

COVID 19 : ETHICAL DILEMMAS IN HUMAN LIVES

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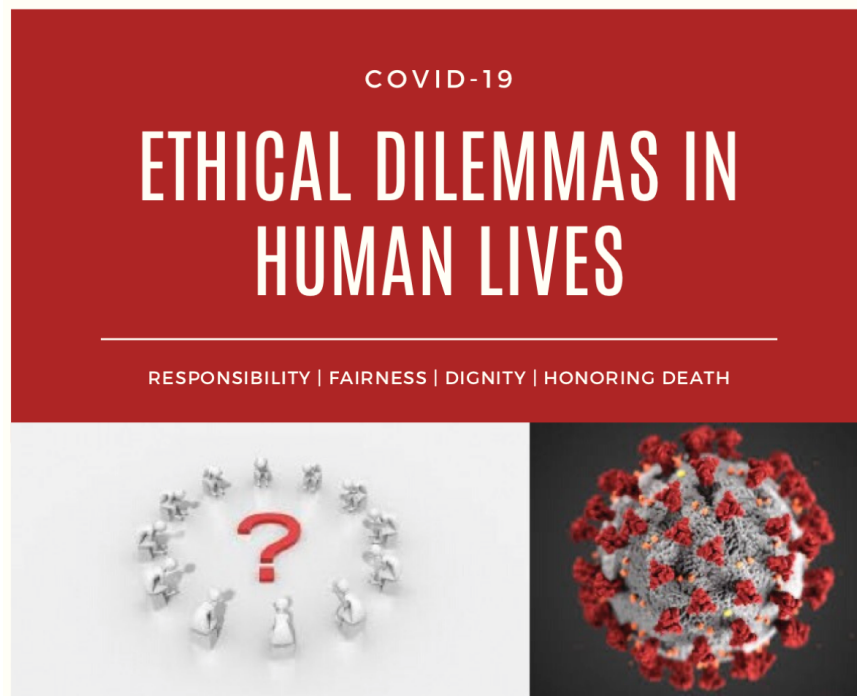
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Abstract

The outbreak of the Covid-19 pandemic obliged us all to handle many dilemmas, some of which we took upon ourselves as philosophers, ethicists, doctors and nurses to discuss around four key ethical notions : responsibility, dignity, fairness and honouring death. The following collection of the symposium acts held online in May 2020 with the Paris Global Center of Columbia University and Columbia Global Centers, attempts to testify to the ongoing pandemic emergency and difficult challenges while evaluating whether the ethical principles in the official recommendations were able to meet the lived reality. Looking at accountability and consistency in regard to the context of exercise, it seemed equally important to examine, through an international exchange, whether the contextuality of Coronavirus across countries and cultures affected the ethical decision making processes. We hope that our discussion can serve as a resource for advanced care planning, helping medical providers and other specialists to consider the shared important aspects of medical ethics in times of great uncertainty.



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- **humanity**
- **philosophy of medicine**
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- **healthcare**
- **medical ethics**

THIS PUBLICATION WAS DIVIDED INTO TWO PARTS FOR THE PURPOSE OF SUBMISSION and as agreed upon with the editors and in order to respect the word count. We would like them to be united into one section upon publication.

PART 2

TRANSITION (better omit in case parts 1 +2 are published as 1 section)

Dr. Smadar Bustan, Philosopher

The Following section is dedicated to two Ethical Dilemmas:

DIGNITY :

Does the need for increased awareness of public harm in a pandemic justify impinging on patients' rights to bodily and personal dignity and privacy?

HONOURING DEATH :

Does public interest in social distancing outweigh the patient's right not to die alone and the family's right to be with their dying relative?

For the symposium video, please view: *COVID-19 ETHICAL DILEMMAS IN HUMAN LIVES*.

I would like to thank the Paris Global Center of Columbia University and their wonderful team for hosting the symposium in these exceptional times along with the Columbia Global Centers in Amman, Nairobi, and Istanbul. And last, I would like to thank all the healthcare and essential workers worldwide for their daily engagement to overcome the COVID-19 virus.

