Relational ethical approaches to the COVID-19 pandemic

David Ian Jeffrey

Correspondence to
Dr David Ian Jeffrey, Edinburgh Palliative and Supportive Care Group, University of Edinburgh Western General Hospital, Edinburgh EH4 2XU, UK; dijeffrey@btinternet.com

ABSTRACT

Key ethical challenges for healthcare workers arising from the COVID-19 pandemic are identified: isolation and social distancing, duty of care and fair access to treatment. The paper argues for a relational approach to ethics which includes solidarity, relational autonomy, duty, equity, trust and reciprocity as core values. The needs of the poor and socially disadvantaged are highlighted. Relational autonomy and solidarity are explored in relation to isolation and social distancing. Reciprocity is discussed with reference to healthcare workers' duty of care and its limits. Priority setting and access to treatment raise ethical issues of utility and equity. Difficult ethical dilemmas around triage, do not resuscitate decisions, and withholding and withdrawing treatment are discussed in the light of recently published guidelines. The paper concludes with the hope for a wider discussion of relational ethics and a glimpse of a future after the pandemic has subsided.

INTRODUCTION

The coronavirus, or COVID-19, outbreak was declared a pandemic by the WHO on 11 March 2020.[1] The COVID-19 pandemic presents ethical challenges for patients, their families, healthcare workers, policy-makers and the public. This paper identifies key ethical concerns for healthcare workers and explores ways of responding ethically. The ethical dilemmas are interrogated in three areas:

1. The ethics of isolation and social distancing.
2. Healthcare workers' duty of care to patients.
3. Access to treatment when resources are limited.

This paper explores the ethical dimensions of the COVID-19 pandemic as it affects the National Health Service (NHS) in the UK. The pandemic presents the NHS with unprecedented challenges which generate great uncertainty. Responding to a public health crisis of this nature demands a broader ethical perspective than the four principle approach (autonomy, beneficence, non-maleficence and justice) of traditional medical ethics.[2] Clinical and research ethics has traditionally focused on the individual whereas public health ethics addresses the interests of a population.[3] This shift in ethical focus is one which most healthcare workers struggle with. Clinicians and nurses are trained to adopt a duty-based (Kantian), ethical approach which stipulates that the care of the individual patient is their prime concern. When health risks primarily affect an individual, respect for autonomy has a high value. However, when a population is at risk, collective interests assume the greatest relevance.[4] I suggest that harsh utilitarian values may be softened by adopting relational ethical values: solidarity, duty, equity, relational autonomy, trust and reciprocity. In this evolving ethical debate, it is essential that all parts of society are considered, particularly the socially or economically disadvantaged, in order to achieve the best possible outcome and to minimise harm.[5] The paper concludes by looking to a future when the pandemic has passed.

THE ETHICS OF ISOLATION AND SOCIAL DISTANCING

The rationale for isolation and social distancing is to minimise mortality and morbidity but also to reduce the burden on an overstretched NHS. Isolation separates those who have a contagious disease from the unaffected, quarantine separates those exposed to a contagious disease to see if they become ill.[6] Quarantine, isolation and social distancing impose limits on an individual's freedom and autonomy and is justified by the principle of utility, one acts to maximise aggregate welfare.[5] There is an ethical need to balance the welfare of society and the rights of the individual when implementing these. For quarantine to be ethically justifiable, there must clear evidence of person-to person spread of potentially serious disease. The restrictions imposed on people must be proportionate to the harms.[6] The principle of reciprocity is relevant, where individual rights are limited, the government has duties to limit any consequent burdens on individuals and communities.[6] Human rights principles provide a framework for evaluating the ethical acceptability of public health measures that limit individual freedom.[5] Principles of distributive justice, or equity, require that public health measures do not place unfair burdens on particular segments of the population. Specific attention should be given to groups that are the most vulnerable to discrimination, stigmatisation or isolation, including racial and ethnic minorities, elderly people, prisoners, disabled persons, migrants and the homeless.[4,5]

