Fr. Alfonso P. Suico, Jr. CSsR

From Triage to Treatment: Shifting Principle-Based Bioethics at a Time of Pandemic[1]

ABSTRACT

This paper assesses the fundamental principles of biomedical ethics in the context of the government and clinical response to the SARS CoV2 or Covid-19 pandemic. Using the lenses of Beauchamp and Childress, it discusses the relevance of these principles and the health providers' dilemma in practice, given the limited resources and the novel nature of the disease. It presents the author's reflection on the principles in the light of the Catholic Social Teachings (CST), showing the poor as the most disenfranchised and marginalized in the fight against Covid-19. Thus, it invokes the CST's principles of solidarity, justice, and the preferential option for the poor as it challenges all sectors to stand united in upholding these principles in resolving the Covid-19 contagion and in preparing for the next global pandemic.

Keywords: *Autonomy; Beneficence; Allocation Principles of Justice; Solidarity; Preferential Option for the Poor*

[1]This text was originally delivered as a lecture during one of SATMI's Theological Hour held last September 29, 2020 via Zoom and Facebook Livestream. Appropriations have been made in translating this lecture notes into a theological article.

INTRODUCTION

Early in the year 2020, a previously unknown enemy confronted the medical community and the rest of the world – a respiratory infection that is highly contagious and potentially lethal. More than several months have passed since the pandemic started, but there is no real indication of its eradication. The new coronavirus disease or COVID-19 affected every person from every sector of society. This viral infection is caused by the SARS CoV 2. Because stopping the virus's spread was critical, doctors and governments appealed for the general population to practice handwashing, wearing masks, and physical distancing. However, the medical community members are among those gravely affected; they got infected with the virus after getting exposed to positive patients. Despite the risks to their health and lives, doctors, like other front-liners, are committed to their profession's fundamental ethical principles.

In March 2020, when COVID-19 spread across Europe to the US, the pandemic was still forthcoming here in the Philippines. However, when it finally hit the country, I got exposed to a colleague here in Cebu who later developed severe COVID. At that time, protocols were just getting set up, and testing was uncommon. I isolated myself for two weeks, even as I had to go for hemodialysis. I became so paranoid that I checked my temperature and oxygen saturation every half hour, thinking that the chill, or headache, or throat irritation were signs of COVID. The thought of getting the virus was disconcerting. I did not develop the symptoms, but unfortunately, the doctor I was in contact with died of COVID. Somehow, that experience made COVID-19 real to me.

Looking back to this experience, I noticed many problems and lapses committed by the government in its response to COVID. Not only were they inadequate, but they also relied so much on the private sector like hospitals. More than that, the medical problems got politicized, which even further hampered the delivery of services. Then there was the economic consequence

of imposing a lockdown, which was met with skepticism if the community quarantine succeeded in flattening the curve.

Despite the overall effects of COVID, our lecture today shall be limited the ethics underlying the clinical response to COVID-19. To do this, we go back to the foundations of present-day medical practice: the principles that ground every skill, knowledge, and clinical judgment of every physician. In this lecture, we shall review, assess, and critique the role of bioethical principles in clinical practice and appraise their application in these changing times. Here are the objectives of this lecture.

OBJECTIVES

1. Define and review the fundamental principles of biomedical ethics of autonomy, beneficence, non-maleficence, and distributive justice.
2. Assess the relevance of these principles in the pandemic's present situation by identifying problem areas in clinical practice.
3. Propose a re-reading and re-application of the bioethical principles.
4. A critique of principle-based ethics through the lens of virtue ethics and Catholic Social Teachings

PRINCIPLE-BASED BIOETHICS

Although the history of bioethics began with moral discussions by theologians, the discipline has evolved away from any religious tradition. While there is a theological lens of bioethics, the discourses shifted to non-sectarian ones in a pluralistic global setting. That is why this lecture may not be theological in the usual sense.

The Principles of Biomedical Ethics by Tom Beauchamp and James Childress has become the standard text for many medical institutions worldwide. Respect for autonomy, beneficence, non-maleficence, and justice have become the four guiding principles in medical practice and biomedical research.

