of ethics. In some cases, what would be ethical and consistent with the standard of care under “normal circumstances” of medical practice may in fact become unethical in times of a pandemic.

The following ethical framework has been developed in an attempt to provide practical guidance in applying the principles and values in this very different than usual way. The goal is to improve the ability of Ascension, its Health Ministries and all of those who serve on behalf of Ascension to make such decisions. As with other ethical frameworks, this framework is intended to inform decision-making, not replace it. It is intended to encourage reflection on important values as well as guide discussion and review of common “hot button” ethical issues that arise during a pandemic. The framework is not exhaustive insofar as additional questions will come up during a pandemic, but the framework will help guide decision-makers in reasoning analogously about those questions and applying the values and principles in new ways. The framework is divided into three distinct parts: 1) the identification and definition of the relevant ethical values and principles; 2) a consideration of the most common ethical challenges or questions that arise during a pandemic with the relevant principles and values correlated and applied to those challenges; and 3) a brief description of additional concerns and strategic considerations that should also be considered in pandemic preparedness and decision-making.

Relevant Values and Principles
There are two types of salient moral values and principles relevant to decision-making during a pandemic: substantive and procedural values. Substantive values are those goods at which the decision-making should be aimed and the behavioral norms that ought to guide a response to issues that arise during a pandemic. Procedural values are those that should inform and guide the process by which decisions are made as well as pandemic preparedness efforts.
Primary substantive values related to decision-making during a pandemic include:

- Human Dignity
- Common Good
- Respect for Autonomy
- Nonmaleficence
- Solidarity
- Equity
- Special Concern for the Poor and Vulnerable
- Stewardship

Primary procedural values concerning decision-making in preparation for and during a pandemic include:

- Reasonableness
- Subsidiarity
- Transparency
- Reciprocity
- Proportionality

It is especially important to understand the implication of these principles, as understood within the Catholic moral tradition, in the context of responding to a pandemic:

**Human Dignity**—the intrinsic moral worth or inherent value of every human life. This intrinsic moral worth of human life is not contingent upon age, race, gender, social status, ethnicity, the ability to function or on any other accidental attribute of the human person. Because all human beings possess this inalienable dignity, all must be respected as inherently valuable members of the human community. Since all persons are worthy of moral respect in light of their human dignity, all persons must be treated fairly and justly. While human dignity implies an absolute negative obligation never to directly intend to harm or kill a person, it does not establish an absolute positive obligation to provide everyone with every effective treatment possible.

Pandemic considerations: This is the foundational substantive value insofar as every ethical analysis and decision, whether during times of extreme scarcity or any other time, ought to begin from the perspective of how best to promote and defend human dignity.

**Common Good**—Grounded in human dignity and the innate social dimensions of human life, the common good consists of all the conditions of society and the basic goods secured by those conditions that allow individuals and groups to achieve human and spiritual flourishing. The social teaching of the Catholic Church insists that the human community – including governments, public and private organizations, and individuals – must be actively concerned with promoting the health and welfare of every one of its members so that each member can contribute to the common good of all.
Pandemic considerations: In times of a pandemic, the Common Good becomes an especially important principle and value as the focus of ethics shifts from individual-based ethics to a population-based public health-centered ethic. Considerations of the Common Good may, at times, including and especially during times of a pandemic outbreak and limited resources, justify limited access to effective therapies and resources.

Respect for Autonomy—Along with respecting an individual’s right to life by not directly intending any harm to an individual, respecting every person’s ability and authority to make their own decisions is a primary way that we honor the image of God within one another and respect the Human Dignity of all individuals.

Pandemic considerations: Individual choices, those of both associates and patients, have a direct impact on the availability of resources and the ability of organizations to respond to a pandemic outbreak. Respect for autonomy then may be limited in a pandemic, whereas it would otherwise be given priority, when necessary to avoid the occurrence of greater harm and to maximize public health outcomes for the community as a whole. In this case, individual autonomy may best be respected through transparent decision-making processes and the sharing of information, but not necessarily by deferring to individual choice.

