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Heather Browning & Walter Veit

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Utilitarian Lessons from the COVID-19 Pandemic for Non-Pandemic Diseases

Heather Browning[a] and Walter Veit[a,b]

[a]London School of Economics and Political Science; [b]University of Sydney

The COVID-19 pandemic has created a unique set of challenges for national governments regarding how to deal with a major international pandemic of almost unprecedented scope. As the pandemic constitutes not only a medical challenge, but a moral one, it is thus not surprising that the topic has received much attention within bioethics. While the initial focus was on how to address these novel challenges, we have now reached a stage where bioethicists are reflecting on the lessons we have learnt and can learn from the COVID-19 pandemic for public policy, medical practice, and medical research.

In the current issue of the American Journal of Bioethics, Lynch et al. (2021) offer an excellent

CONTACT Walter Veit wrwveit@gmail.com School of History and Philosophy of Science, University of Sydney, Room 389 Carslaw F07, Sydney, 2006 Australia; The London School of Economics and Political Science, Centre for Philosophy of Natural and Social Science, London, WC2A 2AE, UK

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exegesis on the cautionary tales of the COVID-19 pandemic for future responses to non-pandemic diseases. As they nicely emphasize, many patient groups looking at the rapid and expansive responses to COVID-19 are asking why their own conditions can't be similarly treated. Despite the obvious need for resource prioritization and the limited availability for research funding that makes it hard for similar fast-tracked success in other diseases, Lynch et al. maintain that the scientific response to the COVID-19 epidemic provides numerous important lessons such as (i) the need for close collaboration between governments and private industry, (ii) the prioritization of the most promising research proposals, (iii) sped-up trials through adaptive trial designs that are nevertheless robust, and (iv) widespread data sharing. We agree with all these, and the point we add here could be seen as a more general one which appears to be implicit in their reasoning: that is the need for and efficiency of utilitarian thinking within health care. This is a further general lesson that has come out of the COVID-19 pandemic that can usefully be applied to non-pandemic diseases.

The COVID-19 pandemic created unique conditions in which the need for utilitarian thinking was made obvious—as Savulescu, Persson, and Wilkinson (2020) point out in the opening of their paper *Utilitarianism and the Pandemic*: "There are no egalitarians in a pandemic" (620). The pandemic placed unprecedented pressure on public health resources that required triaging decisions regarding which approaches to pursue, which research to fund and, perhaps most fundamentally, which patients to treat. The sheer scale of COVID-19 meant that it was not possible to provide all patients with comprehensive care and difficult decisions were required regarding which patients to prioritize. At a state level, governments also had to make decisions regarding appropriate responses to manage the risk of disease spread, while taking into account the costs these measures would impose, such as the social and economic costs of lockdowns. All these decisions required utilitarian thinking, in weighing up the expected costs and benefits of alternative courses of action. As noted by Lynch et al., there are of course difficulties in determining which investments will actually bring about the most good, given difficult questions about tradeoffs between number of people effected, intensity of suffering caused, and chance of success. However, this does not mean that such calculations should not be attempted.

When thinking about non-pandemic diseases, and the questions from diverse patient groups as to why their own disease is not receiving similar massive scale efforts akin to the response to COVID-19, a utilitarian response is that the scale and severity of the pandemic required a level and speed of response far above that of any other disease. It is unfortunate reality that there are a range of diverse challenges to the health care system and these require a method of prioritization, based on the distribution and severity of harm. While all patient groups rightly want their disease to be treated, resource limitations make it impossible to invest equally in all conditions. As Lynch et al. point out, resources need to be allocated not only between different health initiatives, but also weighed up against other social goods such as education, infrastructure, and security. All investments require sacrifices in some other area, and it is thus impossible to avoid some sort of calculus of where these tradeoffs are acceptable.

While Lynch et al. are right to point out that the pandemic has demonstrated that there are ways in which improving and streamlining processes can provide a more efficient use of resources and thus a wider distribution of benefits, this scope is not infinite. Such methods are not new to health care—for example, chance of survival success is a commonly used metric for determining organ transplant recipients (Veatch and Ross 2015)—the pandemic emphasized these concerns and made them more visible. Yet, this reasoning is resisted by many who criticize our health care system and our response to the pandemic as utilitarian and inhumane, using the term in a pejorative manner.[1] This negative understanding of utilitarianism seems to be wide-spread within the population, with recent psychological research having shown that politicians advocating for sacrificing some people to save a much greater number (instrumental harm) are seen as less trustworthy, although the utilitarian doctrine of treating the welfare of everyone equally (impartial beneficence) is seen to increase trust (Everett et al. 2021).

When utilitarianism is derided as an unethical doctrine, it is usually this first component, instrumental harm, that is attacked. Opposition to utilitarianism in these cases appears to arise from two misconceptions: one about the nature of utilitarianism, the other about the nature of the world. The first confusion is conceptual, a failure to recognize the egalitarianism included within the principle of impartial beneficence that gives equal consideration to everyone's interests. The second confusion is more pragmatic, based in the apparent assumption that we could use principles that would avoid sacrifices or tradeoffs altogether. While perhaps possible in principle, in our actual world

[1]See Savulescu, Persson, and Wilkinson (2020) for several examples.

there are limited resources available for treating all sources of suffering and tradeoffs must be made.