Smadar Bustan University of Paris Diderot May 2020, France

Third Ethical Medical Dilemma

DIGNITY

Does the need for increased awareness of public harm in a pandemic justify impinging on patients' rights to bodily and personal dignity and privacy?

DIGNITY: Nurse, Laure Madé

Laure Madé (FRANCE) , is a practicing Covid-19 Nurse at Hospital Bichat, Paris and Epidemiologist. Trained as a nurse in France, she completed a MSc in Epidemiology at the London School of Hygiene and Tropical Medicine. She has been working on emerging infectious diseases at Institut Pasteur, the University of Liverpool.

I worked as a nurse in a Covid-19 ward in a French hospital in Paris during the Covid-19 outbreak. The Bichat hospital is a referral hospital for the treatment of emerging infectious diseases and a leading player for the management of epidemic and biological hazards. During this unprecedented sanitary crisis, I witnessed numerous situations where health professionals faced ethical dilemmas in human lives. After fighting tirelessly against Covid-19 in France and oversea, I am still wondering whether we can effectively control this outbreak while treating both patients and the deceased with sensitivity, dignity, and respect.

In early April 2020, we were overwhelmed with Covid-19's media coverage. Many patients in an artificial coma were exposed to French TV news as an attempt to raise awareness of the threat of the unseen virus. In France, patients have to give consent to appear on TV, but this is not mandatory if they are unconscious as long as their face is covered. According to French law, the consent of the people filmed is not required when the image is illustrating a topical subject. I did not experience this specific situation as I wasn't working in the Intensive Care Unit, but I know some colleagues who felt uncomfortable dealing with this specific situation and found it particularly inappropriate.

We experienced other dilemmas during the outbreak that went beyond the media issue. What called my attention was how the patients were extremely terrified by being infected with Covid-19. It was indeed a new disease, very contagious with no proven treatment available. Every single health worker was entirely covered up with protective personal equipment: mask, gloves, gown, cap, glasses, and so on. All doctors looked similar and patients couldn't differentiate the many different nurses. This was a very stressful environment for them. On top of that, we could not enter the Covid-19 rooms as often as we wanted because we had to restrict our visits to limit the risk of contamination. Relatives and close friends were denied access for the same reason. In many rooms, Covid-19 related news was displayed repeatedly on TV screens leaving these patients with feelings of loneliness, isolation, and fear. They were fortunately allowed to keep their phones with them and

could, therefore, maintain a much-needed virtual contact with their loved ones. Despite these challenges, we tried our best to reassure them, and we made sure to provide emotional support every time we interacted with them.

The fact that our country was unevenly affected meant that a lot of human and material resources were allocated to the most affected areas. We did not experience a lack of staff, as hundreds of health workers came to help from different cities, including medical and nursing students. We were lucky to have at least one nurse for every four patients in the Non-Intensive Care Unit. However, we had severe issues accessing personal protective equipment, especially appropriate masks (34). This was a major challenge because we really wanted to give the best care possible to our patients, but we also needed to feel safe and protected ourselves. We had an incredibly high number of sick colleagues, and we even had to resuscitate one of them who was hospitalized in our ward. The feeling of fear was shared by everyone, patients, and health workers alike.

Finally, Covid-19 protocols in place at the time also impacted the way we handled the deceased bodies. Whenever we had a death in our ward, which was unfortunately frequent during the outbreak, we had to put the body entirely naked in the mortuary bag (35). This situation was distressful as we felt that we could not honor the deceased properly. We were not allowed to dress them up and the family was not allowed to view them. The rationale behind this recommendation was to limit the risk of contamination after death even though no evidence of transmission of SARS-CoV-2 through the handling of the body of a deceased person has been documented. The French High Council for Public Health amended its recommendations end of March (36) when the risk of infectious transmission from bodies was proven to be lower than for living patients. They allowed the viewing of the body for mourners immediately and the presentation of the body to the family. However, these less stringent guidelines did not reach our hospital.