Respect for Autonomy

Autonomy comes from the Greek words autos (self) and nomos (rule, law, governance). Originally, it referred to city-states' self-rule, but later, the word applied to the individual. The concept of autonomy is based on human freedom, including freedom from others' interference.[2] In their book's earlier editions, the focus was on the freedom to choose and freedom for self-determination. In its recent editions, this shifted to respecting the patient's autonomy, an obligation demanded from others; in this case, the medical practitioners.

There are two conditions essential for autonomy: liberty and agency. Liberty means independence from controlling influences, while agency refers to the capacity to take intentional actions. Persons are said to be autonomous when they have the capacity for self-governance, meaning, the capacity for understanding, deliberating, managing, and choosing.

Beauchamp & Childress proposed that autonomous acts consist of intentionality, understanding, and non-control. An action can either be intentional or unintentional with no ambiguity in between, even if some contemplated actions do not have the intended outcome. Autonomous acts require sufficient, but not complete, understanding. (For example, a doctor explains the convalescent plasma therapy process to the patient without necessarily giving the technical details). Finally, an autonomous act is free from controls exerted by forces, both external and internal constraints. (For example, a patient with dementia cannot make sound decisions; neither can one under threat).

Because understanding and freedom from constraints vary in degrees, acts are autonomous by degrees. Thus, ascertaining that patients understand and have a sense of control is necessary to exercise autonomy. Cultures, religions, and social conditioning may influence decision making, but these do not limit nor negate a person's autonomy.

[2]Tom L Beauchamp and James F. Childress. *Principles of Biomedical Ethics.* Seventh Edition. (Oxford: Oxford University Press, 2013), 101.

To respect autonomous agents means acknowledging a person's right to hold views, make choices, and take actions based on their values and beliefs. Respect for autonomy is both a negative and a positive obligation. As a negative obligation, it demands a physician's non-disclosure and observance of confidentiality. As a positive obligation, it means truth-telling and honesty. When competing moral values happen, public welfare overrides this principle.

Informed Consent

Informed consent provides how autonomous agents can express themselves in terms of the quality of the medical care they wish to receive — consent grants permission for doctors to treat their patients. Consent also binds the physician and the patient into a contract. Consent can be explicit, implicit (like agreeing to blood draws), or presumed (silence in CPR). Consents serve as legal protection for doctors against possible litigation for malpractice.

Consent presumes competence by a person to make moral choices. However, competence may vary from one time to another or from one situation to the next. Sometimes patients are not in the best position to consent, like when patients are in pain, under medication, or incapacitated. In these cases, advance directives and proxies may be helpful. Note: doctors do not make choices for their patients.

Beneficence

The principle of beneficence means that healthcare should contribute to the patients' wellbeing. It aims to promote wellness and prevent harm. All forms of medical practice are beneficent since these seek the wellness of individuals as their end. Beneficence looks for what is the best interest of the patient. Others distinguish between obligatory and ideal beneficence. Obligatory means that the right act is mandatory – it is a duty done. Ideal beneficence is going out of one's way to provide a

good deed or service. (Example: a recovered patient voluntarily donates his plasma for CPT). In recent editions, Beauchamp & Childress would say that beneficent conducts are ideals rather than obligatory.

While beneficence demands to do good to the patients, care is also necessary to the health provider who puts oneself at risk to help others. We call this self-care, which is equally essential. The principle of self-care ensures the safety and wellbeing of doctors. Moreover, it avoids doing beneficent acts as messianic tendencies that pose more harm than good.

Non-maleficence

Primum non nocere. The principle of non-maleficence is summarized into one statement: to do no harm. Non-maleficence gets conflated with beneficence, but there are distinctions between the two. Beneficence has a non-maleficent element in it. It directs the healthcare provider to do what is best for the patient. Non-maleficence means avoiding unnecessary action that may harm a patient. Non-maleficence follows proportionality wherein the benefits must outweigh the risk of harming.