Nonmaleficence—the concept of nonmaleficence is generally understood to imply three specific moral responsibilities of individuals: 1. that one ought to never directly (intend to) inflict harm on another person; 2. that one should do what one can in order to prevent harm from occurring; and 3. where harm has already occurred, one ought to do what one can in order to eliminate, diminish or repair that harm.

Pandemic considerations: While nonmaleficence is regarded as a foundational principle of medical ethics governing the treatment of individual patients by physicians, the focus of nonmaleficence during a pandemic shifts to individuals doing what is a reasonable possibility for them to avoid, prevent or reduce harm to the population as a whole.

Solidarity—means that each individual makes a commitment not only to one’s self, one’s family and one’s profession, but also to the community as a whole. When making decisions rooted in solidarity, the focus shifts from one’s own self-interest to what is good for others. Solidarity does not, however, require that one disregard one’s own self-interest; rather, solidarity requires that one considers the good of the community as a whole and thus one’s own self-interest understood within the context of membership in the community. Thus, from the perspective of Solidarity, what is good for the community as a whole is in one’s own self-interest.

Pandemic considerations: At an organizational level, solidarity means that hospitals and provider organizations may have to engage in more collaborative approaches with organizations which they would normally be in competition. On a professional level, solidarity means that health care professionals may have to
consider obligations to their patients and colleagues in a manner that significantly challenges other commitments.

*Equity*—in a general moral sense, equity can be understood as a quality or state of equilibrium in which, all other things being equal, there are no arbitrary inequalities that give an advantage to one group and a disadvantage to another group. Understood in light of Human Dignity and the Common Good, equity means that all persons have an equal claim to receive the health care they need under normal circumstances.

**Pandemic considerations:** Within our society individuals will enter into a pandemic from vastly varying starting points regarding wealth, access to resources and base-line health status. Equity requires that decisions during a time of pandemic are, to the greatest extent possible, objective and impartial. Using sound, evidence-based medical criteria for triage and allocation decisions is the best way to ensure that such decisions are made equitably while fostering the goal of maximizing lives saved. To the extent that some inequality may be inevitable, any inequalities resulting from decision-making during and planning for a pandemic are only justified if they are to the benefit of those who are especially vulnerable due to their economic position in society. This is consistent with the procedural value of “reasonableness” as defined below.

*Special Concern for the Poor and Vulnerable*—the Mission of Ascension calls us to provide spiritually-centered holistic care to all persons, with special attention to the poor and vulnerable. People living with certain chronic health conditions (e.g., asthma, COPD) and other factors (e.g., pregnancy) are at high risk of complications from respiratory illness and, therefore, are especially vulnerable during a pandemic. Moreover, the economic poor are often more likely to have a medical condition that puts them at high risk of complications from respiratory illness due to social determinants of health that disproportionately affect those living in poverty.

**Pandemic considerations:** The reality of a pandemic outbreak does not in any way alter our Mission, but provides for a new way to fulfill that Mission. While the sole focus of decision-making during a pandemic should not be correcting past injustices, pandemic planning and decision-making during a pandemic should at least protect against worsening existing social injustices.

*Stewardship*—is not limited to maximizing outcomes while minimizing resource consumption, but necessarily entails decision-making that respects basic human rights, fosters equity and advances the common good.

**Pandemic considerations:** In times of a pandemic, stewardship requires that resources be used in the way that most effectively contributes to the overall goal of maximizing public health outcomes.

*Reasonableness*—can be defined as the quality of being believable by and acceptable to self-interested, rational persons. Decisions are reasonable when self-interested, rational
persons would be able to agree to be guided by that decision, regardless of whether they were among the most advantaged or the least well-off members of society.

**Pandemic considerations:** Accordingly, triage, allocation and treatment decisions and preparedness plans in general should—to the greatest extent possible—be grounded in science, evidence-based and consistent with clinical experience, and not be to the benefit of one portion of the population over any other. This is the foundational procedural value insofar as every decision and aspect of pandemic preparedness planning must meet these criteria of reasonableness.

