February 2021

> *"The object of philosophy is the logical clarification of thoughts. Philosophy is not a theory but an activity."*
>
> *— Ludwig Wittgenstein*

Happening at the Center

- 02/11 Ethics Committee Consortium Webinar: How do Pandemics End?
  - Faculty: Carla Keirns, MD, PhD, MSc, FACP, HEC-C, Assistant Professor of Medical Ethics, University of Kansas Medical Center
- 02/25 CPB Annual Event: CULTIVATING RESILIENCE, COMPASSION AND MINDFULNESS
  - Featuring: Barry Kerzin, MD, Personal Physician to the Dalai Lama, Founder of the Altruism in Medicine Institute

Hot Topic

Pandemic Mindset: Cure, Care or Both

If anything can be said about the effects of Covid-19 on society, it is that it has been invasive, destructive and modifying. We are now using language such as *the new normal* to imply that the momentous shifts caused by the pandemic will have lasting influence on how society operates after the immediate and apparent direct harm has subsided. This is extremely pronounced in the medical community, where hospital and healthcare workers are responding directly to these shifts and challenges. They are adapting admirably but not without pain and suffering.

The impact of the pandemic has been particularly significant for Intensive Care Unit workers, and especially for nurses and physicians. The culture within an ICU is different for those who live and work within it. ICU staff develop a unique approach to delivery of treatment and care, with one of the major characteristics of this approach being their ability to care for, treat and improve the most challenging and medically difficult patients. As a 2016 study of the culture of ICU nurses states:

> Focus was their primary objective, and for the critical care nurses, witnessing the effects of "going all out" about patient care was what translated into job satisfaction. Critical care nurses in this study saw their input into a patient's care as necessary and important, to both their own well-being and the well-being of their patients. They enjoyed the challenges of caring for a very ill patient. It was important for them to feel that they had made a difference and to experience the improvement in their patients. *(Scholtz, Nel, Poggenpoel, & Myburgh, p.4)*

This is the mentality that nurses will give their everything to provide the best care for their patients. It is a defining character trait that often leads to emotional links between patient and provider. The well-being of the patient is seen as in the provider's hands, with their own well-being deriving from their ability to perform this duty.

Benefits of Care

This mentality is often given the term or identification of *curative medicine* or *the curative model*, and while there is no formally agreed upon definition, it has been described as an "approach to clinical medicine that narrowly focuses on the goal of cure" (Fox, 1997). This approach brings clear benefits, as the goal is to improve or cure the patient of their condition and sufferings. But it is not a complete approach to overall health, or more specifically care, for "According to this model, effective cure is contingent on effective diagnosis and treatment." (Fox). While

diagnosis and treatment clearly have benefits, they lack additional benefits that come with care, as Fox states: "Although cure is unquestionably an appropriate goal of medicine, other goals are important as well: promoting health, preventing illness and injury, restoring functional capacity, avoiding premature death, relieving suffering, and caring for those who cannot be cured. In its purest form, the curative model concentrates solely on the goal of cure and in the process neglects medicine's other goals."

This creates the issue that treatment and care are dependent on the caregiver or provider's ability to cure, which fails to reflect several important and humanistic aspects of care. Additionally, "If medicine is limited to the goal of cure, then medical indications alone dictate which diagnostic tests and therapeutic treatments are appropriate. All medical decisions are therefore reduced to purely empirical questions" (Fox).

The Complete Approach

Covid-19 and the pandemic it caused has challenged this mentality; from the medical benefits, to the curative approach, the well-being of the providers so view their value and worth through the lens of providing a cure. When medicine is focused primarily on curative interventions, then failure to achieve those curative successes can lead providers to feel that they are failing their patients. This is particularly challenging with patients suffering from Covid-19. A recent study shows that Covid-19 patients have a higher mortality rate compared to other ICU patients:

> *Among 8,516 patients with COVID-19 admitted to 88 VA hospitals, 8,014 (94.1%) were men and mean (SD) age was 67.9 (14.2) years. Mortality varied over time, with 218 of 954 patients (22.9%) dying in March, 399 of 1,594 patients (25.0%) dying in April, 143 of 920 patients (15.5%) dying in May, 179 of 1314 patients (13.6%) dying in June, 297 of 2373 patients (12.5%) dying in July, and 174 of 1361 (12.8%) patients dying in August (P < .001). Patients with COVID-19 who were treated in the ICU during periods of increased COVID-19 ICU demand had increased risk of mortality compared with patients treated during periods of low COVID-19 ICU demand. (Bravata et al., 2021).*

Covid-19 is challenging many aspects that were assumed about normal life, from how we live and work, to now, as demonstrated, how we care for patients. The important perspective to hold regarding this data is that providers should not consider themselves as failing a patient because aggressive interventions are not achievable. Just because healthcare workers are not able to cure a patient does not mean they are not able to care for the patient, and thus should never view their work as futile or a failure. *Care* does not necessitate *cure*, and while ICU health workers typically pride themselves on their ability to *cure*, they should also take pride in their ability to *care.* For without their tireless and selfless work, it is unclear where these suffering patients and society as a whole would be right now. But it is safe to assume they would not be better off.