Quality of Life and Best Interest

There are two concepts or principles derived from beneficence: quality of life and the best interest principle. The quality of life principle tells us that patients should live a life that can allow them to enjoy and find fulfillment according to their current situation.

The best interest principle maintains that treatment should be directed to the best interest of a patient. Because minors and vulnerable adults cannot make decisions for themselves, their proxy has the patient's best interest in mind when making life-changing decisions for them.

Justice

The principle of justice. While justice is the fair, equitable, and appropriate treatment of persons in the light of what is their due, in medical ethics, justice as a principle is primarily concerned with allocating limited or scarce resources. The principle of justice follows a distributive definition whereby a fair, equitable, and appropriate distribution of benefits and burdens are determined by social norms.[3] People have rights to medical care, while the government has the corresponding obligation to provide those rights. These matters raise the following questions: How are the limited resources distributed fairly and equitably? How do national policies protect the right to access medical care by individuals? Who has access to these scarce resources? Do they favor the rich over the poor? Do poor people have equal access to these scarce resources? Who determines a fair distribution?

As a corrective measure to this narrow application of justice as a principle concerned with allocating resources, one can appreciate justice as a virtue. In virtue ethics, the emphasis is on the agent's character rather than individual choices and actions. As a virtue, justice means that the moral agent, the medical personnel, seeks to ensure the equitable distribution of goods and foster a fair and honest disposition in fulfilling their duties. Therefore, justice demands both the allocation of limited resources and the necessity for a fair distribution that will not disadvantage the poor.

SHIFTING PRINCIPLES AT THE TIME OF PANDEMIC

The above principles, as practiced by medical institutions, are proven to be applicable in ordinary times. However, the question is this: are the principles of bioethics still helpful, useful, or significant during this pandemic? Do they adequately address the issues and problems arising from the pandemic? Let us consider some of the problems below:

- Problems with consent
- Overbearing families

[3]Beauchamp and Childress, *Principles of Biomedical Ethics,* 250.

- Prioritizing (Triage, Elective procedures)
- Scarcity of resources (Testing and Tracing including the cost of RT-PCR and antibody tests)
- Quarantine protocols and facilities
- Vaccination

To address some of these issues, we need to shift from how we do bioethics – how we apply the principles. I am proposing here a shift in the understanding and application of the four principles.

Reassessing Autonomy

It has become a regular item on the radio to hear grieving family members asking for justice for their loved ones who died of COVID, accusing hospitals of not explaining to them or the patient the management plan. Even if, in reality, doctors and nurses only know too well the importance of information and would, at every instance, consult the patient or the family for interventions done. Some local doctors got shamed by an influential family whose brothers died. Understandably, the frustration fueled the family's anger. Added to that is the stigma of the disease itself, prompting a denial or downplaying the situation. This often happened due to the lack of understanding of the disease's course and the management planned.

These examples show the significance of why medical practitioners need to conscientiously inform their patients and families of their condition, the management, and the prognosis of the disease. This demand adds work to doctors. However, because of the novelty of the disease, these doctors bring stability in these uncertain times.

From Autonomy of Individuals to Relational Ethics

To address the problems related to autonomy, perhaps there is a need to shift the conversation on respecting autonomy to relational ethics. While the current protocol is to test, quarantine, observe physical distancing and treat, there is the danger,

unintentional or otherwise, that respecting the patient's autonomy becomes secondary to controlling the virus's spread by minimizing contact. Even wearing PPEs puts a barrier between the health care provider and the patients. Although these measures prevent overwhelming the hospitals, they risk depersonalizing medical care by limiting individual freedom and autonomy. Persons become cases, and subjects are objectified. This limitation is justified for utilitarian reasons by maximizing the greater good. However, there is also the need to balance this with interpersonal relations.