Social-distancing measures should as far as possible take account of adverse social, economic, psychological and health effects for individuals.[5] Employment protection should be provided for workers who comply with social-distancing measures against the wishes of their employers.[5] Travel restrictions and border controls should be in line with WHO recommendations and be flexible to accord with international recommendations[5] The isolation of symptomatic individuals should be voluntary if at all possible, mandatory measures should only be instituted as a last resort when voluntary measures are seen to be inadequate for the health of the community.[5]

If the public lack trust in the authorities, then they are unlikely to act on the suggested measures to prevent spread of the pandemic with a consequent increase in mortality.[7] A continuing dialogue is needed between health professionals, government and society to maintain trust and solidarity.

Relational autonomy

We are all dependent on others, the interests of the individual and community are inevitably inter-related. Autonomy should revert to its original form, a relational concept which takes account of the effects of exercising one's autonomy on the autonomy of others.[8 9] Relational autonomy involves a change from the individual self to one embedded in a social context.[9] This contrasts with the prevailing Western view which stresses independence in autonomy and so risks fostering a selfish view of autonomy.[8]

Solidarity

To achieve social distancing and voluntary self-isolation of large numbers of affected or vulnerable people requires the ethical concept of solidarity. Solidarity is the agreement between and support for members of a group.[10] The ethical principle of solidarity exists where individuals are firmly united by common responsibilities and interests, and undivided in opinion, purpose and action.[5] Solidarity among members of society is central to limiting damage from the pandemic. Solidarity also comprises virtues such as altruism, kindness, generosity and empathy, extending to include the concept of fellowship.[7 11 12] Solidarity is at its heart another relational construct and reflects a shared interest in survival and safety.[4] One test of our solidarity is to examine how we look after the most vulnerable in our population, since the greatest burdens of the pandemic will fall on such disadvantaged groups.[13] Membership of a disadvantaged social group, for example, the homeless, interferes with people's ability and opportunity to exercise their autonomy.[4] Solidarity is linked with social justice and is concerned with fair access to social goods such as self-respect.[4]

HEALTHCARE WORKERS' DUTY OF CARE TO PATIENTS

Healthcare workers' obligations to care for patients are embedded in the principle of beneficence.

Moral obligations: a Kantian view

Moral obligations are derived from society's understanding of right and wrong behaviour and appeal to universally held values.[5] There is a strong argument for recognising a moral obligation to provide care during a pandemic especially for intensive care staff and others with critical specialised skills. However, the moral obligation to work is not unlimited; factors such as the risks to the worker and their family, competing family caregiving responsibilities and duties of care to other patients must be taken into account.[5] It is difficult to establish clear rules about the scope of healthcare professionals' moral obligations and therefore caution is needed in translating such obligations into legally enforceable duties.[5]

Professional obligations: a duty of care

Professional obligations are based on a particular profession's own understanding of how members of that profession should behave and are set out in guidelines or codes of ethics.[14] Doctors and nurses have a fundamental duty of care and cannot, with integrity, refuse to care for patients with COVID-19 out of fear of contracting the disease.[7] This duty is expressed in professional ethical codes, sometimes only in vague terms.[14 15] There is a need for specific guidance from professional regulatory bodies on the duty of care and its limits.[15 16] Professional bodies and employers need to consider the risks of assigning healthcare professionals to functions not normally within their responsibilities, assigning non-professionals to perform tasks that are normally performed by professionals, or assigning professionals to work in areas for which they are not licensed or trained.[5 16]

Doctors, some of whom are working in new and unfamiliar areas, at times beyond their competence level, are concerned that their actions may result in criminal or professional liability.[16] To clarify these concerns, the BMA and GMC have issued guidance. The GMC state, "Whenever a concern is raised with us, we always consider it on the specific facts of the case, taking into account the factors relevant to the environment in which the doctor is working".[17] While this might provide some reassurance, it takes little account of the enormous stress suffered doctors who later have to undergo a GMC investigation into their actions.

