Philosophy in a Time of Pandemic

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MR. SPOCK POSES THE QUESTION
In the film *Star Trek II: The Wrath of Khan*, science officer Spock, in mortal danger, urges Admiral Kirk to abandon him and save the U. S. S. *Enterprise*, explaining, "The needs of the many outweigh the needs of the few" (Littman, 2016). In the movie, this deeply altruistic and philosophical statement is moving, and on its face, seems clear. But just how applicable is it to real life?

CAN PHILOSOPHY HELP?
Most people think of philosophy -- to the extent they think about it at all -- as an intellectual, academic field with little practical application.

Coronavirus is about to change that. If the worst predictions about the pandemic become reality, Americans in particular are going to have an abrupt encounter with difficult choices that philosophers have been thinking about for centuries.

The decisions we may face already provoke great uncertainty, and as a species, we humans do not tolerate uncertainty well. It is sometimes helpful if we can at least articulate the source of our anxiety in order to discuss it. This is one area where philosophy can help give a name to what we are feeling.

This essay is not a scholarly article, nor is it really an article on ethics or philosophy. It is a brief review of some core concepts in medical ethics, and an introduction to the names of the conflicts we may soon face.

A SHORT REVIEW: MEDICAL ETHICS IN NORMAL TIMES
American views of medical ethics are generally grounded on four core principles: respect for patient autonomy, beneficence, non-maleficence, and justice. As we'll see later, many of these ideas are closely related to principles formulated by the famous philosopher Immanuel Kant (1724-1804). But to start, let us briefly remind ourselves about each of these four major concepts.

Respect for patient autonomy is just what the name implies: the idea that people (patients) have the right to think and make independent decisions about their medical care. It is on the basis of autonomy that medical professionals must provide complete information to patients and respect their decisions, even if the medical professional believes the choice is wrong or unwise.

Beneficence is typically defined as promoting what is best for patients, and especially an individual patient under the care of a particular healthcare provider. This is the idea behind the moral imperative that health professionals must advocate for the interests of individual patients and must advise patients about what seems to be the best course of action.

Who decides "what is best" for an individual? As a practical matter, we speak of "standard of care", the idea of how most professionals would approach the same situation. Sometimes standard of care is based on firm scientific evidence such as clinical trials, or on consensus opinions by experts in the field. Professional judgment may need to substitute in circumstances where there are neither data nor

consensus. The principle of beneficence may come into conflict with patient autonomy when a patient makes choices that the health care provider believes are unwise. In almost all circumstances, the default is for patient autonomy to supersede beneficence. (I am deliberately avoiding special cases, such as children, people with cognitive impairment, or people with severe psychiatric disease.)

Non-maleficence is the idea of avoiding harming patients. The basic idea of doing no harm is, of course, also captured by beneficence and so usually it is not necessary to invoke non-maleficence in medical practice. Most medical ethicists retain non-maleficence as a core principle because, they argue, all humans (and perhaps especially health care professionals) have a widespread duty not to harm anyone, but a duty of non-maleficence is more deeply incurred toward the small number of people directly under a medical professional's care (Hope, 2004).

Justice is a huge topic unto itself. (For an excellent readable overview, see Sandel, 2009.). Within the confines of medical ethics "justice" subsumes four components: respect for the law, rights, distributive justice, and retributive justice.

Rights are greatly debated in medical ethics. In general, it is thought that if a patient has a right to something, that right confers on a patient a special advantage to expect that right to be protected even if doing so decreases the overall social good. Rights are not immutable, however. For example, a right to privacy of health information is widely respected, except in cases of reportable diseases, or if a patient presents a potential harm to others.

Respect for the law is a simple concept provided that laws are morally relevant, enacted through a democratic process, and enforced fairly. More complex ethical situations arise when those criteria are not met.

Distributive justice is so named because it takes into account access to care and resources. It is generally thought that access to care and to medical resources should be distributed fairly. (Saying resources should be distributed "fairly" is not the same as saying they should be distributed "equally." Philosopher John Rawls, among others, has written extensively on the relationship between fairness, equality, and justice. Again, see Sandel 2009, or Freeman, 2003.)