To this end, David Ian Jeffrey proposed relational ethics. Relational ethics emphasizes interpersonal relationships as medical practitioners engage with their patients. Relational ethics include relational autonomy and solidarity as core values.[4]

The principle of relational autonomy is based on how the individual's interests interrelate with that of the bigger society. Relational autonomy somehow reverts autonomy to its original form since it involves changing the individual focus from the self to the broader society. This premise contrasts with the prevailing understanding of autonomy that emphasizes independence fostering a self-centered understanding. Apart from relational autonomy, solidarity is needed during a pandemic. At its core, solidarity is another relational construct that reflects a shared interest in people's safety. A concrete example of solidarity is how the community takes care of the most vulnerable – the aged, the children, and the poor who are the most disadvantaged.[5]

As mentioned, the pandemic's relational approach brings autonomy back to its original purpose: protecting individual interest to benefit others, and therefore, the broader community. From there, we can move from the individual to the communal. Relational autonomy and solidarity may offer us the best guide to navigate this present crisis to the broader global scale.

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[4]David Ian Jeffrey. *Relational Ethical Approaches to COVID-19 Pandemic.* US National Library of Medicine National Institutes of Health, June 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7316115/ (accessed September 11, 2020).
[5]Ibid.

Triage as Beneficence

In April, only the center in Manila approved of running RT-PCR; the satellite testing centers would send them their samples. Because of this limitation, hospitals and even government units started performing rapid antibody testing to check for IgG and IgM immunoglobulins' presence. However, many false-negative results further increased the spread of the virus. These limitations of the country's health care system also limited the diagnosis, isolation, and hospitalization of patients. However, even without lab tests, identifying possible cases by clinical assessment is the core of triage. Patients with fever, cough, shortness of breath, or a history of exposure, were considered persons for monitoring. As more became known about the disease, the list of symptoms also increased.

Based on the principle of beneficence, triage ensures a fair distribution of benefits by identifying which patients need immediate attention. Triage helps distinguish those who need ICU admission from those who require supportive treatment. Triage ensures the care of patients and allocation of resources based on need, not on merit.

Triage as beneficence calls for healthcare providers to do all that they can for the good of the patients. However, the pandemic imposes many restrictions not normally encountered during ordinary times which further limited the patients' options. These resulted in situations where the care given to a patient may cause a lack or delay of treatment to other patients who need less urgent treatment. To this, one can ask if harm done by the postponement of treatment is justified?[6] Nonetheless, beneficence and the practice of triage are essentially utilitarian. Owing to the high demand for care, the limited resources, and the risk to the medical provider, triage remains an essential component in pandemic response.

[6]Marlene Bakker and Eva Asscher. *COVID-19 and Ethics: Lessons from the Netherlands.* Insight July 2020. https://insightplus.mja.com.au/2020/28/covid-19-and-ethics-lessons-from-the-netherlands/ (accessed September 12, 2020).

DEFERRING TREATMENT AS NON-MALEFICENCE

When the number of cases rose to levels that stretched hospital capacities, many people who suffered from other illnesses postponed seeking medical care or going for a check-up visit because of the fear of contracting the disease. Some hospitals also focused their services on COVID patients deferring treatment and limiting elective. Other healthcare providers, such as dentists, followed suit. The reason was partly due to the cost of using PPEs for every patient; but, it was mostly to prevent possible harm from unnecessarily exposing patients to the virus. However, limiting services raise concerns about justice for those needing other emergency interventions that were left wanting medical attention.

Non-maleficence means avoiding harm inflicted on the patients. It seeks to minimize harm by physical distancing and isolation. However, these actions may harm vulnerable groups with a mental impairment like psychiatric patients who cannot understand why there are such measures. Again, the practice of delaying treatment and the preventive protocols while preventing harm to the majority may prove harmful to a minority.

Allocating Scarce Resources for Treatment and Prevention

By the end of last week, there had been more than 309K COVID-19 cases in the country, with 252K recovered and 5,448 deaths (DOH COVID-Case Tracker, 2020). Even if the numbers of severe cases and deaths are remarkably lower than the diagnosed cases, the total number of COVID cases overburdened the system.