Although the focus is on professionals, a duty of care extends to all health workers, since without the support of non-professional workers the NHS would cease to function.[7] In one study, all healthcare workers, regardless of professional standing, felt that they had a duty to work despite personal risk.[18]

The duty of care is linked to the ethics of solidarity between those working within the NHS and solidarity between them and members of society. Some doctors have died in the course of treating patients with COVID-19, so it seems that the duty to care is not dependent on the extent of risk, even if at first glance it seems highly relevant to the extent of the ethical duty.[7] It is essential that risks are mitigated as far as possible by personal protection equipment (PPE). While healthcare workers are willing to take necessary risks, they are not willing to take unnecessary ones.[18] Healthcare workers are assumed to adopt a view that their duty to care overrides self-preservation and there is little debate about any limits to this duty of care.[7]

Social obligations: solidarity and reciprocity

Solidarity between health professionals and society is a key ethical value in minimising mortality and morbidity in a pandemic.[7] Society grants professionals privileges and respect and in a reciprocal way expects them to care for infectious patients. In the current pandemic in the UK, there have been numerous expressions of appreciation of healthcare workers by members of the community, for example, national spontaneous handclapping, banners and congratulatory graffiti. This solidarity is enhanced by 20 000 retired health workers returning to work in the NHS and by half a million people volunteering to help.[19 20] Politically, solidarity is endorsed by the authorities appealing to a mood of 'we are all in this together'. As Brody and Avery point out, organisations as well as individuals may be virtuous.[7] Working within such a virtuous organisation may enhance solidarity with a wider group of workers assuming a duty of care, rather than depending on the efforts of a small group of heroes.[7] Support of workers is essential to solidarity, even small acts of kindness may have beneficial effects.[11]

Reciprocity

Reciprocal moral obligations exist on the part of governments and employers to protect and support those healthcare professionals working during the pandemic.[5] Healthcare workers should not be expected to expose themselves to unnecessary risk where employers have not provided appropriate PPE.[16] Governments and employers should ensure that adequate infection control systems are in place, provide preventive measures, for example, PPE to healthcare workers and access to psychosocial

treatment and support. Doctors and nurses should be encouraged to seek psychological support, since they traditionally are often reluctant to seek help.[21]

To avoid the further spread of infection, workers have an ethical obligation not only to use the protective measures that are offered to them, but also to report if they become infected and to accept temporary exclusion from work until they are no longer infectious.[5] Additionally, healthcare professionals should be considered a high priority for immunisation when this becomes available since they are critical to a successful pandemic response.[5]

ACCESS TO TREATMENT WHEN RESOURCES ARE LIMITED: UTILITY AND EQUITY

Priority setting and rationing of scarce resources are not new problems facing the NHS, although the degree of transparency surrounding the approach used to ration care varies.[22] From a utilitarian perspective, the ethical goal is to save as many lives as possible but this utility principle must be aligned with equity; the distribution of resources should be fair. Fairness through impartiality means that where life and health are involved, every individual is of equal value. Every individual, irrespective of age, wealth, gender, status, religion, political opinions or merits has the same dignity, the same moral value and, therefore, the right to equal treatment in case of illness.[23] Nobody should receive privileged medical treatment at the expense of other affected individuals on the basis of their ability to pay, their standing, their social position or their age.[23]

Conversely, with regard to age, some have put forward a 'Fair innings argument'. This reflects the idea that everyone is entitled to some 'normal' span of life years and so the young have stronger claims to lifesaving interventions than older persons because they have had fewer opportunities to experience life.[5] The false implication arising from this argument is that saving 1 year of life for a young person is valued more than saving 1 year of life for an older person. Triage decisions on access to treatment must never be solely based on age.[16]

Where ethical principles conflict, there should be open discussion with members of society to ensure that decision processes involved in rationing resources are transparent. If there is a shortage of resources for the treatment of pandemic COVID-19, every effort must be made to make more resources available.[23] However, if the resources required to properly treat all patients are not available, then a wholly 'fair' decision and distribution may not be possible and in this case the least unfair solution must be sought.[23] That process should be based on the following objectives: containing the infection and saving the maximum number of patients who are in a life-threatening condition. Those who are suffering from COVID-19 and other patients who require intensive care should be assessed according to the same criteria.[23] Infection with COVID-19 should not guarantee priority over other illnesses requiring intensive care.[16]