During this pandemic, health professionals faced ethical dilemma situations more frequently due to various factors such as time required for the healthcare system to adjust to the crisis (hiring extra staff, set up of space/beds for patients, procurement of appropriate protective equipment, etc.), intensive workload among others, and potentially impacting the standard of care. But despite this stressful period, our intent was always to keep humanity in the care provided. Finding the right balance between the need to control the infection and the respect of the patients and families' rights is a difficult exercise, but the dignity of the patients and the deceased should be respected and must remain a priority, even in such chaotic time.

DIGNITY: RITA CHARON, ETHICIST NARRATIVE MEDICINE

Rita Charon, MD, PhD (USA) , is Chair of Medical Humanities and Ethics at Columbia University. A general internist and literary scholar, she is the founder of the discipline of Narrative Medicine. With an MD from Harvard, PhD in English from Columbia, she conducts research on the impact of humanities in medicine and is the author or co-author of four books on narrative medicine.

I want to thank the Columbia Global Centers in Paris, Amman, Nairobi, and Istanbul for sponsoring this symposium and insisting that the pandemic is an international pandemic. The more we can remember that we are not isolated and not solving our own parochial problems, the more effective and just will be the outcomes of our actions.

Ms. Madé has just given us major testimony not only about the privacy and dignity of the patient's body but also about the privacy and dignity of the other bodies in the room. I am very impressed with what she just did. Here is why. I am a general internist and a literary scholar. I study narratology—how stories are told and understood and received and what happens in the world by virtue of the accounts we give to one another. A group of humanities scholars and clinicians at Columbia University developed the field of narrative medicine in the early 2000s (37). We knew that the humanities, especially literary studies and creative arts, could make

powerful contributions to health care practices and concepts not just through the content of great novels like *Magic Mountain* and *Frankenstein* but by harnessing literary and aesthetic concepts of representation, close reading, intersubjectivity, temporality, and embodiment for use in the clinic. Our work over the years has demonstrated that narrative skills can improve clinical care in many ways, including expanding clinicians' knowledge of individual patients, strengthening teamwork, and reducing burnout (38)(39)(40). It is through the many-focaled lenses of narrative medicine that I have approached this essay's effort to reflect on issues of privacy and dignity in the time of Covid.

The impressive part of what Ms. Madé just did, speaking from a narrative medicine perspective, was to nest the clinical dilemma of the nurses and physicians within the more encompassing clinical dilemma of the patient, allowing her listeners or readers to consider the embodied landscape of care as a whole. She started with the privacy of patients' bodies before and after death, outlining France's policies of privacy and confidentiality accorded to patients and their surrogates. Then she seamlessly drew in the opposite face of privacy of the clinicians' bodies—not that they are unduly exposed but that they are unduly concealed in their personal protective equipment to the point that patients and families cannot distinguish among their encapsulated bodies. Through that deft narrative turn, Ms. Madé encourages us to consider the patient and the clinician as a unit—one sick, perhaps dying, the other risking sickness, perhaps death in the effort to care for the patient. The fear for the clinicians' own lives and the fear for their colleagues' lives cannot be separated from their fear for the lives of their patients, leveling the typical hierarchy by the mournful, terrifying facts of this crisis.

We know that physicians in particular hold strict taboos regarding their physicality within their professional actions. Usually, the body of the physician does not enter the picture of medical practice. Touching of patients is strictly governed (although such rules do not prevent the occurrence of sexual assault on patients by their doctors). Grueling medical training drills the importance—and heroic implications—for doctors to do without sleep and food and ordinary physical self-care. It is not a surprise to learn that doctors are found to have greater levels of anxiety about death than non-doctors but find powerful ways to repress such fears (41). So Ms. Madé's testimony gives us an important and rarely articulated aspect of not just the ethical dilemmas of this crisis but a profound paradox of health care in which some who work very closely with dying persons are perhaps ill-prepared to deal with their own and others' mortality.

