

COVID 19 : ETHICAL DILEMMAS IN HUMAN LIVES

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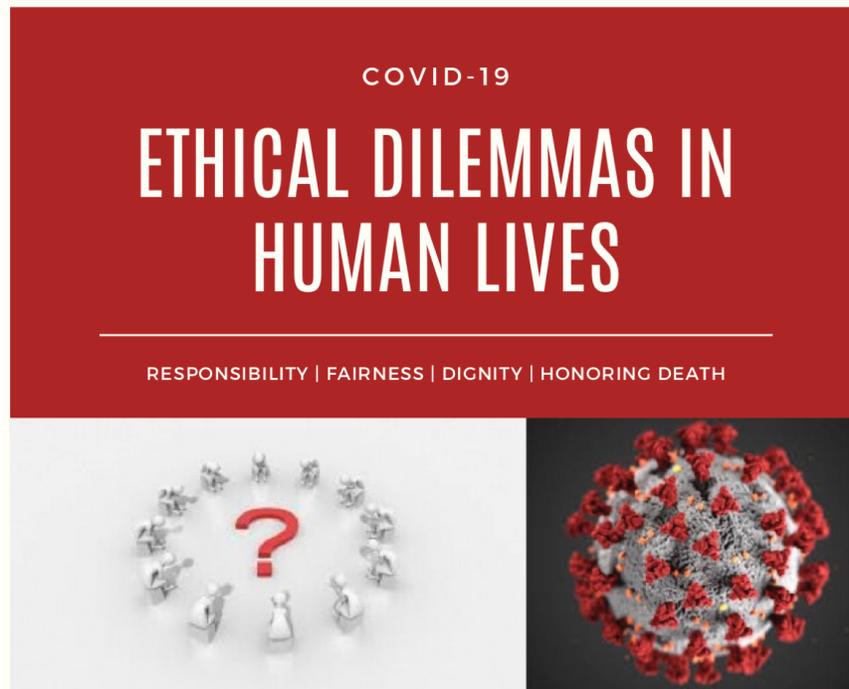
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Abstract

The outbreak of the Covid-19 pandemic obliged us all to handle many dilemmas, some of which we took upon ourselves as philosophers, ethicists, doctors and nurses to discuss around four key ethical notions : responsibility, dignity, fairness and honouring death. The following collection of the symposium acts held online in May 2020 with the Paris Global Center of Columbia University and Columbia Global Centers, attempts to testify to the ongoing pandemic emergency and difficult challenges while evaluating whether the ethical principles in the official recommendations were able to meet the lived reality. Looking at accountability and consistency in regard to the context of exercise, it seemed equally important to examine, through an international exchange, whether the contextuality of Coronavirus across countries and cultures affected the ethical decision making processes. We hope that our discussion can serve as a resource for advanced care planning, helping medical providers and other specialists to consider the shared important aspects of medical ethics in times of great uncertainty.



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- **humanity**
- **philosophy of medicine**
- **public health**
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- **healthcare**
- **medical ethics**

THIS PUBLICATION WAS DIVIDED INTO TWO PARTS FOR THE PURPOSE OF SUBMISSION and as agreed upon with the editors and in order to respect the word count. We would like them to be united into one section upon publication.

PART 1

General Introduction to the Section

COVID 19 : ETHICAL DILEMMAS IN HUMAN LIVES – INTRO- DUCTION

Dr. Smadar Bustan, Philosopher

The novelty of the global outbreak of the highly contagious coronavirus disease brought the entire world together as it shared a collective experience, while at the same time, pulled us apart with closed borders, home lockdowns, extreme social distancing and isolation. This coronavirus threat presented a unique set

of features: everyone had to be treated as potentially positive as it is possible to be infectious while being asymptomatic. The disease often became a death sentence because there is no treatment or vaccine. Moreover, our contemporary evidence-based medicine was challenged as the notion of knowledge became *in transitu*, knocking the solid bottom of the entire healthcare practice. Decisions need to be grounded in science but there was no science to rely upon. Information has been confirmed and refuted on a daily basis: face masks were publicly announced as protective measures but then their viability was debated, medical protocols at hospitals changed continually, confuse the frontline medical staff trying to save lives while feeding substance back to the experiential knowledge of medical care. Nations became indistinguishable by the worry and grief that joined hands: the long lists of hospitalized people shared on social media, the death tolls portrayed by endless lines of military fleet transporting bodies of coronavirus fatalities for burial in North Italy, the mass graves in Latin America or the extent of reported cremations of the Covid-19 victims in China, as well as the alarming cry of healthcare personnel worldwide.

The risk and prevention required to limit the coronavirus spread and rapidly work out the most efficient containment measures, divided the tasks between the political, medical-scientific, public and industrial sectors. Despite their exceptional collaboration, we seem to have turned back to population-oriented medicine after an accomplished era of individualized medicine, looking at the mass instead of the ill human being. In addition, when the whole world seemed to be coping as one, differences emerged in regard to national or even regional anti-Covid-19 management strategies, including sanitary and medical interventions. Since the onset of the outbreak, while keeping people alive has certainly been the immediate and primary imperative, healthcare professionals have been overwhelmed by pressing ethical challenges, having to make hard decisions for which they were accountable and to provide reasons for their actions and omissions. Clearly, clinicians are trained for ethical decision-making, but in view of the pandemic chaos paired with the incredible shortage of medical resources, ethics committees or advisory groups had to help by providing specific guidelines such as those endorsed by the ‘Covid-19 ethical decision-making tool’ (1).

The reality was and still is represented as being constituted in the same fashion as that of decision-making in times of war where the urgency, scarcity of medical supply or critical care beds, rapid spreading of new cases, time sensitive procedures, and fighting the unknown during a public health emergency continue to weigh efficiency (*Is it the most effective? What will be the end result?*) over the ethical (*Is it the right thing to do?*). The dramatic phrasing regarding “the war against Covid-19” announced by politicians and health organization directors-general became integrated into the health care system. It forced challenges that no longer strictly applied to individual patient care (allocation of limited resources such as ventilators, the sharing of patients’ confidential information with relatives or even the media, denying opportunities for families to say goodbye before a death) but also applied to the role of practitioners who found themselves in a newly created chain of command.