We identified above the significant problems of COVID responses from diagnosis to tracing, to isolation and treatment. Indeed, the cost of medication and treatment is so high that the poor are further leaves out other reason, especially when we look at the detail of the treatment and management plan, which includes:

1. Antiviral regimen with remdesivir
2. Immunosuppressant with tocilizumab
3. Convalescent plasma therapy (CPT)

4. Therapeutic plasma exchange
5. Antibiotic treatment with Azithromycin to cover for bacteria co-infection
6. Anti-clotting medication
7. Supportive treatment including oxygen inhalation, nutrition, and IV fluids

Here is the catch: the cost of one vial of remdesivir is about Php 10,000. In severe and critical cases, the immunosuppressant tocilizumab controls the cytokine storm. A vial costs about Php 40,000. Then the patient may require more than one dose of the medicine. The cost is exceptionally high. Add to this is the use of mechanical ventilators, PPEs, and more.

Even the best effort to save COVID patients has a downside: the treatment with CP became problematic at first. It relies on a very limited supply of convalescent plasma. In Cebu, most of the patients given CPT were doctors, family members of doctors, or other prominent individuals who have the financial resources or the right connection. They also have access to tracing convalescent patients who were willing to donate plasma. As plasma demand increased, many recovered patients began selling their plasma for about Php 40,000 to 80,000. They jacked up the price preying on the desperate families willing to shell out money to save their loved ones. That was why voluntary donations were advocated.

All in all, the poor are disenfranchised and even commodified. They are disenfranchised because of the lack of financial backing; they do not have access to the optimal care available to those with money. Consider the financial cost: getting an RT-PCR in non-government centers, payment of ICU, mechanical ventilators, cost of medicines, CPT. Secondly, they lack connections and personal backing: it cannot be denied that some individuals have easy access to hospital care more than others. Persons of influence will only wait for a shorter time to get a hospital bed. The rich, not the poor, are the ones with contact to convalescent plasma donors. There is the issue of commodifying

convalescent plasma donors. Recovered patients become products peddling their blood in exchange for a large payment. Even worse is that COVID-negative individuals intentionally expose themselves to get infected in the hope of becoming potential plasma peddlers. These practices objectify persons.

On the upside, PhilHealth, despite its present moral crisis, can give substantial financial assistance, but even that is not enough, especially that COVID has long term effects on recovered patients.

Nevertheless, how can we address the problems of allocating scarce resources? One aspect of the principle of justice applicable during this pandemic is priority setting – the WHO calls governments and other health systems to ensure the adequate provision of health care for all. However, during a pandemic, this may not be possible, given the limited health resources. Because of this, setting priorities and practicing the rationing resources, while tragic in ordinary circumstances, may be ethically justified.[7]

The WHO went on to explain that when prioritizing, certain factors need consideration: the type of healthcare resource, the present context, and the state of the pandemic. Given that while the ethical principles apply to resource allocation in general, they differ in different pandemics. Nonetheless, they can help make decisions with different contextual circumstances.

Allocation Principles

Then there is the allocation principle. Justice means that all patients should have access to treatment. During a pandemic, justice needs to consider both patients with and without COVID-19, those needing prompt care, and those who may need them later.[8] The principle of justice is not one single blanket principle.

[7]World Health Organization. *Ethics and COVID-19: Resource Allocation and Priority-setting.* https://www.who.int/ethics/publications/ethics-covid-19-resource-allocation.pdf?ua=1.(accessed September 12, 2020).
[8]Bakker and Asscher, *COVID-19 and Ethics: Lessons from the Netherlands.*
[9]WHO, *Ethics and COVID-19: Resource Allocation and Priority-setting.*

Thus, the WHO proposes the allocation principles that apply to different settings and stages of the pandemic.[9]