Doctors' fear of death notwithstanding, Ms. Madé's testimony emphasizes the collective nature of our ethical responses to this plague. Moral philosopher Charles Taylor situates his understanding of personhood within the collective: "One is a self only among other selves. A self can never be described without reference to those who surround it. . . . A self exists only within what I call 'webs of interlocution'" (42). Framed by Taylor's recognition of our webs of meaning-making, I will emphasize in the rest of this essay those relational, cultural sources of the moral compass that governs the actions of any one of us. Like literature itself with its invisible and necessary congress between writer and narrator, narrator and reader, and reader and character, our inner lives and our consequential outward actions are influenced by and opened up by our intersubjective contact with the other. With our patients and clinical colleagues, we are fellow mortals, siblings under the planetary and even cosmic horizons that locate us in time, space, and being.

Questions about the privacy of patients' bodies are old, old questions. Read the *Journal of the Plague Year* of Defoe and Camus's Dr. Rieux in *La Peste* again if you have not done so recently to see how these questions of privacy, ownership, and custody of patients' bodies dead and alive have been with us in all the plagues of the 16th and 17th centuries and beyond (43)(44). Remember too, and this has been mentioned in earlier testimonies in this symposium, that the hospital is a strange insoluble mix of public and private. Illness itself is a subjective experience, a meaningful experience that happens within the context of an individual life as it is at the same time a public situation where some informal or professional group has to do the best they can to care for and protect others. The public functions, however, risk precluding attention to the individual's subjectivity; as phenomenologist Hans-Georg Gadamer asked, "Can science be connected once again with our own lived experience, or must the experience of one's own individuality be lost irrevocably in the context of modern data banks and new technology?" (45).

It was in the 18th and 19th centuries that the hospital became, in the works of Foucault anyway, a place not where persons were cared for but the place where physicians and scientists were able to study and objectify their human bodies (46). Physician and philosopher Mark Sullivan observes that “[i]n the new secular hospital [of the 18th and 19th centuries] organized by disease categories, the patient’s body became the object of scientific study and the focus of clinical medical efforts. Patients with chronic illness that could not be treated successfully within the hospital or clinic were generally sent away” (47). The reductive efforts to study the heart, the lungs, the kidneys so as to learn and not necessarily to be with those who were suffering altered the nature of medicine indelibly toward a time when hospitals needed public policies to protect patients from medicine’s intrusions and instrumental uses of the bodies of others.

But it was not until 1914 when Benjamin Cardozo wrote his decision in *Schloendorff v. Society of New York Hospital* that we had a firm legal platform, at least in the US, to say the patient’s body belongs to the patient. The plaintiff had given permission for an examination under anesthesia, but while the patient was anesthetized, the surgeon removed a tumor from the abdomen. Cardozo’s judgment was very clear. If a surgeon were to operate on a patient without their consent, the surgeon would be liable to charges of criminal assault.

With that rather sordid history as a background to this questions of privacy and dignity of patient’s bodies in our hospitals, let me turn to the traditions and schools of thought that were not available to Defoe or Rieux in their prior very similar plagues and that now might help to guide us toward respectful and ethical care of patients in this time of Covid. Professor Bustan referred to the work of phenomenologist Emmanuel Levinas in the context of the subjectivities and intersubjectivities of clinical care. The phenomenological traditions within continental philosophy are poised to articulate the peculiar dilemmas of illness and embodiment—how individuals find themselves within the world through the sensations and affordances of the physical body and how one embodied person is recognized and called into being by the fact of another embodied person (48). The body is the avenue through which the self lives in the world. Without our bodies, we are not in the world. Through our perception, sensation, and motility, we are able to not just address but to come into contact and to confront the real, whatever the real might mean. Without the body, we would be left only with our own imaginary representations of what we might intimate is out there.