The essential service of medical ethics and its decision making process, as I see it, consists in allowing for one part of the decision to lean upon another part of the decision in order to become unambiguous. In this way, each one of the several aspects in which the ethical decision may be considered, assures the values of the right and the good. Obviously, dilemmas put us in a situation of conflict where a difficult choice has to be made between different options. Medical ethics dilemmas create even more conflict than most because they touch upon human lives. The Covid-19 pandemic obliged us all to handle many dilemmas, some of which we took upon ourselves as philosophers, ethicists, doctors and nurses to discuss during the symposium *Covid-19: Ethical Dilemmas in Human Lives* held on May 7th 2020 and organized by the Paris Global Center of Columbia University and the Columbia Global Centers. Humbly, we may not provide ready-made solutions, especially as the epidemics storm still rages. This discussion testifies to the ongoing pandemic emergency and its difficult challenges while evaluating whether the ethical principles in the recommendations were able to meet the lived reality. Looking at accountability and consistency in regard to the context of this emergency, it seemed equally important to examine, through an international exchange, whether the contextuality of COVID-19 across countries and cultures affected the ethical decision making processes. The following collection of the symposium’s acts maintains the discussion format whereby each dilemma is addressed by a Covid clinician and then analyzed by a philosopher or an ethicist, who, at times, is also a

practicing physician. I organized the discussion around four ethical key dilemmas with leading questions, even though others clearly come up in the various discourses.

The Four Ethical Dilemmas:

RESPONSIBILITY :

Can medical responsibility change in times of pandemic?

FAIRNESS :

In times of emergency, scarce equipment, and contaminated medical staff, where do we draw the line of whom we treat and whom we cannot, who will live and who will die (triaging resources)?

DIGNITY :

Does the need for increased awareness of public harm in a pandemic justify impinging on patients' rights to bodily and personal dignity and privacy?

HONOURING DEATH :

Does public interest in social distancing outweigh the patient's right not to die alone and the family's right to be with their dying relative?

The ethical values at risk may be clearly striking and in this respect, the challenging questions raised are intended to reinforce our values, speak of the well-being of the sick human being, of the dead *person*, in referring to a patient as a person to be cared for rather than a critical case or a contaminating agent. And while the coronavirus continues to widely spread across the globe, we hope that our discussion can serve as a resource for advanced care planning, helping medical providers and other specialists to consider the shared important aspects of medical ethics in times of great uncertainty.

For the symposium video, please view: *COVID-19 ETHICAL DILEMMAS IN HUMAN LIVES*.

I would like to thank the Paris Global Center of Columbia University and their wonderful team for hosting the symposium in these exceptional times along with the Columbia Global Centers in Amman, Nairobi, and Istanbul. And last, I would like to thank all the healthcare and essential workers worldwide for their daily engagement to overcome the COVID-19 virus.

Smadar Bustan University of Paris Diderot May 2020, France

First Ethical Medical Dilemma

RESPONSIBILITY

Can medical responsibility change in times of pandemic?

RESPONSIBILITY: Clinician, Mirco Nacoti

Mirco Nacoti, MD, (ITALY) , is an emergency, anesthesia and intensive care physician at Bergamo Hospital, Italy. An expert in international health and bioethics, he has extensive field experience in humanitarian crises and community approach to vulnerable people.

Two months after the beginning of the crisis I still have major problems sleeping.

I've dragged the corpse, from the bathroom to the bedroom, of a 50 years old man who had died at home.

I've seen dozens of people piled up in emergency rooms with severe dyspnoea and frightened eyes.

I've spoken on the phone to a friend of mine and said to her: you must choose between your father and your mother.

I've run at night to my hospital, taken a drug for sedation and come back to look after an old man dying, as my hospital was too crowded.

I've obeyed an order to transfer to Germany by flight an intubated man and he has died on his way. I've never spoken to his parents.

I know many young anaesthetists in my hospital who have decided alone who were to live and who were to die.

I feel a persistent smell of people suffering on my skin.

The pale light of an old humanitarian actor, with some studies in bioethics, is now a fire. 40 years later, the Alma Ata definition (2) of primary health care seems vital to me.

I've done and watched a lot over these past 2 months. But my night-time question is: have I thought enough? That's why I'm very grateful to have this occasion to think.

Bergamo is a rich and populous city of northern Italy (1.000.000 people) and one of the epicentres of the worldwide COVID 19. Despite the generosity of health workers, we are undergoing a severe humanitarian crisis that is stressing every aspect of daily life.

From outside it is very hard to understand, because houses are closed for lockdown and are not destroyed as they would be in an earthquake. Furthermore, in regard to the dilemma of moral responsibility, the World Health Organisation figures do not represent the reality. WHO is doing a great job, as usual, but the figures provided are a dilemma, as usually occurs during an outbreak. Today WHO shows about 3.500.000 confirmed cases with 240.000 deaths (3) worldwide and in Bergamo 13.000 confirmed cases with about 2500 deaths (4). Unfortunately, the actual deaths reported by town halls are about 6.000-7.000 (nearly 1% of the population) (5). Considering that a fatality rate of 20% is a non-sense, because the Chinese experience (even in Hubei province) reports a rate between 1 and 3% (6), the number of people contaminated in Bergamo is likely to be between 250.000 and 500.000 (which means 25%-50% of the population). More than 2.000 people with mild-severe hypoxia, at the peak of the outbreak, stayed home because all the hospitals were overcrowded. These are the real figures. This is the picture of Bergamo's disaster.

For this reason we wrote a paper which appeared in the New England Journal (7). In regard to the dilemma of moral responsibility, when the global medical community is called on to face a pandemic of unprecedented scale, with little scientific evidence and "crazy numbers" describing the situation, honest and forthcoming advocacy is an ethical duty, and that paper was a wake-up call for those involved in system preparedness and strategic planning.

An outbreak is neither a simple disaster casualty incident like an earthquake or a "simple" disease, but it's a social phenomenon. Historical and social elements are key factors for development (for example, intensive promiscuity between animals and humans) and spread (for example health workers and ambulance rapidly become vector of the virus) of an epidemic (7).

A first consequence of this translation into a social horizon concerns the theme of responsibility. And in regard to the dilemma of moral responsibility, how much does the social narrative about the infection numbers weigh, for example, on the decisions to be taken and on the concepts that guide them (for example, that of proportionality)?

How do inaccurate narratives, from an epidemiological point of view, affect the "judgment in situation", that takes place in triage or in prevention strategies in other countries? How many shocking images are needed if figures are not reliable ?