Despite the fact that utilitarianism is based on egalitarian principles, it has often been criticized during the pandemic for being unjust, as utilitarian triage decisions such as who should receive a ventilator are taken to constitute discrimination against the elderly and disabled. However, even supposedly egalitarian alternatives inescapably contain some utilitarian reasoning. For instance, Savulescu, Cameron, and Wilkinson (2020) show that when institutes such as the Critical Care National Clinical Reference Group and the National Institute for Health and Care Excellence criticize rationing on the basis of the wrongness of utilitarianism, instead advocating for replacement by supposedly egalitarian procedures, they nevertheless reintroduce utilitarian principles. By allowing for decisions to take consideration of survival probability, they draw a "false distinction between the type of rationing they condemn and the rationing they encourage" (13). True egalitarianism would require complete equality between options, such as a coin flip to decide between giving a ventilator to someone with a 50% chance of survival and someone with a 1% chance; or funding a research proposal with a 20% chance of finding a cure and a 1% chance. However, such extreme principles are rarely publicly endorsed, with utilitarian considerations covertly entering back into the fray in the form of expected utility based on probability of success.

Where a resistance to utilitarian thinking leads institutional guidelines to try and steer away from overt utilitarianism, we run the risk of losing clarity in the decision-making process and the cost-benefit calculations required. Well-intentioned efforts to help clinical practitioners and medical researchers avoid discrimination, harm, and injustice, can unfortunately cause confusion and the overall inability to make effective decisions. What the COVID-19 pandemic has shown is that a utilitarian approach—far from creating injustices—is the only effective way of creating the most good in the world. While the utilitarian approach makes its cost-benefit calculations explicit, non-utilitarian approaches can instead create unseen and unaccounted harms. This can be seen, for instance, in resistance to public health initiatives such as mandatory contact tracing, mask-wearing, and vaccination, on grounds of freedom of choice, bodily autonomy, and personal rights. In these cases, it has become increasingly obvious that the reluctance to rely on utilitarian justifications creates more deaths, more suffering, and higher economic losses overall. While values of autonomy may also be valuable, they should not be taken to trump all other considerations (Browning and Veit 2021). There are inevitable tradeoffs with wellbeing (such as also seen e.g. in supported decision making; Veit et al. 2021). Without a common currency to deal with the different considerations and values of different groups, public health is bound to be inefficient, slow, and costly. Rather than a harmful doctrine of sacrifice, utilitarianism can instead be seen as a way of providing such a common currency.

The bad reputation of utilitarianism is thus unfortunate, since it not only holds the key to deciding how to best face the COVID-19 pandemic, but also how to respond to non-pandemic diseases. For example diseases such as endometriosis and fibromyalgia are widespread and cause extraordinary amounts of suffering but have as yet received considerably little attention (As-Sanie et al. 2019; Sarzi-Puttini et al. 2020). A utilitarian model of resource allocation for public health would instead prioritize such diseases, increasing the likelihood of finding a cure and providing a large benefit in terms of increase in wellbeing to a great number of people. Furthermore, COVID-19 has also raised the issue of changing societal norms in order to better fight the impacts of the pandemic (Levy and Savulescu 2021). This opens up avenues for enquiring whether we could encourage public health measures to fight non-pandemic disease, such as mask-wearing in enclosed public spaces during flu season. In these cases, far from sacrificing the elderly and other vulnerable people, utilitarianism may well require the majority to make a small sacrifice to their own wellbeing in order to substantially improve the lives of others—those seen to be in danger of utilitarian ideals. While it is true that utilitarianism requires sacrifices, it is mistaken and potentially harmful to hold that there are alternative ethical approaches that do not. The benefit of utilitarianism is that it provides an explicit account of the costs, and a principled method for making decisions requiring difficult tradeoffs that can minimize the amount of sacrifice required on a societal level. While this is demanding, as COVID-19 has demonstrated, it is the best approach to take under real-world circumstances of resource limitations, to ensure the most effective outcomes.

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ORCID

Heather Browning http://orcid.org/0000-0003-1554-7052
Walter Veit http://orcid.org/0000-0001-7701-8995

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What Can We Learn from COVID-19 Drug Development and Access for Non-Pandemic Diseases? A Chinese Perspective

Hui Zhang[a,b], Zhiping Guo[a,c], Lijun Shen[a], Yongguang Yang[a], Zhenxiang Zhang[b], and Yuming Wang[a]

[a]Henan Provincial People's Hospital, People's Hospital of Zhengzhou University, People's Hospital of Henan University; [b]Zhengzhou University; [c]Fuwai Central China Cardiovascular Hospital

The target article by Lynch et al. (2021) offers approaches for improving trial availability and Expanded Access for non-pandemic diseases based on the analysis of the COVID-19 experience in the US. We argue, in this commentary, that similar approaches are applicable to other countries, citing China as an example.

To begin, we discuss China's exceptional response to COVID-19, which included the development and access of diagnostics, therapeutics, and vaccines.

The Chinese government approved a sizeable allocation of funding for R&D support. It pooled resources from research institutes, universities, and enterprises to focus on five areas: clinical treatment, new medicines and vaccines, testing techniques and products, viral etiology and epidemiology, and animal model construction. It developed vaccinations in five categories: inactivated vaccines, recombinant protein vaccines, live attenuated influenza vaccines, adenovirus vaccines, and nucleic acid-based vaccines. Meanwhile, the National Medical Products Administration (NMPA) immediately began reviewing applications for registration of emergency medical

CONTACT Yuming Wang henanyuming@sina.com Henan Provincial People's Hospital, People's Hospital of Zhengzhou University, People's Hospital of Henan University, Zhengzhou, 450003 China

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