Situations of health care, especially the hospital during a time of plague, poignantly enact the dramas of the body and the self that Heidegger, Husserl, Merleau-Ponty, and their followers so deeply investigated. Such contemporary phenomenologists as Drew Leder and Havi Carel continue the work of phenomenology by examining questions of social justice—imprisonment and maltreatment of animals—and the plight of individual patients whose serious and sudden illnesses derail their on-going lives (49)(50).

When I discuss the body of the patient, I do not invoke the Cartesian assertion that one can think of one’s body as if disengaged from or outside of it but, in Gadamer’s words, of “the absolute inseparability of the living body and life itself” (45; p. 71). And so it is that I particularly appreciate Ms. Madé’s comments on dignity, coming from the perspective of the nurse, that the body of the clinician as well as the body of the patient is involved in these clinical questions. More than medicine, nursing has been influenced by and has been the source of care ethics and feminist ethics formulations that bear on our question. The ethics of care, as proposed by Carol Gilligan in the 1980s and continued by Nel Noddings and Joan Tronto, among many others since then, focus on the relationship aspects of care (51)(52)(53). From the perspectives of care ethics, clinicians must be present themselves in order for care to be ethically and clinically effective—present not just in their cognitive and diagnostic capacities but in their moral, values-based, and even physical incarnations in the orbit of the patient. Such an ethics is a highly “costly” personal one, shifting the notions of duty from disengagement to engagement. I believe this ethical perspective clarifies some aspects of the dilemma we are faced with here. As one follows the literature in the ethics of care and feminist bioethics, one sees expansion beyond its initial focus on the perspectives of women in health care toward nongendered formulations of relational moral visions, spreading from health care and education to intersectional, global, political, and economic issues (54).

At their cores, the feminist approaches in bioethics and care ethics formulations seat the personal commitment

of the care-giver—family, teacher, health care provider, legislative representative, policy maker—to address both the impersonal and personal dimensions of the situation and its ethical calculus. The “address” is one-to-one, with the one who is cared for—in whatever situation—and the one giving the care as partners in the outcome. In our Covid setting, the patient’s body is in the clinician’s hands. The patient’s body has been entrusted to this clinician who is present in her own body, however protected or unprotected from the physical and existential contact she may be.

I conclude this essay by thinking back to our opening case, that of the cameras in the intensive care unit taking images from the bed of a dying patient to broadcast those images into the public media. However protected such photojournalism might be by France’s equivalent of the U.S. freedom of speech laws and however allowed such photographing may be by the consent of surrogates, it seems to me like a greedy gesture on the part of the media to take and display what they think will be most shocking and the most potentially “viral” of images. I wish the photographers were more skilled than that. I wish they could capture perhaps less violent and intrusive but perhaps more telling images. We all probably remember the Holocaust photographs of the pile of children’s shoes that most spoke to the horror of that genocide. So my closing request is a request for nuance instead of flamboyance, depth instead of shock. What we have to endure in the pandemic requires our capacity to see in great, great detail and delicacy all that unfolds, to not be catapulted to facile and false conclusions but to take the measure of the complexity of the time and the need for our utmost discretion in learning and teaching its lessons.

Forth Ethical Medical Dilemma

HONOURING DEATH

Does public interest in social distancing outweigh the patient’s right not to die alone and the family’s right to be with their dying relative?

HONORING DEATH: Clinician, Meinhard Kritzinger

Meinhard Kritzinger, MD ICU-Anesthesia (ITALY) is a specialist in anesthesia and intensive care with diploma in tropical medicine and public health. He has trained in Austria, South Africa, Italy, America, and in several war zones working for MSF-Italy.

I am a consultant in Intensive Care Medicine and Anaesthesia working and living in South Tyrol, the northern most Italian province bordering Austria. We serve a population of 500.000 people with one large and four smaller hospitals, all with Intensive Care Unit (ICU) facilities. The experiences I will recount are based partly on my own experiences and experiences of fellow doctors working in the wards.

The 1990s was the last time that a special Italian law for infectious diseases was applied for the then new “AIDS epidemic. When HIV patients were admitted to hospital, they had to stay in a newly constructed unit which had negative pressure isolation rooms and closed doors. The rooms had glass panels facing balconies and the visitors could see their relatives through the glass window (55).

