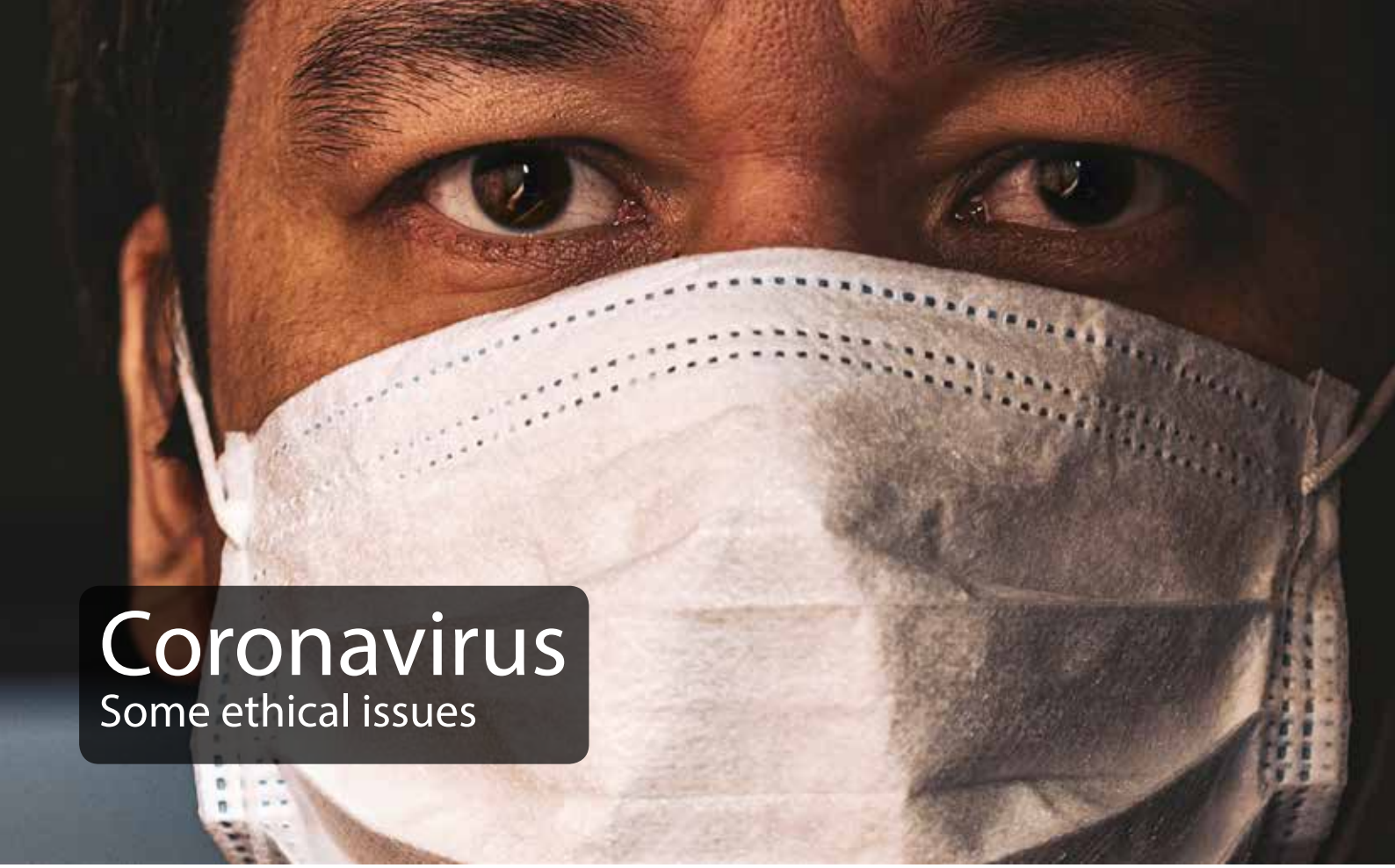

Coronavirus
Some ethical issues

Philippa Taylor

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From the restriction of fundamental liberties to the allocation and rationing of scarce medical resources, there is no shortage of incredibly difficult ethical questions facing governments and healthcare systems around the world as they respond to the spread of a new strain of coronavirus, which causes the illness Covid-19.

The pandemic raises a multitude of issues relating to care for individual patients and their families; risks for healthcare professionals; the capacity of healthcare systems to cope with the pandemic; allocation of resources; competing health and public policy decisions for government; economic fallout; restriction of civil liberties, and so on. While the main focus has been on the healthcare sector thus far, the decisions made in dealing with Covid-19 today will also have an impact beyond healthcare and our national borders and far into the future.