Unequal rules can only be justified if they lead to more effective containment of the infection or to the saving of a relatively large number of human lives, for example, giving healthcare workers some priority for vaccination (when this becomes available). In this context, the utilitarian argument is that the pandemic is an exceptional situation which permits the pursuit of the greatest common benefit.[23] Other groups who might have a claim for priority for vaccines include people known to be central to spreading infection or 'super-spreaders' and people at increased risk of death if infected.[5] Such policies that favour certain categories of people may be perceived as unfair and undermine public trust in the NHS.

If there are insufficient resources, then those who will suffer the least as a result of exclusion should be excluded.[23] At the same time, additional resources should, as much as possible, be mobilised to maximise availability. Rationing must be based on ethical criteria which should be reviewed in relation to the progress of the pandemic.[23] Ethical criteria include four key elements[23]:

► Transparency: the measures are explained and well justified.
► Health benefit: the measures are evidence based.
► Efficiency: the measures should reach the greatest possible number of individuals.
► Adaptability: review and modify previous measures in the light of new findings.

An example for the allocation of scarce resources is the Swiss Influenza Pandemic Plan[23]:

1. The first phase, everyone who needs treatment will receive it until the number requiring treatment exceeds the capacity of the treatment facilities.

2. The second phase, when it is no longer possible to treat everyone because therapeutic capacity is exhausted, scarce therapeutic resources will be reserved for those whose conditions are most life threatening.

3. The third phase corresponds to the triage used in war or disaster situations. Scarce resources should be reserved for patients with life-threatening conditions. When all those with life-threatening conditions can no longer be treated actively, priority will be given to those who are expected to have the best chance of survival as a result of treatment. Active treatment in this phase will be withheld only from those who are unlikely to benefit from it. It is important to ensure that people with disabilities and the vulnerable have an equal opportunity to benefit from treatment. Triage decision-makers should not be influenced by subjective determinations of long-term survival which may be influenced by biased personal values or quality-of-life opinions.[24] Individuals with a poor prognosis who would not benefit from intensive care will be given palliative care.[23] The details of the criteria for triage must be transparent and open to revision.[25]

Triage however is a complex area and results in tragic choices, stressful for staff and particularly for patients. Some have argued that a first come first served approach may be hard to escape.[26] However, such an approach would discriminate against the socially disadvantaged who have less access to care.[26] Triage decisions should be discussed and agreed and the criteria adopted discussed with the public in an open honest way. The alternative is that the public may come to distrust the NHS.[26]

It should be remembered that there is no ethically significant difference between decisions to withhold life-sustaining treatment or to withdraw it.[16] Doctors however may feel that there is a psychological difficulty in withdrawing treatment and may find it easier to suggest a time-limited trial of treatment.

The public have unrealistic ideas, derived from TV soaps, that cardiopulmonary resuscitation (CPR) is usually successful.[27] However, if patients have such comorbidities or frailty that they would not be admitted to an intensive care unit, then CPR should not be attempted in the event of their collapse.[16] Attempting CPR for patients when postresuscitation intensive care is not available causes harm to the patient, wastes resources and puts the team at risk.[16] CPR decisions should be part of advance care planning discussions and explanations with patients and their families.

The conversations around these decisions are often incredibly difficult since individual situations often do not fit easily in

distinct criteria. Health workers need psychological support and time to reflect and to discuss their dilemmas with colleagues.