Another aspect of the dilemma of moral responsibility concerns the care of decision-making process and the fragmentation of responsibility. Modern western medicine has centralized the care of patients in the

hospitals (and our region does represent this process), preventing the community from being the main actor in the sphere of public health and putting into practice an “expropriation of health”, as Ivan Illich’ says in *Medical Nemesis* (8). Body has been progressively fragmented in small pieces by super-specialized doctors and responsibility has ended up being a question of legal responsibility, an economic matter, and not an ethical one. In this fragmentation, it has been acceptable for us to execute orders, even if epidemically dangerous or not ethical, because we were living an urgent situation, and during the fight against COVID 19 the mantra was “to do and not to think”. It seems, as Hannah Arendt writes in her “Banality of evil”, that “nobody was responsible, or rather, nobody felt they were; they just did their job” (9). Would have been useful to have a mechanism of control of decision makers in close contact with territories? Only the awareness that the weight of a decision is to be shared can prevent us from turning the triage into a moment of irresponsible superhomism.

A further aspect of the dilemma of moral responsibility is the ethics of the research in urgent situation. As Derek C. Angus wrote in a JAMA view point (10), one stark example is the debate over prescribing available drugs, such as chloroquine, or testing these drugs in randomized clinical trials. At the heart of the problem is one of the oldest dilemmas in human organizations: the “exploitation-exploration” trade off. Exploitation refers to the “just do it” option. Exploration refers to the “must learn” option.

During his captivity in the 1940s, Archibald Cochrane treated many prisoners, often ill with tuberculosis, by observing how the disease benefited more from a good caloric intake than from drugs of uncertain or zero efficacy. The germs of Evidenced Based Medicine arose from those observations. 80 years later, in regard to the dilemma of moral responsibility, how many helmets to deliver respiratory assistance have been placed without any enteral feeding in Bergamo? Chloroquine, antiviral, anti IL6, anti-complement, steroids, antibiotics have been distributed without a real methodological approach, without monitoring, with people arriving at the hospital worn out after days of dyspnoea. What data, what ethical research can be produced in such a mess, what if you publish on an important indexed medical journal but the “*garbage in, garbage out*” approach is still considered the right one (11)? Furthermore, in regard to the dilemma of moral responsibility, what about signatures extorted for consensus from a dyspneic patient with no family member nearby? Such a touchy a matter would require competence and experience, and yet it was often managed by residents instead of specialists. Not everything is lawful in urgency and there is an ethics of research even in urgency.

Derek C. Angus suggests at the end of Jama view point (10) that an integrated approach of “learning while doing” is essential in a crisis. Nevertheless, in our current context, it’s very important not to lose the capacity to think and probably we have to subtly shift from Angus’ suggestion to a “thinking/learning while doing”, as Hannan Arendth writes (12).

Goisis, a philosopher coauthor of the New England article, says that it is not true that nothing will be as it used to be before COVID 19. Millions of people in the world will be more vulnerable and isolated. But the economic, scientific, political and social mechanisms leading to this pandemic humanitarian disaster are still there. “Doctors have to give back to the community the capacity to promote health”, could have said Ivan Illich today.

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RESPONSIBILITY: Philosopher, Smadar Bustan

Smadar Bustan, PhD , (FRANCE) , is a philosopher, ethicist and scientist at the University of Paris Diderot. In her research on human suffering and pain, she developed a tool for evaluating the suffering of chronic patients following experimental and clinical studies in Luxembourg and France. She co-founded at Harvard and heads the International Program on Suffering and Pain (www.suffering-pain.com).

The dilemma discussed here bears on responsibility, a Latin term from 1590 *respōns(us)* or response, which became philosophically prominent rather late in the 18th century. Our question is, does responsibility, and more specifically medical responsibility, change during a global health crisis? Is responsibility limited in the avalanche of an infectious transcontinental disease, obliging us to relieve clinicians from the burden of decision-making process carried out in individual cases?

A broader conceptualization of the nature of responsibility is necessary in order to deal with this dilemma, by first asking: *what does it mean to be responsible in times of pandemic?* Responsible behavior during the coronavirus infection outbreak was very much present in every household and country around the globe. Yet the lack of adequate knowledge caused significant inconsistency leading to public panic and raised doubt about what it means to act in a responsible manner, both personally and collectively. The problem with a pandemic is that the personal and the social intermingle to the extent that the most casual individual acts, such as coughing, sneezing, going out of our homes, or walking around maskless, turns a person into a biological agent engaging into irresponsible behaviors that some would qualify as criminal or immoral. This Covid-19 Epidemic has been enhancing *mutual accountability* to such an extent that individual responsibility is transferred from an autonomous self to a self intrinsically bound to others. One can no longer exert free will to live carelessly and be prepared to risk contamination.

What we have learnt from this epidemic as a globalized society is that individual responsibility is no longer *exclusively centered* on what we are bound to undertake by duty, of a person being responsible for something or someone (a parent for their child, a doctor for their patient) since *simply by being, breathing, existing, we are accountable, all of us together and every one of us individually.*

Unfortunately, under such circumstances, our responsibility becomes as vulnerable as we are.

The fragility of a pandemic causing this involuntarily *responsibility by existence*, with its inevitable sharing of accountability, leads us back to our main ethical dilemma when asking what motivates us to make the right choice for a responsible act during a health crisis. For the overwhelmed practitioner inquiring how to fully know what the right act is, how to best choose in relation to the available resources and to whatever is in one's power, the resignation to do 'the best we can' may provide protection from liability but not necessarily satisfaction or peace of mind. When the medical model of responsibility is guided by reasoned thought in regard to what we can do and the means that lead us to better ends, It is difficult not to notice the unrest when this intellect-based definition of being responsible entails a sense of feeling morally, medically or even humanly irresponsible. When reading Dr. Nacoti's testimony, it becomes clear that even though a well-regarded thought led him and his colleagues to make decisions for saving lives, the strong remorse experienced following the death of their patients shows that a reason-based decision for acting responsibly with a negative end result may leave clinicians with a feeling that they are partially at fault for the failure.