Finally, retributive justice is concerned about fitting punishments to crimes. In medical ethics, retributive justice often arises in the context of tort claims, and in situations where an individual's medical or psychiatric condition has bearing on the commission of a crime.

That is a very superficial overview of the four core values of medical ethics that underlie most Western medical practice, especially in the United States. Next we'll examine how a pandemic changes the fundamental way society and health care providers approach the practice of medicine.

MEDICAL ETHICS IN A TIME OF PANDEMIC

In 2011 the CDC released a document on the ethics of ventilator allocation during a hypothetical influenza pandemic. The document is very comprehensive and worth reading, but a key sentence regarding the ethical underpinnings of medical decision making is this:

> "The utilitarian rule of maximizing the number of lives saved is widely accepted during a public health emergency" (CDC, 2011).

"Utilitarianism" is the key concept that will come as a shock to most Americans, at least in the medical setting. It is also the idea that may provide significant personal moral, ethical, and practical hurdles for American health care providers. The "utilitarian rule" bears closer examination, as it also leads to statements like these:

> "Critical Covid-19 interventions — testing, PPE [personal protective equipment], ICU beds, ventilators, therapeutics, and vaccines — should go first to front-line health care workers and others who care for ill patients and who keep critical infrastructure operating, particularly workers who face a high risk of infection and whose training makes them difficult to replace" (Emanuel et al., 2020).
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> "[In a public health emergency], healthcare institutions and public health officials also have a duty to steward scarce resources, reflecting the utilitarian goal of saving the greatest possible number of lives" (IOM, 2009).

The Discomfort of Societal Benefit vs Individual Benefit

Much of our modern concept of the respect for individuals is based on the profoundly influential work of Immanuel Kant. One of his major works included a detailed and highly influential argument that respect for persons as individuals possessing intrinsic dignity and importance is a worthy moral end in itself. Kant argued strongly that individual, conscious choices and respect for other people are the foundations of moral life (Warburton, 2011). Although science and objectivity have become touchstones of modern medicine, the ancient moral imperatives of attendance to personhood and alleviation of suffering of the patient remain central to Western ideas of the patient-physician relationship (Cassell, 1991).

Respect for individuals, the intrinsic worth of people, and the requirement of medicine to respect personhood and alleviate suffering, are all values inculcated early and deeply in medical training (Ludmerer, 2015). Discomfort arises in times of pandemic when physicians are asked to set aside these values and instead focus on the broader needs and benefits of society at large.

What is Utilitarianism?

Consequentialism is an umbrella term. It represents the idea that the main thing that matters in any moral choice is the result of that choice; motivation is of little or no importance. If the outcome is good -- however that is defined, as better for you, the community, or some abstract idea -- your action was justified (Pettit, 1993). Spock's notion of "the needs of the many outweigh the needs of the few" is one example of consequentialism, and more specifically, utilitarianism.

Utilitarianism is the best-known philosophy that espouses consequentialist ideas. Its main proponent was Jeremy Bentham (1748-1832). In brief, Bentham argued that "the highest principle of morality is to maximize happiness, the overall balance of pleasure over pain…the right thing to do is whatever will maximize utility" (including decreasing suffering) (Sandel, 2009). Utilitarian approaches often take the form of a cost-benefit analysis. Businesses routinely calculate cost-benefit analyses, but this becomes more complex in many ethical situations.

As noted above, the CDC, the Institute of Medicine, and various prominent medical ethicists advocate a utilitarian approach in times of a public health crisis. And it is precisely this approach that generates anxiety and conflict for health care providers and patients alike: the utilitarian approach that seeks to maximize the benefit for *society* is in direct conflict with our usual (Kantian) view of respect for *individuals* among whom we usually seek to maximize autonomy, beneficence, non-maleficence, and justice.