CONCLUSION
Looking to an uncertain future
In the UK, the government and public health experts have held daily broadcasts to the public to explain the current issues and the measures adopted to limit the spread of COVID-19. They have demonstrated that they are adaptable in changing policies as the evidence emerges, for example, abandoning a proposed herd immunity strategy early in the trajectory of the pandemic.[28] However, there has been concern at the lack of testing for COVID-19 and the lack of provision of PPE.[29 30]

A global ethical response requires attention to the needs of all populations, regardless of their legal status in a country. International monitoring by organisations such as WHO should ensure access to healthcare for refugees, asylum seekers, migrants and travellers.[5] The poor and socially disadvantaged will bear the brunt of the tough public health measures which have been introduced to contain the spread of the virus.[31] The government and public health officials have taken care to stress that they wish to help people rather than punish them.[32] The COVID-19 pandemic is a global disaster which has exposed social realities in our communities.[31] Brody and Avery claim that our response to pandemics prompt us to question, 'What sort of society do we want to live in?'.[7]

I have argued that a relational approach to ethics, which emphasises solidarity, connectedness, transparency and trust, offers the best guide as to how to respond in a moral way to the crisis.[33] There is a possibility of deriving a more relational approach to ethics, which acknowledges our interconnection, vulnerability and shared humanity. Autonomy can become to be viewed as an ethical construct with responsibilities to other members of society rather than a manifestation of selfishness. The pandemic has demonstrated the power of shared emotion in a public solidarity which has enabled the measures to slow the spread of disease and in some ways enriched our lives.

I hope that this paper stimulates discussion and reflection on the ethical issues involved in coping with the COVID-19 pandemic. Ethical frameworks to guide decision-making in a pandemic are published.[34] The most recent from the BMA identifies factors such as equity, maximise benefit, working together, reciprocity, proportionately, flexibility and open decision-making.[16] Ethical frameworks that help to build trust, solidarity and guide decision-making will continue to evolve.[3]

Among the losses caused by COVID-19, there are some gains, hopes of a better future in the aftermath of the pandemic. Disasters can reveal reserves of human solidarity and kindness in the midst of loss and pain.[35] People have found ways to connect and help each other; air pollution has plummeted. Perhaps responding to the pandemic has shown us how we might in the future respond to the even greater threat of climate change.[31]