The severity of the pandemic has exposed many of the medical workers, as those in the frontline in north Italy where Dr. Nacoti works, to face the toughest triage procedures in medical care with the prospect of having to ration equipment and care, sacrificing certain people for saving others and facing unthinkable choices regarding life and death. The lack of treatment led to the use of drugs on the basis of limited evidence concerning their effectiveness and therefore not without risk while trying to assure the highest rate of survival. In this respect, even when providing immunity against malpractice during the emergency of Covid-19 and hence excluding any legal responsibility, as Dr. Fischkoff recounts about the State of New York, the problem with ethical responsibility persists not only in regard to the possible damage caused by one's own act, but also to the consequences of this act on the people to whom they must answer. We find here the two aspects of the modern idea of responsibility, associating legal and moral responsibilities. The interdependence of these two aspects may explain why, despite excluding any legal sanctions and therefore legal responsibility in a time of unprecedented crisis (facing scarce resources and exceptional emotional burden on healthcare personnel), the ethical dilemma persists because medical decisions remain attached to our moral obligations. Treating clinicians whose actions are based on well justified rational decisions may still carry blame, unable to wash away the guilt, because these fail to comply with their moral convictions.

The lived reality of the pandemic obliges us to go beyond the first form I named *responsibility by existence* to better examine the medically relevant form of *responsibility by deliberation*, introducing the idea of making a choice as a result of deliberation and of fully *knowing* what is the right thing to do. Two philosophers who represent this strand of thought with the traditional concept of responsibility as dependent on knowledge, striving to certainty and regulatively knowing everything or at least as much as possible, are Aristotle (4th century BC), in his account of Ethics, and John Stuart Mill almost two millennia later with his utilitarianism (13) (19th century). In the third book of *Nicomachean Ethics* (14), Aristotle examines what is good for the human being— what we need to undertake, aim at, and act upon, in order to do good. In our case, medicine aims at health, and physicians aim at healing. In this respect, what Aristotle also taught us is that when we deliberate, we always have some end in view. If I deliberate about whether to put a mask, I consider this in light of a future end in view, which is to avoid catching or spreading the COVID-19 virus. If I deliberate about whether to respect the extreme social distancing of the quarantine and stay at home, I consider this in light of a future end in view which is to slow down and eventually stop the epidemic’s spread.

Aristotle claims, however, that there are two things we cannot deliberate about: facts (which could only be examined) and end views, for the simple reason that we cannot change them. Hence our choice based on deliberation of doing good and acting responsibly are dependent on end purposes and on sticking to the facts, and basically on knowledge. At the same time, if during the Covid-19 pandemic we apply this philosophical recipe with reason-based choices regarding medical responsibilities, we soon realize that clinicians are being severely undermined, which only intensifies our dilemma. In reality, we have witnessed misinformation emanating from situation reports and official communications, including from public health authorities, through inaccurate or misguided information. For example, It was said that smokers are less likely to be contaminated, ibuprofen or aspirin can worsen the Coronavirus symptoms, or the virus is unstable at high temperatures and therefore will go away when the weather warms up. In the upheaval of the aggressively spreading epidemic, scientific facts continuously evolved so action based on facts had to adapt, inducing further confusion relative to our standard approach of evidence based-medicine that canceled out knowing beforehand and making a contingency plan accordingly. Furthermore, at the outbreak of the pandemic, the end view of medicine and its therapeutic goals, shifted from healing to prevention from dying, totally destabilizing the standard therapeutic goals.

Under a state of emergency and threatening rapid death, we could simply proclaim that without a solid foundation to rely upon for making choices, the entire undertaking of medical and social responsibility is bound to perplexities. Medical professionals must respond when facing flows of Covid patients with severe respiratory distress out of active commitment to vulnerable patients. De facto, they do respond. But do they need, in this unique scenario, to take responsibility for their medical response? In respecting their devotion and diligence, can we relieve clinicians from a part of the responsibility in the decision-making process as normally carried out in individual cases?

A comprehensive approach should be compatible with extant principles of responsibility under the given circumstances. A broad approach to analyze responsibility for pandemic diseases should consider both forms of responsibility, by existence and by deliberation. This would be better overall for society and healthcare, considering the disruption due to shifting facts and undermined medical ends, thus promoting more careful policies and actions.

At the same time, the outcome of the discussion so far has been to show us that a person or an act can be considered responsible so far as one is bound by it, or thinks it to be right. My first observation in examining “what is it to be responsible” in times of pandemic consists in introducing the idea of *responsibility by existence for all*, regrettably excluding the freedom to be able to do otherwise. And my second observation examining “what is it to act responsibly” consists in introducing the idea of *responsibility by deliberation*, of accountability for our actions and their consequences, and the praise and blame attributed to the moral agent. Deliberation is a reasoned thought about what we can change by our efforts and where we need to act differently in various occasions. And yet, in times of pandemic the foundation for well-reasoned and thoroughly discussed decisions, fostering a collegial consultation as standardly required, is damaged because

neither the facts nor the end views are stable enough to serve as references for deliberately acting responsibly. Dr. Nacoti raised this point when he spoke about referring to the general qualification of the Covid pandemic as a war with a chain of command whereby clinicians were to simply obey, following the mantra of “do and do not think” and inexperienced doctors found themselves having to decide alone who will live and who will die. The resulting epistemological helplessness of the Coronavirus pandemic puts the idea of responsibility in a new light due to the conflict between the medical naturally learned profession and not knowing. This novel chaotic situation cancel’s Aristotle and Mill’s rationalist view of acting by virtue and for the benefit of good on the ground of knowledge, as clinicians who have an occupation requiring them to be well-informed in order to act responsibly lack in effect the necessary knowledge.

This outcome for the practice of medicine and our philosophical inquiry requires to rethink the notion of responsibility and moral obligation by moving philosophical fields, going from Aristotle’s guiding but failing rationality to Levinas’ field of ethical phenomenology. The reason is that none of the perspectives that have been actually presented here has paid full attention to a third form of responsibility, based on an entirely different philosophical pattern and that provides a way out of this dilemma regarding acceptable or unacceptable changes in medical responsibility in times of pandemic. *This alternative view consists in arguing that responsibility is involuntary, not bound by rational choice, certainly not a deliberate one and is totally experiential. Becoming responsible for a sick person is imposed upon us by his needy, vulnerable presence when calling for help, often without words, in an appeal conveyed by the misery and helplessness of their facial expressions. This sense of ethical responsibility goes beyond that of a reflective commitment. And just like the first form of responsibility by existence, it separates one from oneself by giving precedence to the other person, while emphasizing here that this other person is weaker and more at risk. Levinas considers the experience of responsibility as what binds one person to another, as the foundation for humanity and ethics which he demonstrates through the well-known theme of the meeting face-to-face, when encountering the face of the other person causes a phenomenological shock that makes one feel inevitably responsible for their fellow human being (15).*