Since there were no real therapeutic options at this time, those patients did not have any contact with relatives or the outside world. Their families could only see them from the balconies through a closed and locked glass window. As knowledge about this disease improved, this inhumane practice was abandoned. Little did we know that 30 years later, this practice was to be reintroduced.

On the 31st of January 2020, a state of emergency was declared and a COVID task force, introduced by the Italian Ministry of Health, was created to handle the health emergency crisis and to govern all clinical decisions (56). End of February 2020 saw the beginning of a widespread lock-down following the disastrous

spreading of the disease in the Province of Bergamo, situated 2 hours south of our hospital. There were dramatic pictures from the overflowing emergency departments and ICUs. The first cases in South Tyrol were diagnosed at the beginning of March with the peak around middle of April (57).

In the subsequent weeks the number of ICU beds was increased from 25 to 60. This was achieved by converting operation theatres to ICUs, and normal wards were converted to COVID only wards. Triage units were created and doctors from other departments such as dermatology, urology or ophthalmology found themselves in charge of newly admitted patients with almost daily differing case definitions and treatment protocols. Diagnostic pathways and responsibilities changed throughout the emergency, and doctors who never had seen a patient die under their care, had to face dying patients every day.

By the beginning of April, at the peak of the epidemic, sick patients were flown out to Germany and Austria. The daily death count reached 10 patients a day with 234 patients admitted to different hospitals in the region (58).

When caring for terminal patients in ICU we would normally invite family members to spend the last hours with their loved ones. Despite strict visitor regulations of only one close family member per patient and only close family, in such situations, makeshift rooms were created with privacy screens, so that family could accompany their loved one.

In the normal wards, family would be given ample space and possibility to talk to nurses and doctors while staying with the dying patient. Once the death had occurred, the corpse would be brought to the hospital chapel, where the deceased would be dressed and rested for 24 hours. This allows friends and family spend some time in prayer with the deceased since it is not customary to display the deceased in an open cask at the funeral in our region. The next day, the mortician would remove the body for the funeral, which takes place after a couple of days. Cremation is the exception since people like to see a coffin at the funeral and not an urn.

During the COVID epidemic ,a “no visitor” policy was strictly enforced by the task force for COVID but also non COVID patients. Doctors shifts were adjusted on daily basis as the workload dramatically increased. Changing diagnostic pathways and triage options left patients on the ward with a different doctor being responsible for them almost daily. Dermatologists and ophthalmologists, who had never cared for dying patients, let alone discuss terminal care faced difficult situations, as they were never trained in this area. Daily increasing patient numbers, uncertainty and fear to get infected decreased the time, that staff interacted with family and patients to the absolute minimum. Personal protection equipment with mask, gown and a triple layer of gloves did contribute to reduce any personal contact.

The majority of the COVID patients were elderly and they had to stay in an isolation room, deprived of human contact during their final hours. In contrast to people dying of other diseases, patients with COVID sometimes were lucid until the very end. They were well aware that they were suffering from a disease where no cure was known and they were about to die from it. Nursing staff even at the deathbed was reduced to a minimum for fear of contagion.

Not only did the patient have to die alone, sadly even family members were also left on their own. They could not leave their house as lock-down prohibited all movements so they could not even meet to mourn.

In addition, frequently an elderly spouse was left alone at home confused and startled by having to stay in quarantine, with their partner taken in an ambulance with people dressed in gowns and masks, only to have him or her back as ashes in an urn a week later.

Once the death had occurred, the corpses were undressed and soaked with disinfectant and zipped into a plastic body bag. There was no way any relative could see the deceased, nor was it possible to dress the body with clothing sent from the family.

Once the ashes were returned to the household, funerals were limited to 10 people attending and lasted for a couple of minutes only.

