



# Ethics in a time of coronavirus

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doi:10.1136/medethics-2020-106282

By the time this issue of the Journal is published, the world will have moved on. More will be known, than at the time of writing this, about how medicine and societies are responding to the ethical challenges presented by the COVID-19 coronavirus pandemic. In his guest editorial, (first published online on first April 2020), Dominic Wilkinson writes (see pp 287–288) from the perspective of a UK clinician and ethicist facing the then still impending likelihood that ‘the number of critically ill patients will overwhelm the capacity of intensive care units’ and that ‘it will simply not be possible to provide mechanical ventilation to every patient who might need it’. The ‘unpalatable question’ for clinicians then will be ‘which patient to save’?

In his response to this question, Wilkinson identifies benefit and fairness as the key ethical values at stake in such triage decisions: ‘how much ethical weight is given to each of these values’, he argues, will depend not only on the need to find a fair balance between them, but also on the availability of resources. ‘As resources become more limited’, he writes, ‘there is some need to temper equality with benefit’. In the limited provision of publicly funded intensive care, there already exists ‘a need to decline admission to intensive care for some patients who have a low probability of survival, or of benefiting from the treatment’: but ‘in a situation where resources are overwhelmed, and choice cannot be avoided’, he argues, the ethical balance must shift to emphasizing benefit, which in practice means prioritising ‘those patients who have the highest chance of surviving’, or ‘a shorter duration of intensive care stay’.

Wilkinson does not pretend that this will be easy to put into practice. ‘With a novel illness and limited experience’, he observes, ‘it is difficult to know which patients fall into better or worse prognostic groups’; and this may be particularly difficult in the lead-up stage before ‘the surge’, when ‘pre-emptive selection may deny some patients intensive care who could have been saved’. Later, ‘when the crunch comes’, these may include ‘patients already admitted to intensive care’, a no less difficult decision, nevertheless, Wilkinson argues, one that can be defended by the well-established argument

that there is ‘no ethically significant difference between decisions to withhold or withdraw treatments (if other factors are equal)’, and if it is made ‘explicit on admission to intensive care that treatment is provided as a time-limited trial’.

Apart from Wilkinson’s editorial, the papers in this issue reflect ethical concerns from what may come to be thought of as the pre-coronavirus era. As Wilkinson’s use of the well-established argument about withholding and withdrawing treatments illustrates, this does not mean that arguments not apparently related to the immediate ethical concerns raised by the pandemic have no part to play in the coronavirus and post-coronavirus eras. Just as clinicians on the front line depend for their work on an armamentarium developed patiently and painstakingly in the laboratory, so may the ethical tensions highlighted and the ethical equilibrium achieved by philosophers, social scientists, theologians and lawyers, assist clinicians in their communication with patients, families, the public and one another, providing a degree of ethical comfort as well as ethical challenge.

Diverse aspects of this ethical enterprise are evidenced in this month’s issue. In our Editor’s Choice, for example, Shane Morrison and colleagues (see pp 295–299) contribute to the growing literature on transgender ethics, and specifically on ‘how to proceed if a minor and their parents have disagreements concerning their gender-affirming medical care’. Examining the clinical and ethical ‘literature surrounding the risks and benefits of gender-affirming therapy in transgender children and the existing legal basis for recognizing minors’ decision-making authority’, they conclude that ‘the capacity of the transgender minor should be strongly advocated for [by clinicians] in a manner consistent with a provider’s general treatment of adolescents in any other medical decision-making settings such as STI services and contraception.’

Children also are the focus of Daniel J Hurst and colleagues’ paper on ‘Paediatric xenotransplantation clinical trials and the right to withdraw’ (see pp 312–316). For some time now, concerns about the ‘risk of new zoonotic infection to both the immunocompromised transplant recipient and possibly the public’ have ‘led

to the current ethical consensus... that XTs recipients must consent to lifelong monitoring’. This ‘presents challenges to the right to withdraw in the adult population’: but in paediatric clinical trials it raises additional ethical questions about parental consent to ‘a decision whose consequences will remain present as the child develops the capacity for assent, and finally the capacity for informed consent and refusal’. Envisaging that such clinical trials ‘may begin early in the next decade at our institution’, the authors argue that public health ethics makes it ‘justifiable to require XTs patients - both paediatric and adult - to comply with post-transplant monitoring.’ Nevertheless, they conclude, ‘the ethical tension remains over whether the abrogation of the right to withdraw from these monitoring requirements is justifiable in the paediatric population’. The authors add mention of the possibility that ‘the frequency and type of monitoring required for xenograft recipients in a clinical trial may change based on further evidence of the risk posed by XTs to public health’. Since the risk here is that of a ‘new zoonotic infection’, it remains to be seen how what is learnt from and about COVID-19 may reframe this ethical debate.

Medical research in more general terms is the context of Angela Ballantyne’s paper on ‘How should we think about clinical data ownership?’ (See pp 289–294). Much has been written in recent years about who owns clinical data and the implications of this for the permissibility and possible profit of its management in research, clinical care and service provision. When it is assumed that ‘ownership’ implies ‘private property’, Ballantyne observes, concerns about the ‘the disenfranchisement of citizens and collectives’ may lead too rapidly to the conclusion that ‘the data belongs to the patient’. A more careful examination of this ‘complex and fragmented’ area, suggests rather that ‘private property is only one type of relevant relationship between people, communities and data’, and that because ‘clinical data are co-constructed... a property account would fail to confer exclusive rights to the patient’. Ballantyne argues instead for ‘a broader relationship account of ownership – rather than the data belonging to the patient, the data are about the patient’; and since ‘the

data are equally about families, communities, diseases and health systems', more 'flexible models "to reconnect" patients and communities with their clinical data' now need to be developed.

Other no less relevant ethical debates addressed in this issue include: Ben Davies' innovative discussion of whether 'the fact that a patient has an obligation to know' necessarily implies that 'she does not also have a right not to know', together with commentaries on this by Benjamin Berkman, Lisa Dive and Aisha Deslandes (see pp 304–311); Ben Colburn's argument that legalizing assisted dying may 'appeal to the autonomy of people who don't want to die' as well as those who do (see pp 317–320); Susan Kennedy's essay on 'ectogeneis and the role of gestational

motherhood', which proposes 'a reframing of procreation and parenthood from a feminist perspective that recognizes gestational motherhood as involving robust moral obligations that ought to be voluntarily undertaken' (see pp 321–328); and Arianne Shahvisi's 'Towards responsible ejaculations' (see pp 329–337), setting out significant reasons why 'men should take primary responsibility for protecting against pregnancy'. The issue also includes three responses to papers previously published in the Journal and a brief report on a case in the German Federal Court concerning 'potentially unlawful clinically assisted nutrition and hydration at the end of life'.

In forthcoming issues of the Journal we expect to publish more papers directly

related to the COVID-19 coronavirus pandemic, appearing also Online First. Because there is an unavoidable delay for papers appearing online, we encourage authors of COVID-19 papers also to submit a blog to <http://blogs.bmj.com/medical-ethics/> when they submit a paper on this topic; and we encourage readers to explore the growing number of helpful contributions to be found there.

**Funding** The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

**Competing interests** None declared.

**Patient consent for publication** Not required.

**Provenance and peer review** Not commissioned; internally peer reviewed.

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