Subsidiarity—often considered a corollary of the principle of the common good, subsidiarity requires those in positions of authority to recognize that individuals have a right to participate in decisions that directly affect them, in accord with their dignity and with their responsibility to the common good. However, a higher authority properly intervenes in decisions when necessary to secure or protect the needs and rights of all.

**Pandemic considerations:** In times of a pandemic, when resources are extremely limited, it may be appropriate for those with responsibility and authority for the continued operations of a health system, a hospital or other provider organizations to make decisions that would normally be left to individuals or to a “lower” level within the organization or society. Correspondingly, it may also be necessary for those individuals who usually make decisions on behalf of those health systems, hospitals and other provider organizations to relinquish some decisions to local, state or federal government authorities. It is important to note that “participation” does not necessarily mean that all individuals affected by a decision are involved in the decision-making process to such an extent that they influence the outcome of that process, but “participation” may be limited to the sharing of information that was used in making a decision.

**Transparency**—Decision-making is transparent when the rationale for a particular decision and the information used in developing that rationale are readily accessible and understandable by those affected by the decision. The norm of publicity supports transparency insofar as one should only make decisions based on reasons that one would be willing to make widely publicly known.

**Pandemic considerations:** Transparency in decision-making helps ensure that: 1) those seeking treatment have the information they need in order to avoid preventable harm to themselves or to others; 2) that everyone understands why and how decision-making (and corresponding policies and practices) during a pandemic differs from routine, everyday decision-making; and 3) that individuals whose autonomy is being limited have the ability to assess and evaluate the reasonableness of decisions.

**Reciprocity**—requires that society support those who face a disproportionate burden in protecting the public good, and take steps to minimize those burdens as much as possible.
Pandemic considerations: In times of a pandemic, physicians and nurses and other allied health professionals may experience a greater share of burdens and risks. These professionals have an increased obligation and duty to care that is rooted in their professional codes of ethics, in their particular ability to do so (above and beyond that of the general public), and the implicit social contract they entered into upon entering into the profession of medicine. At the same time, the organizations on whose behalf these individuals serve have a corresponding obligation of increased proportion to protect and support those individuals as they are challenged to weigh the demands of their professional roles against other competing obligations to themselves, to their family and to their friends.

Proportionality—requires that those measures taken to protect the public from harm should not exceed the actual level of risks to or needs of the community.

Pandemic considerations: Thus, restrictions on individual liberties, limits on participation in decision-making and the burdens placed on healthcare professionals should not exceed what is actually required. In the beginning phases of a pandemic outbreak, this means that a gradual or phased in implementation of pandemic preparedness plans may be appropriate.