Another conundrum, of course, is defining the true consequences of our actions. It is all well and good to talk about weighting the "costs and benefits" or a situation, but actually knowing these things is almost impossible. One of the major criticisms of utilitarianism is that there is no universal way to tally up the pros and the cons in many moral choices. While Bentham proclaimed that utilitarianism was objective by seeking maxima and minima, in truth, the calculation of such parameters is nebulous at best.

A Case Example with Variations

There are many possible scenarios. Assume that, as now, the healthcare system is greatly overwhelmed and there are insufficient resources to provide usual standards of care for all patients. Patient A is young, relatively healthy, a nurse, with a reasonable chance for survival for many decades provided he is put on a ventilator. Moreover, patient A fell ill while providing care to critically patients, and should he recover, patient A is likely to help many more sick people. Patient B, in contrast, is elderly, frail, with numerous underlying health problems. Patient B also requires a ventilator, but is unlikely to be survive the illness, and his life expectancy is less than 12 months should he somehow survive.

In normal times -- times when resources are plentiful -- both patients would likely be given the option of maximal critical care support. Patient A would likely be treated aggressively, since he has a good prognosis for survival. Patient B's status is less clear. It would depend on B's advance directives, B's preferences as they could be known, and the opinions of B's family. Even so, with many factors against B's prognosis, at least a time-limited trial of maximal support could be reasonable. The choices for each patient would take into account autonomy, beneficence, non-maleficence, and justice. These are Kantian principles of respect for the worth of persons as persons, not contingent on any other criteria.

Now imagine the same scenario in a time of a pandemic. Both A and B are as described, but the physician has only one ventilator available. Given the scarcity of supplies, utilitarian thinking, as codified by the CDC and other professional medical groups, assert that A should be given the ventilator, and B should not. The choice is strictly consequentialist: A has a greater likelihood of survival than B. Kantian principles and usual medical ethics are abandoned in favor of the single action that (we believe) can most benefit society.

There are other variations. Assume A is young and healthy, but a convicted murderer, while B is elderly, generally healthy, a model citizen known for her work on behalf of children with cancer. Many would argue in favor of B getting the ventilator, even though, based on age criteria alone, her chance of survival is less than A. But in an age of pandemic, more "objective" criteria, such as age, may apply.

There are endless variations even on this simple scheme. You can think of many yourself. In the end, however, during a time of pandemic and limited resources, hard choices must be made. These are usually based on utilitarian reasoning, and often cause discomfort, especially to healthcare providers in places like the US where we typically have abundant resources.

CONCLUSIONS

There are no simple answers. If there were, there would be no need for medical ethicists, philosophers, and medical professionals to contemplate these questions.

Most health professionals working today have never faced these choices outside of a classroom discussion. Those of us who were around when AIDS first appeared on the scene recall the anguish of

delivering a diagnosis that was then a virtual death sentence. That was hard, but it had nothing to do with allocating scarce resources.

What are the "right" principles to guide medical decision making? It's not clear. Even in normal times, for example, many countries in Europe view medical decisions with greater weight based on costs and benefits to society than in the United States, where the notion of "individualism" has been strong since at least the 1930s. Should that be the norm? Or should the individual be paramount? There clearly must be a balance, but how to find it is far from clear.

Most American physicians and other healthcare professionals strongly adhere to the core principles of what I have called Kantian medical ethics. Most respect deeply their patients' wishes, and most advocate vigorously on behalf of their patients. This is a good, noble, and honorable aspect of medical practice.

And yet, in a time of pandemic, when resources are scarce, profoundly difficult, life-altering and life-ending choices must be made. There is no easy way to do this. The principles of utilitarianism may be the best answer; they may need to suffice until we have a better answer. Perhaps you now have a way to begin to articulate the conflict.

But it is good to feel conflicted about moving from a patient-centered to a society-centered model of thinking. The conflict means we have not lost sight of the importance of the *person*. It means we still respect the individual, even if we cannot save them. As long as we are uncomfortable withholding care because of arbitrary contingencies like age, other health problems, and the like, we retain a moral sense that people matter just because they are people.

Do the needs of the many outweigh the needs of the few? As long as we continue to question that idea, we are on safe moral ground.

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