REFERENCES
1 World Health Organisation. Who announces COVID-19 outbreak a pandemic, 2020. Available: http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/news/news/2020/3/who-announces-covid-19-outbreak-a-pandemic
2 Beauchamp T, Childress J. *Principles of biomedical ethics*. New York: Oxford University Press, 2013.
3 Thompson AK, Faith K, Gibson JL, *et al*. Pandemic influenza preparedness: an ethical framework to guide decision-making. *BMC Med Ethics* 2006;7(1):12.
4 Baylis F, Kenny NP, Sherwin S. A relational account of public health ethics. *Public Health Ethics* 2008;1(3):196–209.
5 World Health Organisation. *Ethical considerations in developing a public health response to pandemic influenza*. Geneva: World Health Organization, 2007.
6 Shearer J. Coronavirus and the ethics of quarantine-why information matters. *British Medical Journal* 2020 https://blogs-bmj-com.ezproxy.is.ed.ac.uk/bmj/2020/02/17/coronavirus-and-the-ethics-of-quarantine-why-information-matters/
7 Brody H, Avery EN. Medicine's duty to treat pandemic illness: solidarity and vulnerability. *Hastings Cent Rep* 2009;39(1):40–8.
8 Dworkin G. *The Conceot of autonomy*. Cambridge: Cambridge University Press, 1988.
9 Mackenzie C, Stoljar N. *Relational autonomy*. Oxford: Oxford University Press, 2001.
10 Cambridge English dictionary. Available: https://dictionary.cambridge.org/dictionary/english/solidarity
11 Jeffrey D. A duty of kindness. *J R Soc Med* 2016;109(7):261–3.
12 Jeffrey D. Empathy, sympathy and compassion in healthcare: is there a problem? is there a difference? does it matter? *J R Soc Med* 2016;109(12):446–52.
13 Rawls J. *A theory of justice*. Harvard university press, 2009.
14 General Medical Council. *Good medical practice*. London: General Medical Council, 2013.
15 Ruderman C, Tracy CS, Bensimon CM, *et al*. On pandemics and the duty to care: whose duty? who cares? *BMC Med Ethics* 2006;7(1):5.
16 British Medical Association. COVID-19 ethical issues. A guidance note, 2020. Available: https://www.bma.org.uk/media/2226/bma-covid-19-ethics-guidance.pdf
17 General Medical Council, 2020. Available: https://www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus
18 Damery S, Draper H, Wilson S, *et al*. Healthcare workers' perceptions of the duty to work during an influenza pandemic. *J Med Ethics* 2010;36(1):12–18.
19 The Guardian. More than 500,000 people sign up to be NHS volunteers, 2020. Available: https://www.theguardian.com/world/2020/mar/25/astonishing-170000-people-sign-up-to-be-nhs-volunteers-in-15-hours-coronavirus
20 The Independent. Coronavirus: 20,000 retired NHS staffhave returned to fight COVID-19, Johnson says, 2020. Available: https://www.independent.co.uk/news/uk/politics/coronavirus-latest-retired-nhs-workers-staff-return-boris-johnson-a9433001.html
21 Jeffrey D. *Medical Mentoring: Supporting Students,Doctors in Training and General Practitioners*. London: Royal College of General Practitioners, 2014.
22 Nuffield Trust. Rationing in the NHS London, 2015. Available: https://www.nuffieldtrust.org.uk/files/2017-01/rationing-in-the-nhs-web-final.pdf
23 Federal Office of Public Health. The Swiss influenza pandemic plan, 2018. Available: https://www.bag.admin.ch/bag/en/home/das-bag/publikationen/broschueren/publikationen-uebertragbare-krankheiten/pandemieplan-2018.html
24 Ne'eman A. When it comes to rationing disability rights law prohibits more than prejudice, 2020. Available: https://www.thehastingscenter.org/when-it-comes-to-rationing-disability-rights-law-prohibits-more-than-prejudice/
25 Christian MD, Hawryluck L, Wax RS, *et al*. Development of a triage protocol for critical care during an influenza pandemic. *Can Med Assoc J* 2006;175(11):1377–81.
26 Pagel C, Utley MRS. Bmj opinion: British medical Journal, 2029. Available: https://blogs.bmj.com/bmj/2020/03/09/covid-19-triage-in-a-pandemic-is-even-thornier-than-you-might-think/
27 Huntington G. Cpr rarely works-Why do peopler have so much faith in it? the guardian, 2020. Available: https://www.theguardian.com/healthcare-network/views-from-the-nhs-frontline/2018/jun/04/cpr-misconception-death-doctors
28 Boseley S. New datanew policy:why UK coronavirus strategy changed The Guardian, 2020. Available: https://www.theguardian.com/world/2020/mar/16/new-data-new-policy-why-uks-coronavirus-strategy-has-changed
29 BBC News. Coronavirus:NHS staff at risk over lack of protective gear, 2020. Available: https://www.bbc.co.uk/news/uk-51950276
30 BBC News. Coronavirus:Health experts frustratedby low UK virus testing, 2020. Available: https://www.bbc.co.uk/news/uk-52130230
31 Baker P. We can't go back to normal; how will the coronavrus change the world? 2020. Available: https://www.theguardian.com/world/2020/mar/31/how-will-the-world-emerge-from-the-coronavirus-crisis [Accessed updated 31st 2020].
32 American Civil Liberties Union. Pandemic preparedness: the need for a public health-not law enforcement/national security approach, 2008. Available: https://www.aclu.org/report/pandemic-preparedness-need-public-health-not-law-enforcementnational-security-approach?redirect=cpredirect/33642
33 Jeffrey D. Communicating with a human voice: developing a relational model of empathy. *J R Coll Physicians Edinb* 2017;47(3).
34 UK Government. Pandemic flu, 2020. Available: https://www.gov.uk/guidance/pandemic-flu#ethical-framework
35 Solnit R. *A paradise built in hell*. London: Penguin, 2010.