I have to admit that in my writings on ethics and the sufferer and especially in my review of what I call the “French School of the Ethics of Suffering” (16), I always criticized this uncompromising level of responsibility and priority Levinas claims we can grant another person, even when we are ourselves sick, exhausted and emotionally strained (17). But when I caught the Corona virus at the beginning of the outburst here in France, the sense of responsibility and giving priority for the well-being of another took over me. My symptoms were mild, but sudden. I fell down on the floor without being able to get up again, feeling the chill and honestly the fright of the unknown progression of this aggressive virus that literally took control over my body within minutes. While lying on the floor, what bothered me most was the possible contamination of my children and particularly of my asthmatic elder son who was designated as part of the Covid-19 risk group. I was sick, not being able to give anything, let alone move my body, and yet, just as Levinas claims, the disinterested sense of responsibility towards another invaded me and my responsibility for not contaminating them became my absolute priority. It was not a voluntary or deliberated sense of responsibility and it very much obsessed me when I was most helpless.

Obviously, one could contest this example by rightfully claiming that children are an extension of the parent and do not represent a ‘real Other’ in the full Levinasian sense. And as I demonstrate in my book on Levinas’ ethics, the unreflective encounter with the other person rather represents a situation that makes me surrender myself to them, often against my own will and without being able to expect anything in return (18). The Other could be a stranger one has to commit oneself to despite wanting to walk away, a patient entering an already overbooked Covid unit whom an overburdened doctor would rather put to wait or a contaminated elderly person placed in the care of a scared nurse, wearing a plastic bag due to lack of proper protective equipment (reminding us of the institutional responsibility towards the caregivers and the safety protocols). The other person may even constitute a threat but since their urgent call for help precedes me and is imposed upon me immediately, I am obligated to be there for them, unable «to get out from under responsibility» (19). It is the lived experience and encounter between human beings that make us responsible, not knowledge or deliberation on the account of facts. Human responsibility is simply being there for the

other, claims Levinas (20). The activated sense of responsibility towards the survival of others places them first, prior to worrying about our own survival and prior to any conscientious processing. One is compelled to worry and care for the other says Levinas, since responsibility does not originate from within oneself, but is rather an *order* or command that one receives. It precedes us in the sense that it originates from a prior time and our ascendants (ancestors or past generations), as Ezekiel Mkhwanazi beautifully explains (21), it is pre-original (22)(23).

In transposing this view to our discussed dilemma of medical responsibility, it soon becomes clear that what stems from this sense of duty, of a caregiver or a medical worker, is not a Greek agency or freedom to choose the good, but a fundamental archaic obligation of oneself towards another, and that it “commands me and ordains me to the other” (24). In this perspective, this amounts to saying that our dilemma is cancelled since no judgement can be made about treatment or availability of the medical caregivers during a pandemic. Their mere presence beside a Covid patient’s bed is a celebration of being there for the patient and of human responsibility at its best.

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Second Ethical Medical Dilemma

FAIRNESS

In times of emergency, scarce equipment, and contaminated medical staff, where do we draw the line of whom we treat and whom we cannot, who will live and who will die (triaging resources)?

FAIRNESS : Clinician, Katherine Fischkoff

Katherine Fischkoff, MD, MPA (USA) is an Acute Care Surgeon and intensivist at Columbia University and is the Medical Director of the Surgical Step Down Unit. She is an active member of the Columbia Ethics Committee, the SCCM Ethics Committee and an ethics consultant.

Fairness has been a driving principle of the treatment of COVID patients throughout the pandemic response. However, given the overwhelming number of patients in New York City, the challenges to fairness evolved as the COVID crisis unfolded.

To begin with, on March 16, 2020, all elective and semi-elective surgeries and other procedures were cancelled in New York City to allow hospitals to free up resources in anticipation of the surge of patients (25)(26). This presented the first questions of fairness. Patients who were scheduled for often time-sensitive treatments were postponed in order to be able to care for the thousands of COVID + patients. This was, of course, not just a question of fairness, but also of patient safety, reallocation of resources and preservation of PPE. However, any time one group of patients is prioritized over another, we must ask ourselves whether the outcomes were proportional. In this case, the overwhelming answer is yes. Shutting down normal hospital operations was essential in being able to safely take care of the enormous crush of patients that presented. However, should there be another wave, the proportionate harm to those patients who would be postponed needs to be considered and alternative options proposed in order to avoid interrupting their care again.

The second question of fairness came when questions of triage arose. In the United States, there is a strong cultural and legal emphasis on patient and family autonomy. This American phenomenon persists in part because the health care system is so resource rich. As an example, New York State law in the form of the Family Health Care Decision Act (27) does not permit physicians to withhold or withdraw life-sustaining therapy over the objection of patients and their families. In this cultural and legal context, when the COVID

surge began and there were serious concerns about scarcity of resources, the governor of New York decided that rather than approve a triage system to decide which patients would get a ventilator and which would not, he would work to provide ventilators for everyone and New York hospitals committed to rapidly expanding their ICU capacity (28). My hospital typically has 117 ICU beds but over the course of two weeks, we expanded to nearly 300 ICU beds and pop up tents provided extra inpatient beds. This was done without a compensatory increase in staffing. But because of this, no patient was turned away.

In 2008 after the H1N1 flu outbreak, many states put together a resource allocation plan that could be used in the case of crisis when resources were overwhelmed. The New York State Ventilator Allocation Guidelines (29) were built on the ethical principle of fairness- that all patients would be given equal access to ventilators regardless of socioeconomic factors. It begins with a set of immediate exclusion criteria that are applied to a patient when he or she is determined to need a ventilator, such as unwitnessed or recurrent cardiac arrest, severe traumatic brain injury or irreversible hypotension refractory to fluids and pressors. If a patient meets any of those criteria, he or she is not given a ventilator but is offered either best medical management or palliative care. If a patient needs a ventilator but does not meet any of the immediate exclusion criteria, he or she goes on to evaluation by a “Triage Committee” which follows a very specific pre-determined algorithm to decide whether a patient would be given access to a ventilator.