My focus in this article is on these ethical issues and how we are responding to them. I hope this will stimulate readers to consider the complexities in the approaches we have taken, because the values and principles driving our responses, individually and corporately, are revealing.

Best interests

The ethical obligation to put the 'best interests' of a person first and foremost would seem to be relatively straightforward. But, as with many such concepts, 'best interests' operates at the individual, institutional and societal level. So, for example, an individual doctor has a primary ethical obligation of personal care to each patient and must put that patient's 'best interests' first. However, a hospital must take into account the 'best interests' of all patients. This means they must consider the just allocation of resources along with the efficiency and effectiveness of their use.

Governments have even wider considerations to incorporate into decision making, including protection of vulnerable people, as well as civil liberty and freedom. In situations where different 'best interests' conflict, who decides and on what basis?

Do no harm

The current crisis has exposed the harsh reality facing many decision makers: there is frequently no 'no harm' option available, so the choice is 'whom to harm'. For example, two people need a ventilator but only one ventilator is available, or all the ventilators are already in use. Who should receive the one ventilator? Should another person be taken off a ventilator to make it available for the second person? Again, who should decide and on what basis?

Some countries have set an age limit on ventilator support for people with Covid-19, but this is discrimination based on age. Yet, even with treatment, elderly people have a worse prognosis for surviving infection than most younger people. Every assessment for a given treatment has to include the likely benefit of it to the patient. So great care needs to be taken that a valid consideration – such as a likely lack of medical

benefit for an elderly person as compared with a younger one – is not used as a cover for unethical discrimination based on age or disability alone. I will return to the potential for discrimination later.

Resource allocation

One of the underlying problems brought into stark relief by an influx of Covid-19 patients to hospitals is the allocation of scarce resources, which is forcing already strained health systems to confront difficult questions. Where resources are insufficient, it seems reasonable to prioritise access to intensive interventions (such as ventilators) for those who are most likely to benefit. However, the application of this principle is challenging.

Two Christian clinicians, James Haslam and Medlody Redman, state that the overarching priority when making decisions about who should receive treatment is how likely a person is to survive, and the speed of anticipated benefit. Relevant factors include:

- Severity of acute illness.
- Presence and severity of additional health problems.
- Frailty or, where clinically relevant, age.[1]

Clearly, this will help, but it does not remove entirely the need for difficult decision making within finite resourcing. So what then?

Haslam and Redman continue:

> *As Christian healthcare workers, we are called to be good stewards of our resources. However, utilitarianism – 'the greatest good for the greatest number' – often makes us deeply uncomfortable. Yet the Covid-19 crisis is an example of an extreme circumstance with an overwhelming need and limited, finite resources, where a soft utilitarian ethic may be justified … It is important to clarify here that we are only endorsing a form of 'soft' utilitarianism in these extreme circumstances – what we might consider an emergency stewardship ethic in these extraordinary times.*[2]

Changing the term from soft utilitarianism to stewardship has some validity but, nevertheless, still leaves the question of who decides in the really difficult cases and on what basis. As I show below, official guidance has already begun to differentiate between people. Haslam and Redman strongly affirm that all people have intrinsic value and significance, being made in God's image, and are all equally worthy of care. However, they explain that even though all people are equal, this does not mean they should all receive the same treatments. Equality is not the same as uniformity.

A further pressure on resource allocation is that the Covid-19 pandemic obviously does not prevent people being ill in other ways. During the pandemic there has been a decrease of 29 per cent in accident and emergency attendance[3] and an increase in overall deaths, many of which are not attributable to the virus.[4] There could be up to 18,000 excess deaths amongst patients with cancer as a direct result of the disruption.[5] If access of non-Covid-19 patients to scarce healthcare resources has been restricted or suspended, this is a serious harm.

But how do we care for those requiring other treatments if hospital resources and staff are close to exhaustion? These are difficult challenges and we need to pray for wisdom for healthcare workers.

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Discrimination

The problem of resource allocation can all too easily lead to discrimination against some people. For example, should limited life saving treatment be prioritised for people who work in essential services?

Discrimination is not an abstract concern. In April 2020 the British Medical Association (BMA) issued guidance to UK doctors suggesting that there may be circumstances where it would be justifiable to discontinue treatment in order to treat others assessed as likely to have a more favourable outcome:

> *Difficult decisions will arise where strenuous intervention could reduce mortality significantly but would mean that individual patients use resources that could lead to better outcomes for a larger number of other patients.*[6]

The BMA also proposed, controversially, the prioritising of certain groups of people according to their utility to society, such as those who work in essential services.[7]

James Hurford, a lawyer, writing in *The New Bioethics*, believes that the BMA is taking a dangerous route and a 'brutally utilitarian ethical approach' that cuts across fundamental values of English medical law. 'Sanctity of life and patient autonomy both arguably take a back seat to an approach based principally on maximising benefits to the greatest number.'[8]