To alleviate their patients' final hours, the nursing staff would sometimes stick printouts of photos of the family onto the surrounding walls, so that the patient could picture the presence of their loved ones in the room. In one case, a little dog was smuggled into the isolation unit for a quick farewell as this was the patients last wish. In other cases, the relatives could see their loved ones through a glass window standing on the balcony of the isolation unit. Even though the regulations were uniform in the whole province, they were only strictly adhered to in the main hospital. In the smaller hospitals, one family member with protective clothing could sit with their dying relative.

The provincial ethical committee was aware of this problem and on the 1st of April, they wrote an urgent letter to the task force regarding the increasing loneliness of the patients, the lack of patient's involvement in therapeutic decisions and access to terminal care (Irmgard Spiess RN, Alessandro Felici MD, e-mail communication, April 2020). Unfortunately, this letter was never published nor did the task force respond to this letter.

It was as if regarding the dilemma of honouring death, the epidemic had abolished patient's rights.

HONORING DEATH: Philosopher and Clinician, Jeremy R. Simon

Jeremy Rosenbaum Simon, MD, PhD (USA), is an emergency physician, medical ethicist and philosopher of medicine on the faculty of Columbia University. He is a member of several local and national ethics committees and chair of the International Philosophy of Medicine Roundtable, the leading organization of philosophers of medicine.

The question at hand is Honoring Death: Does the public's interest in social distancing outweigh the patient's right not to die alone and the family's right to be with their dying relative? The issues raised by the situation Dr. Kritzinger describes in this regard need to be ethically analyzed on two levels. The first is the question of the nature of the rights under consideration, and the second is the question of the nature of rights in general at this time of public health crisis.

The dilemma as posed presupposes two different but related rights. That of the patient not to die alone, bereft of their family, and that of the family members not to be separated from their dying loved one. Of course it would be difficult to honor one of these rights without honoring the other, but with two rights in play, there are more arguments to be made in favor of respecting them.

One might think that right of the dying person is the more powerful right here. The dying are often given special consideration due to their status, even those being executed (last meal, cigarette, blindfold). The right to have comfort in dying, which ordinarily is not problematic, would seem to be something patients are entitled to. And certainly on some level they are. Being alone in a stressful time is frightening, and patients have a right not to be subject to undue fear. But if we focus on the right to visitors particularly of the *dying*, and not all patients, this right may seem to be somewhat reduced, especially in the current situation. First, patients can only be considered dying for a brief part of their hospitalization, when it becomes clear that they cannot be kept alive much longer, or when life support is being removed. Thus, any harm that may be caused by violating this right is mitigated by the relatively short time during which the right is being violated and the patients are exposed to unnecessary stress. Second, and this is relevant particularly to COVID, a large percentage of the patients who die are intubated and sedated at that point. Even to the extent that patients in general may have a right not to die alone, it is not clear that this right extends to unconscious patients. This is not to say that it does not. It may be an intrinsic matter of human dignity not to be abandoned at the time of death. But, even given that, hospitalized patients are not abandoned; they are not even without those who care for them. They are just without those with whom they have long-term bonds of affection. Note that the second point is of limited applicability, since many patients also die without being intubated. In those cases, the other arguments presented here will have to suffice.

What then of the family? They are conscious, and the harm done to them could potentially reverberate

for years to come. And familial rights are certainly recognized in medical ethics, at least when it comes to surrogate decision-making. Perhaps it is their right that is stronger. But, whether or not it is stronger, it cannot be absolute. For, there is a very simple case where a hospital may, and must, keep out such a visitor—at the patient’s request. Likewise, if the family member has behaved badly, even to the staff, during prior visits. This is of course not what is happening here. However, it does show that the family’s right to visit is defeasible.