1. The equality principle means that each person's interest accounts equally unless there is a good reason justifying the reprioritization of resources. Factors such as race, religion, politics should be set aside. Allocation can be done randomly or by lottery. (Example: Vaccines can be done by lots or vaccinate on a first-come, first-served basis.)
2. The best outcome principle (utilitarian) means allocating resources based on the capacity to do the most good and minimize harm to save the most number of lives possible. (Example: in the lack of ventilators, those expected to survive will be given priority. This system will exclude many, especially the elderly and those with comorbidities.)
3. Prioritizing those who in most need (or worst condition) means allocating the resources to those in greatest medical need or those at most risk. Example: PPEs for front-liners, admission for severe and critical cases, vaccines to individuals at risks (e.g., high incidence rate), rationing antivirals to severe or critical patients over moderate cases.
4. Prioritizing those tasked with helping others: the medical staff, experts who have skills and knowledge to save many, and first responders.
5. A fifth principle is proportionality. We saw above how the scarcity of resources proved a determining factor in the care of COVID patients. Proportionality underlies all the other principles, but specifically, it means that interventions must be proportional to the possible good achieved relative to the potential harm as an outcome. In medical ethics, this means that

[9]WHO, *Ethics and COVID-19: Resource Allocation and Priority-setting.*

interventions and risks must be proportionate to the lives that can be saved.[10]

Each of these allocation principles may be useful in different contexts and stages of the pandemic. For example, at the beginning of the pandemic, the equality principle (first come, first served) can be applied. As more patients test positive and severe cases increase, prioritizing the severely ill will be done. It is also possible for multiple principles applied like the distribution of PPE prioritizing helping the sick. At the same time, first come-first served applies to the patients coming to the hospital.[11]

To effectively apply these principles, there must be transparency and consistency in delivering services to the public and avoiding the special treatment of families and VIPs, like politicians. There must also be accountability. Doctors and other persons in authority are held responsible for their actions, lack of actions, and inadequate actions. The matter of accountability is also especially true regarding pharmaceutical companies developing the vaccines. To be accountable is to be answerable to the public, like when a particular official advocated for tuob (steam inhalation) while shaming doctors who called her out. The practice only caused more inconvenience, delay in seeking medical attention, and potentially contributed to the spread of the virus. Finally, decisions, i.e. on the vaccine issue. must also be inclusive in determining who gets to be treated first or which country receives the vaccines.

BIOETHICAL PRINCIPLES AND CATHOLIC SOCIAL TEACHINGS

We have seen the bioethical principles, their definitions, applications, and shifting understanding. The principles presented above are ideals, if not compromises, of the ideals to combat COVID. As we saw with justice, it can be seen as either a principle

[10]Kate. Jackson-Meyer. *The Principle of Proportionality: An Ethical Approach to Resource Allocation During the COVID-19 Pandemic.* April 2020. http://www.bioethics.net/2020/04/the-principle-of-proportionality-an-ethical-approach-to-resource-allocation-during-the-covid-19-pandemic/ (accessed September 3, 2020)
[11]WHO, *Ethics and COVID-19: Resource Allocation and Priority-setting.*

or a virtue. The same is valid for solidarity. Virtue ethics is an approach to doing ethics that focuses on the character of the agent. Virtues, from the Greek word arete, are moral excellences that a person can possess. They are habits that one can harness through constancy and consistency of practice. Unlike the two main approaches of ethics: utilitarianism and deontology, which focus on the rightness or wrongness of the action, virtue ethics considers not what the agent is doing but the underlying character that moral agents possess. For example, a physician possesses integrity, compassion, fairness, and patience, among others. However, during a pandemic, when time is critical, and resources are limited, virtue, while essential in carrying out a physician's duties, does not take the role of the biomedical principles intended to save the lives, if not of all, at least, of the majority.

It seems that the bioethical principles are sufficient to enable, at the very least, a working system to answer this pandemic given the personnel and resource conditions. However, we saw how the poor are the most affected by the lack of resources and as victims of the government's failure to provide a sensible COVID response. This disparity brings us to Church teachings and how they take our reflection a step further. Given that with respect for human dignity and rights and the pursuit of the common good, the Catholic Social Teachings emphasizes the principles of solidarity and justice and a preferential option for the poor.