The BMA's implication that it may be lawful to withdraw life-saving treatment for the purposes of providing it to others who may benefit leads Hurford to warn that, 'If this is what is meant, it represents a worrying misunderstanding of the law. It is not generally lawful to kill one person on the basis that it is necessary to preserve another's life.'[9]

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1. J Haslam & M Redman, 'When demand outstrips supply: A Christian view of the ethics of healthcare resource allocation during the COVID-19 pandemic', in *Christian Journal for Global Health*, 7.1 (2020), pp. 13–19. CMF Briefing paper http://admin.cmf.org.uk/pdf/When_demand_outstrips_supply-COVID19_briefing_paper.pdf

2. Ibid.

3. A&E Attendances and Emergency Admissions March 2020 Statistical Commentary. www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/04/Statistical-commentary-March-2020- jf8hj.pdf

4. J Appleby, 'What is happening to non-COVID deaths?', in *The British Medical Journal* (2020); 369:m1607.

5. AG Lai et al., 'Estimating excess mortality in people with cancer and multimorbidity in the COVID-19 emergency', April 2020. See www.researchgate.net

6. 'COVID-19 – ethical issues. A guidance note', British Medical Association, 1 April 2020. P5. bit.ly/2UDzos2

7. Ibid.

8. www.tandfonline.com/doi/full/10.1080/20502877.2020.1762027

9. Ibid.

Once again, we are challenged to ask: 'Who is to be the judge of this sort of necessity? By what measure is the comparative value of lives to be measured? Is it to be strength, or intellect, or what?'[10]

We need guidelines and policies listing ethically valid considerations to guide decision making regarding Covid-19, and much is good in the BMA guidance, but it is unethical, and concerning, to have a predetermined policy which would exclude people in a particular category from treatment on that criterion alone.

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The potential for discrimination is not solely a consideration for frontline health professionals. Several countries, including the UK, have considered the usefulness of 'coronavirus passports' – official certifications that a person has had the disease or has been vaccinated (if and when a vaccine is found).

Some bioethicists believe this is sound and ethical. Oxford University bioethicist Alberto Giubilini argues that since we can accept compulsory measures when the cost is very large (lockdown of whole populations), we should accept compulsory measures when the cost and infringements involved are vastly smaller (tracing apps and vaccination) and the benefits greater.[11]

However, others warn that if employers, governments and service providers require them, it will lead to a two-tier society where some people can work, play, or travel while others cannot.[12] Immunity 'passports' would be ripe for both corruption and discrimination, not forgetting concerns about privacy and data protection.[13]

The role of government

While healthcare workers consider the patients in front of them, governments must weigh the 'best interests' of whole populations, not just one subset. The harms to those who contract the Covid-19 virus are obvious, but there are also harms caused by the decision to 'lockdown' populations in the consequent disruption to both social and economic life.

Social distancing, isolation, closure of schools, prohibition of cultural practices (such as weddings, baptisms, funerals), the suspension of team sports and lockdown into homes, to name but a few disruptions, can have a significant impact on the physical and psycho-social health of those thus isolated. The costs in terms of loneliness, emotional detachment, mental illness, breakdowns, alcoholism, suicides and domestic abuse, not forgetting disrupted educations,[14] employment and physical health, will be a high price to pay if isolation continues for any length of time.

Moreover, a disproportionate burden of harm often falls on the most vulnerable. For the well-off, with well-stocked larders, fast broadband and decent pay, staying at home may be feasible. However, for poorer families and individuals, those with disabilities and the elderly, physical distancing can be harmful if they are cut off from sources of income, the support of family or friends and assistance from others in the community who may help provide food and deliver medicines. Furthermore, a long-term economic downturn will disproportionately impact the most vulnerable.[15]

So here, as with the individual doctor and patient, it may be that there is no 'no harm' option available, and the choice is who to harm.

Amongst these complexities, other more sinister ethical agendas may also be at play. Movement restrictions have been used by a powerful abortion lobby to pressure the UK government into relaxing regulations for home medical abortions, which have been introduced without any of the usual parliamentary scrutiny.

Governments must also perform a balancing act between all public health concerns and respecting human rights and civil liberties. Most have concluded that restricting our rights and freedoms will dramatically reduce the spread of Covid-19 and reduce the number of people who die after contracting the virus. However, whenever a government restricts human rights, especially so dramatically, we should expect them to do so in a way that is evidence-based, justifiable and transparent. 'Good facts are necessary for good ethics and for good law. Sometimes facts are unavoidably uncertain so we need to develop an "ethics of dealing with uncertainty"'.[16] That requires transparency and honesty from leaders, as well as constant reviews of the evidence.