The goal of the Allocation Guidelines is to determine a patient’s access to a ventilator based on prediction of likelihood of survival and not based on value judgements. In fact, to uphold the fairness of the process and to ensure there would not be any decisions based on social or economic factors, the triage committee is a third party whose representatives are not directly involved in the care of the patient and does not receive any demographic information.

As noted above, the Allocation Guidelines were not activated during the COVID crisis. With an incredible show of collaboration, creativity and immense hard work, hospitals in New York City were able to care for all patients who had COVID. The question must now be asked, is it *ever* fair to activate a triage process and deny access to critical care resources if there is the option to stretch resources further? The Institute of Medicine describes the spectrum of hospital expansion in response to a public health emergency (30). Conventional capacity is the normal operating capacity of a hospital. Contingency capacity is defined as operating significantly above a hospital’s usual capacity but is a state in which normal standards of care can be delivered. Crisis capacity is the final stage in which hospital resources are stretched so thin that normal standards of care cannot be provided. It is often recommended that triage systems be activated before a hospital enters crisis capacity as a mechanism to help avoid providing crisis standards of care.

New York made a decision to enter crisis capacity rather than activate a triage system. This necessarily meant that hospitals were providing crisis standards of care to *all* patients rather than normal standards of care to *fewer* patients. Nursing and physician ratios were tripled, non-ICU trained physicians were caring for ICU patients and all manner of hospital spaces were repurposed to create rooms for ICU level patients. One particular example was the provision of dialysis. So many critically ill patients required dialysis that hospitals quickly ran out of machines and supplies (31). This meant that in some cases, in a manner not consistent with typical standards of care, patients received fewer hours of dialysis than normal or had peritoneal dialysis as a manner of stretching the supply of dialysis to meet the demand.

As an acknowledgment of crisis standards of care and in order to support clinicians’ ability to continue to care for so many patients, the governor of New York passed the Emergency Disaster Treatment Protection Act (32). The Act’s stated purpose is to broadly protect health care facilities and professionals from liability for the treatment of patients during the COVID-19 pandemic. The Act shields health care professionals from civil and criminal liability in connection with services provided to any patient as a result of and during the COVID-19 crisis, so long as decisions are made in good faith. For decisions that are alleged to be unlawful, the Act also provides immunity if they result “from a resource or staffing shortage.” Such legal protections were imperative to allow healthcare workers to continue to practice in the crisis environment but also are a recognition that the provision of crisis standards of care may contribute to adverse events.

While there are many ongoing conversations about whether New York should have activated triage systems, I have never been prouder of my city and my colleagues for their response to the COVID crisis. Taking care of nearly 120,000 New York City patients required perseverance, courage, resourcefulness and a willingness to accept personal risk. It will be months before we have outcomes data on the COVID patients and even longer before we will fully understand the consequences of our decision to treat all New Yorkers. But until then, we can stand tall in the knowledge that while our healthcare system was under unprecedented stress, we performed heroically and fairly.

TRIAGE AND FAIRNESS IN THE NAME OF QUALITY OF LIFE? Mylène Botbol-Baum, Philosopher

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Katherine Fishkoff has been addressing the issue of fairness from a regulatory perspective and the responsibility of the mayor of New York who has decided to protect medical doctors from trials when they take a reasonable decision in a context of emergency. These decisions raise dilemmas linked to conflict of interests and interpretations around the word fairness and even about what constitutes a fairness dilemma.

My first question, as a European benefiting from a providence state, is at what condition can we have fairness in an unfair system, i.e. a non-egalitarian context? What are our basic assumptions about moral reasoning when we address dilemmas in situation of uncertainty?

We must take seriously the health system capacity of anticipation that refers to public health at large since the issue of fairness is essentially a biopolitical issue, which has global consequences during a pandemic.

We know that the pandemic reduction was not a priority for the United States government, and many other opulent countries did not prepare adequately for it, so that the enormous responsibility to confront it befell on the medical providers. This imposed on them an uneven focus on present day patients, rather than the actual and prospectively sick. If we speak of fairness, we state that reducing the pandemic risk is a global public good inscribed in a complex temporality.

- Who gets healthcare resources?
- Can it be based on meritocracy, age, or function?
- Can we apply the same principles to all Covid19 and non-Covid19 patients?
- How to prioritize access to healthcare?

According to American bioethicists, referring to utilitarian principles, maximizing benefits is the most important principle, followed by the principle of care versus stewardship of resources.

Prioritization should aim at both saving the most lives and allowing empowerment of individuals post-treatment (definition of *Dalys* : to ensure future years of life with minimum handicap).

But what about the subjective perception of quality of life?

What kind of dilemmas are we confronted with, if we take the subjective dimension of quality of life seriously and not only qualys?

Dr Fishkoff underlines the dilemma of providing medical assistance below our standard of care to all patients, versus normal standards to fewer patients.

Is this a dilemma between equality versus quality of care?

How does the notion of fairness lead us to respond and resolve, or not, the dilemma? It seems to me that there is no dilemma here when the basic principle is care. We should indeed maximize care. For instance,

New York has a good public health system and has prolonged the obligation of social distancing. It should therefore not suffer too much of scarcity of medical resources leading to dilemma.

If we want to solve this dilemma in terms of rational arguments, we can address:

- Moral intuition
- Symmetry
- Incommensurability of the previous point

Dr Fishkoff tells us that the extreme shortage of dialysis machines conflicts with caring for all, which does not support a systematic account of triage. The difficulty is that the modern notion of dilemma confronts us with an impossible choice, even though to exclude the possibility of dilemma moral rules are precisely established to prescribe the choice of one action and exclude the other. This dilemma problem can thus be divided into two correlated parts:

1. The epistemological choice where it is logically difficult to determine what is my duty, when facing scarcity of ventilators for instance (either / or).
2. When both actions are necessary, but I can only do one of them, I encounter my finitude and my own vulnerability to act as an agent of choice.

So that any agent of care, or doctor here, is confronted with two sorts of conflict of obligation narratives:

1. One obligation is stronger than the other (so the conflict is not a real one).
2. The two obligations are equivalent, and I am facing an unsolvable dilemma because, in terms of fairness, there is no hierarchy between the two choices.

But during a pandemic, which is a natural and societal threat, we are facing the fact that rules can be consistent only if the context of disruptions of my narrative representations, my narrative world, can remain a consistent world as well. . .

