



# COVID-19 and justice

John McMillan, *Editor in Chief*

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John Rawls begins a *Theory of Justice* with the observation that 'Justice is the first virtue of social institutions, as truth is of systems of thought... Each person possesses an inviolability founded on justice that even the welfare of society as a whole cannot override'<sup>1</sup> (p.3). The COVID-19 pandemic has resulted in lock-downs, the restriction of liberties, debate about the right to refuse medical treatment and many other changes to the everyday behaviour of persons. The justice issues it raises are diverse, profound and will demand our attention for some time. How we can respect the Rawlsian commitment to the inviolability of each person, when the welfare of societies as a whole is under threat goes to the heart of some of the difficult ethical issues we face and are discussed in this issue of the *Journal of Medical Ethics*.

The debate about ICU triage and COVID-19 is quite well developed and this journal has published several articles that explore aspects of this issue and how different places approach it.<sup>2-5</sup> Newdick *et al* add to the legal analysis of triage decisions and criticise the calls for respecting a narrow conception of a legal right to treatment and more detailed national guidelines for how triage decisions should be made.<sup>6</sup>

They consider scoring systems for clinical frailty, organ failure assessment, and raise some doubts about the fairness of their application to COVID-19 triage situations. Their argument seems to highlight instances of what is called the McNamara fallacy. US Secretary of Defense Robert McNamara used enemy body counts as a measure of military success during the Vietnam war. So, the fallacy occurs when we rely solely on considerations that appear to be quantifiable, to the neglect of vital qualitative, difficult to measure or contestable features.<sup>6</sup> Newdick *et al* point to variation in assessment, subtlety in condition and other factors as reasons why it is misleading to present scoring systems as 'objective' tests for triage. In doing so they draw a distinction between procedural and outcome consistency, which is important, and hints at distinctions Rawls drew between the different forms of procedural fairness. While we might hope to come up with a triage protocol that is procedurally fair and

arrives at a fair outcome (what Rawls calls perfect procedural justice, p. 85) there is little prospect of that. As they observe, reasonable people can disagree about the outcomes we should aim for in allocating health resources and ICU triage for COVID-19 is no exception. Instead, we should work toward a transparent and fair process, what Rawls would describe as imperfect procedural justice (p. 85). His example of this is a criminal trial where we adopt processes that we have reason to believe are our best chance of determining guilt, but which do not guarantee the truth of a verdict, and this is a reason why they must be transparent and consistent (p. 85). Their proposal is to triage patients into three broad categories: high, medium and low priority, with the thought that a range of considerations could feed into that evaluation by an appropriately constituted clinical group.

Ballantyne *et al* question another issue that is central to the debate about COVID-19 triage.<sup>4</sup> They describe how utility measures such as QALYs, lives saved seem to be in tension with equity. Their central point is that ICU for COVID-19 can be futile, and that is a reason for questioning how much weight should be given to equality of access to ICU for COVID-19. They claim that there is little point admitting someone to ICU when ICU is not in their best interests. Instead, the scope of equity should encompass preventing 'remediable differences among social, economic demographic or geographic groups' and for COVID-19 that means looking beyond access to ICU. Their central argument can be summarised as follows.

1. Maximising utility can entrench existing health inequalities.
2. The majority of those ventilated for COVID-19 in ICU will die.
3. Admitting frailer or comorbid patients to ICU is likely to do more harm than good to these groups.
4. Therefore, better access to ICU is unlikely to promote health equity for these groups.
5. Equity for those with health inequalities related to COVID-19 should be broadened to include all the services a system might provide.

Brown *et al* argue in favour of COVID-19 immunity passports and the

following summarises one of the key arguments in their article.<sup>7</sup>

1. COVID-19 immunity passports are a way of demonstrating low personal and social risk.
2. Those who are at low personal risk and low social risk from COVID-19 should be permitted more freedoms.
3. Permitting those with immunity passports greater freedoms discriminates against those who do not have passports.
4. Low personal and social risk and preserving health system capacity are relevant reasons to discriminate between those who have immunity and those who do not.

Brown *et al* then consider a number of potential problems with immunity passports, many of which are justice issues. Resentment by those who do not hold an immunity passport along with a loss of social cohesion, which is vital for responding to COVID-19, are possible downsides. There is also the potential to advantage those who are immune, economically, and it could perpetuate existing inequalities. A significant objection, which is a problem for the justice of many policies, is free riding. Some might create fraudulent immunity passports and it might even incentivise intentional exposure to the virus. Brown *et al* suggest that disincentives and punishment are potential solutions and they are in good company as the Rawlsian solution to free riding is for 'law and government to correct the necessary corrections.' (p. 268)

Elves and Herring focus on a set of ethical principles intended to guide those making policy and individual level decisions about adult social care delivery impacted by the pandemic.<sup>8</sup> They criticize the British government's framework for being silent about what to do in the face of conflict between principles. They suggest the dominant values in the framework are based on autonomy and individualism and argue that there are good reasons for not making autonomy paramount in policy about COVID-19. These include that information about COVID-19 is incomplete, so no one can be that informed on decisions about their health. The second is one that highlights the importance of viewing our present ethical challenges via the lens of justice or other ethical concepts such as community or solidarity that enable us to

frame collective obligations and interests. They observe that COVID-19 has demonstrated how health and how we live our lives are linked: that what an individual does can have profound impact on the health of many others.

Their view is that appeals to self-determination ring hollow for COVID-19 and their proposed remedy is one that pushes us to reflect on what the liberal commitment to the inviolability of each person means. They explain Dworkin's account of 'associative obligations' which occur within a group when they acknowledge special rights and responsibilities to each other. These obligations are a way of giving weight to community considerations, without collapsing into full-blown utilitarianism and while still respecting the inviolability of persons.

The COVID-19 pandemic is pushing ethical deliberation in new directions and many of them turn on approaching medical ethics with a greater emphasis on justice and related ethical concepts.

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