Our response

How we are responding as individuals and as a country to these dilemmas is revealing. The importance of the sanctity of human life has come to the fore. The willingness for whole populations to isolate in order to protect the lives of others from harm reflects our high value of human life, especially for the vulnerable. Covid-19 is particularly harmful for the elderly and there has been outrage over the number of deaths in care homes.

The Christian concept of stewardship indicates that we should use health resources wisely and effectively (Genesis 1.28), whilst guarding against letting quality of life assessments lead to discriminatory outcomes in the context of social

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10. These are the questions put by Lord Coleridge in R v Dudley and Stephens (1884) 14 QBD 273 to justify that it is not lawful to kill one person on the basis that it is necessary to preserve another's life.

11. A Giubilini, 'Contact-tracing apps and the future COVID-19 vaccination should be compulsory', 6 May 2020. See http://blog.practicalethics.ox.ac.uk

12. H Creely, 'Covid-19 "immunity certificates": practical and ethical conundrums', April 2020, at www.statnews.com/2020/04/10/immunity-certificates-covid-19-practical-ethical-conundrums/

13. R Christopher, 'A short step from contact-tracing to mass surveillance', at www.spiked-online.com/2020/05/13/a-short-step-from-contact-tracing-to-mass-surveillance/

14. Institute for Fiscal Studies, 'Learning during the lockdown: real-time data on children's experiences during home learning', May 2020. See www.ifs.org.uk/publications/14848

15. 'UK's lowest earners bear the brunt of COVID job hit - survey', 16 May 2020, at https://uk.reuters.

16. M Sommerville, 'Thinking through the ethical challenges of Covid-19', 5 May 2020. See https://mercatornet.com/thinking-through-the-ethical-challenges-of-covid-19/62589/

and political pressures. Christians are called to demonstrate the compassion of Christ to each patient. The care and compassion shown by so many individual healthcare workers and carers, not just Christians, in this time of crisis perhaps demonstrates, as Tom Holland argues, 'that increasingly empty as the pews may be, the West remains firmly moored in its Christian past'.[17]

However, being made in God's image means that we are also relational, holistic beings. God created us to be interdependent. He created Eve with the words, 'It is not good that the man should be alone; I will make a helper suitable for him' (Genesis 2.18 NIV). We need relationships to thrive and even survive, as a recent news report tragically shows:

> *Care home residents confined to their rooms and forbidden visits from loved ones are giving up on life and 'fading away' … Residents who were giggling, happy and active before the crisis now just lie in their beds or sit alone in their rooms with their doors closed … Many now barely respond when you speak to them.*[18]

As medicine has become more able to treat and save lives, there has been a shift towards more technical care, often employing complex technology with great efficacy, while relational care and its interpersonal human interactions (far less measurable or quantifiable), has become less prioritised in practice.[19] Yet meeting the emotional, relational and spiritual needs of people has a significant impact of their health and well-being. We are an integrated psycho-physical unity.

> *One aspect that has been particularly difficult is that instead of our usual promise that 'We'll do everything we can to keep him alive until you get here,' we find ourselves telling families, 'Because of hospital policy, we cannot allow visitors at this time.' This conversation takes place … as families beg to see their loved ones before they die. A seemingly simple request, which in other times would be encouraged, has become an ethical and health care dilemma.*[20]

Isolating to 'save lives' and 'save the NHS', or socially distancing and avoiding other people, will inevitably impact negatively on who we are as relational beings. For some people, even a short time of isolation can take away their whole purpose for living. Loneliness and social isolation can both increase the risk of premature death because we need relationships and face-to-face human contact. We need human touch.

'We are not merely *homo economicus,* we are also *homo socius*.'[21] So when government and populations think about 'do no harm', or 'best interests' do they consider relational health? Because in our desire to protect lives we must not forget that our personal and social well-being, our flourishing as humans, depends as much on the quality of our relationships as on our physical health.

NOTES

17. T Holland, *Dominian: The Making of the Western Mind* (London: Littlle, Brown, 2019).

18. See www.theguardian.com/society/2020/may/14/isolated-uk-care-home-residents-fading-away-say-staff-and-families

19. S Fouch, 'Care and Compassion', Christian Medical Fellowship file 50. See www.cmf.org.uk

20. Not Dying Alone - Modern Compassionate Care in the Covid-19 Pandemic, Wakam et al, *New England Journal of Medicine*, April 2020, at www.nejm.org/doi/full/10.1056/NEJMp2007781

21. Bishop M Nazir-Ali, 'We need to start reopening our society, not just the economy', 6 May 2020, at https://michaelnazirali.com