In this disruptive moment, one realizes that rules are only useful if there are circumstances in a possible world of coherence, which is precisely what we lose in a situation of emergency, where all priorities seem to be reversed.

Choosing is the first duty in a situation when there is a clear hierarchy between the duty of care and the efficiency rule. In a state of uncertainty and urgency, the agent chooses first and foremost according to what I called her moral intuition. Facing a dilemma, she will use reason or moral rules to prioritize her decisions. These two states might be in tension with the efficiency logic of a public health ethics, where the collectivity is supposed to come before the individual interest of the singular patient. . . as if the collectivity was not constituted by individuals. Therefore, in a situation of uncertainty, I would prefer to advise the bottom up approach that combines moral intuition and rationality around the notion of quality of life. The reason is that it associates fairness as a form of loyalty to a subjective vision of quality of life or standard of living.

Indeed, the concept of fairness was developed within a framework in which tastes or values, although varying among individuals, remain constant.

We understand at this stage that the notion of fairness is hard to use in the contingencies of a pandemic. Perhaps because, during a pandemic, socially accepted values can be toppled upside down. This could explain that, in New York, egalitarian care became the priority over the rationing of care, which is the accepted cultural model in a highly competitive society based on meritocracy.

The climate of uncertainty and the sudden lockdown allowed for the surrealist scenario that all former economic priorities have been put aside from a quasi-species survival instinct.

So, what could have been a dilemma in normal settings? Economics versus Health becomes an evidence in terms of moral intuition in times of pandemics.

This fact is very reassuring about the human pragmatic capacity to develop solidarity, above the logic of distributive justice and the utility level associated with it.

In Amartya Sen's terms, "*Quality of life should come before Qualys in order to maintain capabilities and functioning*" (33). Life expectancy after the pandemic in opulent societies, in terms of future opportunities and capabilities, are precisely not invariant. They are related to the well-being and capabilities of surviving individuals. *Dalys* is a measure of the burden of diseases which combines time lived with a disability and the time lost due to premature mortality, estimated with respect to a standard age-dependent life expectancy. So, the notion of time lost because of the burden of a disease is very important to correct the abstract notion of fairness.

This leads me to have a critical gaze on a notion of fairness based on mere rationality.

Rationality and consistency

In terms of rationality, the main rule of public health ethics is that whatever rule is chosen must be applied consistently. Reasonable life expectancy does not consider the dimension of narrative or care ethics. Is it fair, can it be justified? For instance, young versus old, and the equal value of life. One of the main issues of triage is the discrimination based on age. When do we begin to count the value of life? Is a fetus more important than a teenager? The idea of withdrawing treatment in a situation of scarce resources, in order to provide a respirator to a younger person for instance, may reach consensus in times of war, but here the metaphor of war is certainly not appropriate. This pandemic emphasizes mostly a bad governing of resources and not a lack of resources in the long term. The lack of anticipation cannot justify withdrawing treatment. It would be unfair.

In a utilitarian model, scarce resources go first to efficient patients. What do we lose in such a simplistic model? Should we provide care only to those who have instrumental value? This should be a societal choice, which goes far beyond medical ethics and raises true biopolitical dilemmas of distributive justice. Do we want to survive in a society of care, or in a mere society of efficiency? We have known this situation in Africa for access to drugs during the HIV/AIDS epidemic. Drugs were so scarce that medical doctors had access priority, but then nothing was left for the patients. The efficiency model can thus lead to absurd decisions, if no good decisions can be made to resolve the dilemma.

Rationing policies and the limit of their rationality

Is a pandemic the appropriate moment to erase the plurality of judgements and stop weighing each particular case in the name of urgency? The risk of non-transparent rules of experts is to lose the confidence of the public. Real time decisions are certainly harder than applying efficiency rules. We should make room to moral intuition in entering the framework of decision that leads to adapt the rules in context. Should ethicists then help apply guidelines or assist with rationalizing decisions? I doubt it. It would mean to transfer the responsibility from the patient or his/her family to other efficiency bodies. I would suggest avoiding these real and false dilemmas to prevent the scarcity of medical resources by collaborating in solidarity with those who are still handling the matters, the medical doctors themselves.

Paradoxically, this pandemic has isolated half of humanity. It reminds us first that we are all mortals, and that is what makes us equals. Secondly, solidarity is the main ethical principle to escape from false dilemmas. What is a false dilemma? It questions rational evidence in the face of moral intuition. It is interesting to note that no regulation of triage rules has been adopted internationally, which reinforces the decision-making dimension associated with the survival and the preservation of people's abilities to survive. It could simply mean that it is a matter of isolating patients at risk of dying or losing their motor or cognitive abilities, if they are not treated, as an arbitrary priority of these rules, or at least their relativity and adaptability.

These reflections force us to redefine the fairness models introduced in this rationalizing, and to rethink a model of public health founded not only on data driven medicine, but on deep and responsible democracy.

Can we really talk about scarcity, in our societies of abundance, or is it more linked to ineffective management of priorities for the social good, or to inadequate assets management?

The question will be *why*, and many speakers in the public debate have stressed the unpreparedness of most states. It will also be necessary to ask in what healthcare model this unpreparedness has been possible, to clearly determine the responsibilities shared among the different actors. We talk in peace time about the prioritization of care, but some rulers preferred to talk about war, a term used to justify all ethical transgressions. The wording of scarcity conditions is not acceptable. It is necessary to give common reasons to all caregivers as well as to the patients and their loved ones.

The procedural decision grids exist, but they do not free the medical doctors from the difficult freedom of personal responsibility in the heat of the moment. These tools are necessarily incomplete and therefore do not exist, because a clinician will always have to use his ethical imagination to practice a coherent care, adapted to any context and to a diversity of needs in terms of gender, race, or class, having fairness as its main horizon.

Indeed, if these decision-making grids are tools that have some effectiveness in the emergency, we must not overlook the after-effect of these decisions on the doctors and nurses in the aftermath of pandemics.

Prioritization is a societal choice that makes us all co-responsible. The main issue remains prevention, which can avoid both lockdown and tracking, and foster collective intelligence instead of infantilization. Fairness is thus more than equality because it is sensible to plural forms of vulnerability, while always aiming at the recovery of capabilities for each person. Fairness is a plastic notion that implies the articulation of care and justice.

References

R McDougall, L Sheahan, D Ko. Planning for and managing COVID-19: Ethical decision-making tool. Published March 8, 2020.