Charting the Challenges: Issues, Values and Implications

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<th>Challenge / Issue</th>
<th>Primary Principles and Values</th>
<th>Practical Implications</th>
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<td>Vaccination policy for HCWs with direct patient contact</td>
<td>Common Good, Stewardship, respect for autonomy, nonmaleficence, reasonableness, subsidiarity, proportionality</td>
<td>The goal of any vaccination policy during a pandemic should be two-fold: 1) to ensure a sufficient workforce to provide care to the community; 2) to protect patients, other co-workers and associates’ family members from possible nosocomial infection. The first of these goals is directly related to stewardship of human resources during a pandemic. Additionally, the first goal may have a positive impact on stewardship of stockpiled resources, such as antivirals and PPE. The second goal is related to the obligation of HCWs rooted in non-maleficence to do what they reasonably can to prevent additional harm from occurring. Both goals are essential for maintaining the common good of the community during a pandemic.</td>
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<td>Distribution of vaccine and anti-virals to general public</td>
<td>Equity, Special Concern for the Poor and Vulnerable, Common Good, Stewardship, Subsidiarity, Transparency</td>
<td>HMs should make vaccines, anti-virals and other resources available to the general public in accord with guidance from their local health departments and/or the CDC. This is consistent with the common good and subsidiarity insofar as these governmental organizations have responsibility and authority for public health measures intended to minimize bad outcomes from communicable diseases. In the absence of such guidance, such resources should be made available according to clinical and scientific evidence regarding safety, effectiveness and risk factors for complications of respiratory illness. This is consistent with equity and stewardship insofar as it will help maximize positive outcomes through the most efficient and effective use of resources. Co-pays and fees for vaccines and anti-virals should be waived for those who are economically disadvantaged, and there should be additional campaign efforts to ensure the vaccine is available and utilized in underserved localities. Because of the potential for benefit from these resources for those who receive them, it is especially important that the public has the information necessary to understand the rationale for prioritization (transparency).</td>
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<td>Allocation of ventilators and ICU beds (pandemic related and non-pandemic related use)</td>
<td>Human dignity; equity; stewardship; transparency</td>
<td>Given that all people have an inherent equal moral worth, equity requires that allocation decisions be made on the basis of clinical prognosis regarding survivability and clinically relevant criteria (age may be included to the extent that it is clinically relevant). In cases of extreme scarcity, the basis for decisions to withdraw life-sustaining treatment shifts from one of individual autonomy to a system of triage based on medical expertise and authority. A</td>
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A standard mass casualty triage system that classifies patients by those who are likely to survive regardless of treatment; those likely to die regardless of treatment; and those who might live if they receive treatment, would be consistent (but not necessarily exclusively so) with these values and principles. Those who are likely to receive the same benefit from like treatments should be served on a first-come first-served basis. Clinical exclusion criteria, such as unwitnessed cardiac arrest, end-stage organ failure, and metastatic malignancy with poor prognosis, could be an acceptable component of triage. Additional methods, such as the SOFA scale and/or OHPIP Triage Tool, would also be acceptable ways of making allocation decisions, so long as the clinical criteria used do not tend to benefit one segment of the population over others (or disadvantage one segment of the population more than others—especially when social circumstances already predispose a population to scarcity). The basis for triage and allocation decisions must be communicated to the public in a way that is generally understandable.

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<th>PTO, sick leave and other Human Resources benefits for medical professionals</th>
<th>Solidarity; subsidiarity; reciprocity; proportionality</th>
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Inherent in professional codes of ethics and the social contract between the medical profession and society is the “duty to care.” This duty to care implies an increased obligation on the part of medical professionals to care for the general public, even when doing so presents a certain amount of risk or results in less availability to their own family members. Pandemic related Human Resource policies should be developed in such a way that acknowledges the medical professionals increased obligation, contains proportionate incentives,
| Compensation for pandemic related illness/injury, and includes components aimed at ensuring as adequate as possible staffing levels to meet needed surge capacity (may need to include revised absenteeism policies). | Storage and distribution of stockpiles (vaccines, antivirals, PPE, etc.) | Common good; solidarity; equity; stewardship; transparency; subsidiarity | Storage and distribution of stockpiled resources should ensure equitable access to potentially scarce resources in a way that maximizes public health outcomes for the population as whole and not simply certain segments of the population served by particular organizations. HMs, therefore, have an obligation to work in a coordinated and cooperative fashion with governmental authorities who have responsibility for the common good (subsidiarity). Solidarity requires that HMs may have a responsibility to share resources with other organizations in their immediate community first. Thus, collaboration and cooperation between organizations that normally compete may be required and even receive priority over other Ascension HMs. Information regarding amounts and locations of stockpiled resources should be readily available to government authorities and health care providers who may need those resources, consistent with the principle of transparency. |
| Visitor Policies | Non-maleficence; common good; transparency; reasonableness | Visiting policies may need to be restricted during a pandemic to reduce the spread of infection/disease. While this comprises a restriction on individual liberty it is necessary to ensure the prevention of avoidable harm to individuals and to reduce the spread of the virus. Signs and information explaining the reason for the restrictions should be posted in public areas as well as advertised to the general public. |
| Non-pandemic related procedure scheduling | Stewardship; solidarity; proportionality | When surge capacity exceeds certain levels it may become necessary for reasons of stewardship to postpone previously scheduled procedures and divert those resources to responding to the pandemic. Consistent with proportionality, postponed or canceled procedures should begin with elective procedures. Only in cases in which resources that would be directly needed in responding to the pandemic, e.g. respirators, could non-elective procedures be postponed or canceled. |
| Spiritual and emotional support for HCWs | Reciprocity; stewardship | In light of the potential for HCWs to experience psychological, social and emotional trauma during times of great scarcity combined with their increased obligation to respond to suffering, HMs should be prepared to provide pastoral care and mental health services to associates during and after the pandemic. |
| Associate and public participation in planning and decision-making | Transparency; subsidiarity | Because associates and the public will be directly affected by the planning process and decisions made during a pandemic, they should be provided with both information they can understand regarding the rationale for the plans and the opportunity to provide input into the planning process. Communications Depts. should therefore be an integral part of the planning and decision-making processes. Moreover, plans should be posted and made publically available and technology should be utilized to provide the general public with the opportunity to provide feedback regarding pandemic preparedness. |
| Providing adequate Palliative and Hospice Care | Human Dignity, non-maleficence | Human dignity requires that care continue even when medicine is no longer able to cure. All HMs must be prepared during a pandemic to provide increased levels of palliative care services. Palliative care is essential for those individuals who are not |
benefiting from ongoing treatment or for whom a decision has been made to withdraw life-sustaining treatment. In such cases, palliative care becomes the central means of avoiding additional harm and suffering that could result not only from the disease process itself, but directly from an ethical decision to withdraw treatment. Pain management, including pharmaceutical means, is appropriate, even when it may diminish consciousness or indirectly hasten death, consistent with the principle of double effect.