These, then, are the rights in question. What I have shown thus far is not that they do not exist here, just that they may not be as solid as they at first appear. The next question is, how should we approach rights during the time of a pandemic. Traditionally, ethical analyses can be broken into two types, consequentialist, or outcomes based, and deontological, or rules based. A consequentialist, or utilitarian, decides whether an action is right based on the outcome that results—did it create more good in the world than the alternative? A rules based ethicist sees whether an action follows certain ethical rules—thou shall and thou shalt not—without looking to see what the impact is of following the rules in a given case. But that dichotomy is a bit misplaced here. Even a deontologist, a rules-based ethicist, may have rules that take into account outside impacts. So to have a specifically rules-based argument that visits to the dying is a right at this time, one would have to have a rule that implied that not only was it a right, but that it was a more or less absolute, first-tier right that no amount of bad consequences could override. I have trouble seeing this in general, and certainly in light of the arguments made earlier.

That was a bit quick I am afraid. The main point was just to argue that we need to analyze the ethics of our dilemma, as to whether the public’s interest in social distancing outweighs the patient’s right not to die alone and the family’s right to be with their dying relative, based on the real world consequences of taking one side or the other, and not based on abstract, timeless rules. Therefore, we are left considering the consequences of allowing or not allowing visits to dying patients during the COVID pandemic.

Ultimately, answering this question requires objective data, or at least assumptions about such data, about the risk to visitors of acquiring COVID (and then also perhaps spreading it to others) and the risk of their already having COVID and spreading it within the hospital. This is information that I do not have. It also depends on the organization of the intensive care units and the potential for disruption visitors could create. I know that at our hospital at Columbia, operating rooms have been converted to intensive care units, so that in addition to the MICU, or medical intensive care unit, and SICU, or surgical intensive care unit, etc., we also now have a new beast called the ORICU, operating room intensive care unit. These do not necessarily have the same space and barriers that normal intensive care units have, and may have less room for extra people in them.

How could one use this information to make decisions here? Certainly, if wearing a simple mask is enough to prevent getting or spreading infection, then the danger to the visitor, the other patients, and to society at large is not a real issue, and is not a reason to forbid visitors. Of course, we do not know this to be the case, and so this danger must be considered. Given the degree of disruption to everything else that our assessment of the risk from COVID is causing, it is not unreasonable (though not necessary) to take a conservative approach here too. Note that the risk to the visitor is only part of the issue here, and so we cannot simply leave it up to them to take on the risk or not.

But even if the risk of virus transmission is small, the disruption to the intensive care units, and especially the makeshift ones, could be real. And I think that there is an argument to be made that if some intensive care units cannot have visitors, none should. At the very least having different policies for different units would lead to arbitrary distinctions between patients, and at the worst it could lead to placing patients in preferred intensive care units for nonmedical VIP (“Very Important Person”) reasons, which is certainly unjust.

Thus, I think that while keeping visitors away from dying patients is certainly a bad thing, it is not an absolute wrong, and may indeed be justified at times, perhaps even now. We broadly restrict rights during public health emergencies, and the right to visits is not stronger than others, and is perhaps weaker than

some of the even more fundamental rights, such as engaging in religious worship and commerce, that life under COVID has, of necessity, interfered with. Nonetheless, if it is possible to have a safe, nuanced policy, with small numbers of visitors to those patients who would benefit from it, this is certainly desirable.

Any philosophical analysis of difficult human issues is in danger of losing the human, even when the analysis is rooted in the real world. Without pulling back from the somewhat difficult conclusions I have presented, I would like to pair them with a quotation from Rodrigo Marquez. Marquez is the son of the novelist Gabriel Garcia Marquez, author of *Love in the Time of Cholera*, and the quotation comes from a column he wrote as a “letter” to his late father, describing the pandemic to him. He says: “It’s not just death that frightens us, but the circumstances. A final exit without goodbyes, attended by strangers dressed as extraterrestrials, machines beeping heartlessly, surrounded by others in similar situations, but far from our people” (59).

Conflict of interest statement for all authors : attached individually and signed

Appendices (if relevant). Meinhard Kritzinger’s Italian committee letter in Italian and German that could be translated and added following editors’ decision

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COVID-19

ETHICAL DILEMMAS IN HUMAN LIVES

RESPONSIBILITY | FAIRNESS | DIGNITY | HONORING DEATH