<https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/news-and-events/planning-for-and-managing-covid-19-ethical-decision-making-tool> Accessed May 27, 2020 https://mspgh.unimelb.edu.au/___data/assets/pdf_file/0015/3330060/COVID-ethical-tool-McDougall-Sheahan-Ko-v3.pdf Accessed May 27, 2020

1. Social determinant of health. WHO called to return to the Declaration of Alma-Ata. https://www.who.int/social_determinants/tools/multimedia/alma_ata/en/
2. World Health Organization: Coronavirus disease (COVID-19) PANDEMIC, situation report https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200506covid-19-sitrep-107.pdf?sfvrsn=159c3dc_2. Accessed may 6 2020
3. Italian Civil Protection Department. <https://datastudio.google.com/reporting/91350339-2c97-49b5-92b8-965996530f00/page/RdlHB> Accessed may 10 2020
4. The real death toll for COVID-19 is at least 4 times the official numbers https://www.corriere.it/politica/20_marzo_26/the-real-death-toll-for-covid-19-is-at-least-4-times-the-official-numbers-b5af0edc-6eeb-11ea-925b-a0c3c3dbe1130.shtml
5. Wu Z, MCGoogan JM. Characteristics of and important lessons from the coronavirus disease 2019 (COVID-19) outbreak in China. *JAMA* 2020; 323: 1239-1242
6. Nacoti M, Ciocca A, Giupponi A, Brambillasca P, Lussana F, Pisano M et al. At the Epicenter of the Covid-19 Pandemic and Humanitarian Crises in Italy: Changing Perspectives on Preparation and Mitigation. *New England J of Medicine*. Published online March 21, 2020. DOI: 10.1056/CAT.20.0080.
7. Hillic I. *Medical Nemesis*. Milano: Boroli Editore; 2005
8. Arendt H. *Eichmann in Jerusalem. The New Yorker, Feb 16, 1963* issue

9. Derek CA. Optimizing the trade-off between learning and doing in pandemic. *JAMA*. Published online March 30, 2020. doi:10.1001/jama.2020.4984
10. Beam AI, Kohane IS. Big data and machine learning in health care. *JAMA* 2018; 319: 1317-1318
11. Arendt H. *The life of the mind*. New York: Harcourt Brace Jovanovich; 1978
12. Mill JS. and Bentham J. *Utilitarianism and other essays*. UK: Penguin; 1987.
13. Aristotle and Sachs J. *Aristotle : Nicomachean Ethics*. Newburyport, Ma: Focus Publishing; 2002.
14. Levinas E. On the Trail of the Other. *Philosophy Today* 1966;10.1: 41.
15. Bustan S. L'ambiguïté d'une éthique de la souffrance dans la pensée française contemporaine. Maurice Blanchot et la Philosophie, suivi de trois articles de Maurice Blanchot. Paris: Presses Universitaires de Paris Ouest 2009:179-198.
16. Bustan S. Suffering—a premise for the social and political thought. *Zeitschrift für kritische Sozialtheorie und Philosophie* 2016; 3(2): 379-417.
17. Bustan S. From intellectualism to Ethics – Emmanuel Levinas and the Phenomenology of Edmund Husserl/De l'intellectualisme à l'éthique – Emmanuel Levinas et la phénoménologie d'Edmund Husserl. Brussels: Ousia; 2014. 350-363, 376-406 p.
18. Levinas E. On the Trail of the Other. *Philosophy Today* 1966;10.1: 41.
19. Levinas E. and Lingis A. *Otherwise than being or beyond essence*. The Hague: Nijhoff; 1981. 77 p.
20. Mkhwanazi E. To be human is to be responsible for the Other: a critical analysis of Levinas' conception of Responsibility. *Phronimon* 2013;14.1: 133-149.
21. Levinas E. and Lingis A. *Otherwise than being or beyond essence*. The Hague: Nijhoff; 1981. 101 p.
22. Levinas E. and Lingis A.. *Totality and infinity. An essay on exteriority*. Dordrecht: Kluwer Academic Publishers; 1969. 56, 85, 89 p.
23. Levinas E. and Lingis A. *Otherwise than being or beyond essence*. The Hague: Nijhoff; 1981. 11-12 p.
24. Centers for Disease Control and Prevention. Interim guidance for healthcare facilities: Preparing for community transmission of COVID-19 in the United States. <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html> Published 2020. Accessed April 14, 2020.
25. Centers for Medicare & Medicaid Services. Recommendations on Adult Elective Surgeries, Non-Essential Medical, Surgical, and Dental Procedures During COVID-19 Response. <https://www.cms.gov/newsroom/press-releases/cms-releases-recommendations-adult-elective-surgeries-non-essential-medical-surgical-and-dental>. Published 2020. Accessed April 14, 2020.
26. Fact Sheet: Family Health Care Decisions Act & HIV/AIDS. https://www.health.ny.gov/diseases/aids/providers/regulation/fact_sheet.htm. Accessed on May 25, 2020.
27. Goldstein J, Rothfeld M, Weiser B. Patient Has Virus and Serious Cancer. Should Doctors Withhold Ventilator? <https://www.nytimes.com/2020/04/01/nyregion/coronavirus-doctors-patients.html>. April 1, 2020.
28. New York State Task Force on Life and the Law. New York State Department of Health. Ventilator Allocation Guidelines. November 2015. Accessed March 16, 2020. https://www.healthcare.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf.
29. Hick JL, Barbera JA, Kelen GD. Refining surge capacity: conventional, contingency, and crisis capacity. *Disaster Med Public Health Prep* . 2009 Jun;3(2 Suppl):S59-S67.
30. Kulish, N. A Life and Death Battle: 4 Days of Kidney Failure but No Dialysis. <https://www.nytimes.com/2020/05/01/health/coronavirus-dialysis-death.html>. May 1, 2020. Accessed May 25, 2020.
31. *New York Public Health Law 3080-3082*. Accessed May 25, 2020. <https://www.mlmic.com/wp-content/uploads/2020/04/NYS-Article-30-D-of-the-Public-Health-Law.pdf>.
32. Amartya Sen and Martha Nussbaum, *The Quality of Life* , Clarendon Oxford Press, 1993.

COVID-19

ETHICAL DILEMMAS IN HUMAN LIVES

RESPONSIBILITY | FAIRNESS | DIGNITY | HONORING DEATH