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<th>Involuntary Quarantine (Associates and Patients)</th>
<th>Common Good, non-maleficence, solidarity, subsidiarity</th>
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<td>In past pandemics, local governments have placed restrictions on three basic individual liberties: mobility; freedom of assembly; and privacy, when necessary to reduce the spread of communicable disease. In addition to patients, HCWs may also be affected by such restrictions. HMs should prepare to assist government authorities in implementing large scale quarantines by developing applicable policies and protocols.</td>
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**Additional Concerns and Strategic Considerations**

1. Hospital surge capacity is a significant concern in pandemic preparedness. However, in a pandemic outbreak of significant proportions, hospitals may not be able to surge large enough, no matter what efforts to prepare have been undertaken. In such cases, most care will take place outside of a hospital. Thus, pandemic preparedness should include a focus on satellite facilities as well as hospital readiness. This focus should include considerations of non-affiliated entities (e.g., universities with nursing schools) and even some non-healthcare related entities.

2. In cases of significant demand on hospital ICUs, Emergency Departments could be overrun with patients in respiratory failure who will need to be intubated and bagged for a reasonable time until a ventilator or transfer becomes available. Hospitals need to consider whether or not in such circumstances they will seek volunteers who are not healthcare workers to help bag the patients instead of nurses or health-care workers as an absolute last resort (acquisition of sufficient supplies for such measures also need to be included in preparations).

3. Internalization of protocols prior to emergent situations is more practical for guiding actions during times of scarcity rather than relying purely on stated or identified norms of behavior.
4. Decisions and preparations must be monitored and evaluated on an ongoing basis and revised as required by changing circumstances, keeping in mind the procedural values identified above.

5. Internal communication structures should be developed to ensure the flow of consistent, real-time information that decision-makers will need to respond in an appropriately efficient manner and therefore avoid preventable harm resulting from a delay in information, inconsistent information and/or unsubstantiated data claims.

6. Triage criteria should be established by a multidisciplinary team prior to the outset of a pandemic. A team of individuals should then be identified to implement the triage criteria. Recognizing the spiritually and emotionally burdensome nature of this role, individuals performing this function should rotate frequently and receive emotional, spiritual and psychological support services.