Bioethics in the News

- The Ethics of Prioritizing COVID-19 Vaccination
- COVID-19 and bioethics: Looking back and looking forward
- How legacies of the Holocaust should inform health care
- Bioethics in the COVID era: Physiatrists advocate for patients with disabilities
- Bioethics society expresses regret in case of man denied food and water

Case Study

Jennifer is an ICU nurse, having been working for Pleasantville Medical Center for 20 years. She says that is currently taking the Covid-19 pretty hard. She has confined to friends and fellow hospital staff that she feels that she is carrying a large burden. Covid has impacted her relationship with her husband and children, as well as her extended family. But mostly, it is impacting her as a nurse. She feels that she is not able to do what she was trained to do. She says that "patients that come here with Covid just don't recover. What are we doing for them? We are just watching them as they slowly die and die alone." When a new patient presents to the hospital that she is to take on, she says, "I can't do it. I can't go in there and handle another one." A fellow nurse, and friend, reached out to ethics to see if there is anything that can be done.

Ethical Musings

Deontological Ethics and the Limits of Moral Duty

The idea of moral duty, also known as deontological ethics, is an ethical system that has clear benefits and merit. But it also has glaring holes that run counter to a modern understanding of human actions.

The most famous deontological system is called Kantianism. Developed by 18th century philosopher Immanuel Kant in *The Groundwork of the Metaphysics of Morals* and further in *The Metaphysics of Morals*, Kant conceives of the Categorical Imperative, which comes in three formulations.

The Categorial Imperative

The first formulation states, "I ought never to act except in such a way that I could also will that my maxim should become a universal law" (G 4:402), while the second formulation states that we should never act in such a way that we treat humanity, whether in ourselves or in others, as a means only but always as an end in itself (SEoP). What these formulations are attempting is to articulate is a system that creates a universal, objective moral duty of individuals, while also respecting the unique nature of humans.

Kant argued that humans were rational beings and thus deserved additional moral objections. Because humans can rationalize and are each individuals, they are able to understand the universality of individual actions, how those actions can impact others (particularly other humans), and have moral objections or duties both to themselves and others. We also have to respect the individual nature of each person; they can think and act and others can think and act upon them, while both maintain autonomy and freedom in those thoughts and actions.

Deontology in Healthcare

Therefore, for actions to be ethically sound, they need to be able to be willed to be done by all individuals (universal law), and done to the direct benefit of the individual impacted (using others as an end to themselves, not a means). What all this comes down to is the idea of *duty*. Simply being a rational individual endows us with duties to others, and also gives other persons duties towards us. It is not an objective universal morality that gives the ethical permissibility to actions, but rather the assignment of duties and responsibilities. These duties derive from the fact that humans are rational, and further to create obligations for how other rational creates should interact with each other.

Healthcare ethics and bioethics are often viewed as fields that are very much in the nature of deontology. While they are certainly not exclusively based on deontology, there is a heavy influence within the field. Physicians and healthcare workers have duties and obligations towards patients, towards larger communities, towards other professionals, etc. The idea of rights is a very deontology idea. As are oaths, which is the individual choosing to self-assign additional obligations. Physicians choose to adhere to additional duties that come with being a physician, thus a personal accepting of a deontological idea of the duties of the physician towards others.

An Incomplete Theory

But while deontology certainly holds a valuable place within society and healthcare, many philosophers have argued that it is incomplete. That there are additional aspects needed for actions to be ethical, possibly due to the unique nature of humans. One such philosopher is Michael Stocker. In his 1976 paper, *The Schizophrenia of Modern Ethical Theories*, Stocker makes the argument that adhering to duty only is not enough to determine an action to be ethical. He uses the thought experiment of a friend coming to visit you in the hospital. Imagine that you are in the hospital recovering from a long illness, and your friend stops by and visits you. You would initially, in theory, feel good about seeing your friend. It would make you happy and cheer you up to know that your friend has gone out of his way to visit you. But while you are praising him, he tells you that he is only visiting you because he believes it is his duty to visit you in the hospital.

Stocker argues that surely there is something lacking in this action, that your friend visiting you only from a sense of duty is not the same as your friend genuinely wanting to visit you. The intention of the action is as important, if not more important, then the adherence to the duty. As Stocker put it regarding other ethical theories, "What is lacking in these theories is simply – or not so simply – the person. For love, friendship, affection, fellow feeling, and community all require that the other person be an essential part of what is valued." He calls this *moral schizophrenia* because "they are split between one's motives and one's reasons".

There is more to our interactions with each other, and particularly with patients, than a sense of duty. Healthcare workers do not conduct themselves only because of a sense of duty but rather a deliberate intention to care for others. While deontology and medical duties are important, something is clearly missing than just caring for a patient because of duty. To put it simply, the most rewarding patient interactions for all come with "love, friendship, affection, fellow feeling, and community".