Solidarity

The Compendium of the Social Doctrine of the Church teaches that the principle of solidarity underscores intrinsic human relationships, individual rights and dignity, and the common path shared by people towards unity. It is a commitment to the common good. Solidarity is both a social principle and a moral virtue. As a moral virtue, solidarity is a firm and persevering determination to commit oneself to the common good: to the good of neighbor with Gospel readiness. As a principle, it is a guide

to overcoming social sin structures by modifying laws, policies, and structures.[12]

In his most recent encyclical, Fratelli Tutti, Pope Francis identified the need for fraternity and social friendship. He said that the sudden eruption of COVID-19 exposed our false securities and caused fragmentation in the world.[13] The pandemic brought us to recognize the need for solidarity – that we can only be saved together. Moreover, it forced us to recover our concern for everyone, not just for the benefit of the few.[14]

Justice

In Catholic teaching, justice consists of the constant and firm will to give their due to God and neighbor. The most classical forms of justice are respected: commutative, distributive, and legal justice. There is a greater importance to social justice that regulates social relationships according to the criterion of observance of the law. Social justice, a requirement related to the social question which today is worldwide in scope, concerns the social, political, and economic aspects and, above all, the structural dimension of problems and their respective solutions.[15] To ensure the common good, every government has the duty to harmonize the different sectoral interests with the requirements for justice. The common good of society is not an end in itself; it has value only in reference to attaining the ultimate ends of the person and the universal common good of the whole of creation.[16]

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[12]*Compendium of the Catechism of the Catholic Church* (Vatican City: Libreria Editrice Vaticana, 2005), no. 193. Vatican Website http://www.vatican.va/archive/compendium_ccc/documents/archive_2005_compendium-ccc_en.html. (accessed September 24, 2020).
[13]Francis. *Fratelli Tutti.* Encyclical Letter on Fraternity and Social Friendship (Vatican City: Libreria Editrice Vaticana, October 3, 2020), no.7. Vatican Website http://www.vatican.va/content/francesco/en/encyclicals/documents/papa-francesco_20201003_enciclica-fratelli-tutti.html. (accessed October 29, 2020).
[14]Ibid., nos. 32-33.
[15]*Compendium of the Catechism of the Catholic Church*, no. 201.
[16]Ibid., nos. 169; 170.

Preferential option for the poor

The universal destination of goods requires that the poor, the marginalized, and in all cases, those whose living conditions interfere with their proper growth should be the focus of particular concern. To this end, the preferential option for the poor should be reaffirmed in all its force. "This is an option, or a unique form of primacy in the exercise of Christian charity, to which the whole tradition of the Church bears witness. It affects the life of each Christian since he or she seeks to imitate the life of Christ. It applies equally to our social responsibilities and manner of living and the logical decisions made concerning the ownership and use of goods. The option for the poor gives us a new challenge to respond to the poor today: the sick and the hungry, the needy and the homeless, and especially those who live without hope.[17] Overall, the CST presents us with the challenge of reaching the ideals of solidarity and justice to pursue the common good, to have a preferential option for the poor, and ensure that their rights and dignity are respected and promoted.

CONCLUSION

A principle-based approach to medical ethics and practice is valuable both in ordinary times and during a pandemic. Although they are limited, they are also realistic. They can provide a working set-up to respond acutely to a grave worldwide situation. When juxtaposed with the Catholic Social Teachings, we see the same principles of solidarity and justice as ideals that guide different sectors in societies, including the medical community, both in ordinary and extraordinary times.

While we set our goals to such ideals, the urgency of responding to the most pressing issues is more critical and crucial. Without denying the Catholic Social Teahings or perhaps guided by them, it might prove more helpful to shift our understanding of the principles from their minimalist and utilitarian applications to

[17]*Compendium of the Catechism of the Catholic Church*, no. 182.

maximizing their potential. Thus, we are introduced to the relational model of autonomy, expanding the implications of beneficences and non-maleficence, and applying the allocation principles of justice.

Perhaps there will be other models, the ones that go beyond the present articulation of autonomy, beneficence, non-maleficence, and justice. To this end, bioethicists, theologians, physicians, and medical practitioners, with their patients and governments, must work together and move forward to prepare for what might be the next global pandemic.

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