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Medical Ethics, Moral Courage, and the Embrace of Fallibility

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Abstract

Experts have an obligation to make difficult decisions rather than offloading these decisions onto others who may be less well-equipped to make them. This commentary considers this obligation through the lens of drafting critical care rationing protocols to address COVID-19-induced scarcity. The author recalls her own experience as a member of multiple groups charged with the generation of protocols for how hospitals and states should ration critical care resources like ventilators and intensive care unit beds, in the event that there would not be enough to go around as the COVID-19 pandemic intensified. She identifies several obvious lessons learned through this process, including the need to combat the pervasive effects of racism, ableism, and other forms of discrimination; to enhance the diversity, equity, and inclusion built into the process of drafting rationing protocols; and to embrace transparency, including acknowledging failings and fallibility. She also comes to a more complicated conclusion: Individuals in a position of authority, such as medical ethicists, have a moral obligation to embrace assertion, even when such assertions may well turn out to be wrong. She notes that when the decision-making process is grounded in legitimacy, medical ethics must have the moral courage to embrace fallibility.
Medical ethics straddles two different intellectual domains. One is philosophy, where the vicissitudes of the fleshly world are pushed aside to permit a glimpse of the underlying truths. The other is medicine, where precisely those fleshly vicissitudes constitute the objects of exploration. In philosophy, remaining intellectually modest by only asserting that for which one has a valid argument is not only a virtue, but a requirement. For everything else, the rigorous philosopher uses conditionals. If you find yourself lost in the hallways of a university, and you overhear something like, “If it were the case that tables exist, then an argument for mereological essentialism could be made. Though I am in no way committed to the claim that tables exist. Which of course doesn’t rule out that mereological essentialism is true,” you can be pretty sure you have stumbled into a philosophy department. A skilled philosopher can spend her career speaking in conditionals, remaining agnostic on how the world in fact is, committing herself only to how it would be if such and such were the case.

Needless to say, no such practice will work in medicine. If your physician were to tell you, “If it were the case that you have a virus, then an argument for rest and fluids could be made. Though I am in no way committed to the claim that you have a virus. Which of course doesn’t rule out that rest and fluids could be indicated,” it would be wise to look for a different physician. In medicine, agnosticism—at least of the intractable sort—is absurd. Sooner or later, a medical provider must come to a diagnosis, determine the options, and provide a recommendation. The medical ethicist is neither a philosopher nor a medical provider but contains elements of both. While wielding the analytic rigor of the former, she should embrace the pragmatic goal-directedness and attunement to lived experience of the latter.
Practicing Medical Ethics in a Pandemic

COVID-19 has had an uncanny ability to cast even innocuous-seeming differences into stark relief, exposing the dangers of underlying tensions. Like many of my medical ethics colleagues, in March and April of 2020, I was a member of multiple groups charged with the generation of protocols for how hospitals and states should ration critical care resources like ventilators and intensive care unit (ICU) beds in the event that there would not be enough to go around. We were shaken by reports out of Northern Italy, where medical providers were so desperate to help their ever-growing population of patients that they resorted to reserving ventilators for those under 65.\textsuperscript{1,2} Clearly we needed a plan for the seemingly imminent scenario in which our ICUs would be overwhelmed and we would have to decide who ought to receive a critical care resource and who ought not to receive it. It seemed obvious that trying to save the most lives was of paramount importance. But that still left questions, for example, whether a younger patient ought to be prioritized over an older patient, both on the grounds that the former likely had more years left to live, and that she had had less of an opportunity to experience different life stages. For me, as a philosopher, the visceral tangibility of considering these questions while the world was being ravaged by a deadly disease made my stomach turn. No graduate seminar in moral philosophy could have prepared me for this.

Part of what made the protocol-drafting process so excruciating was that we had little time to do it. We were convened only when it became undeniable that such guidelines would likely be needed within weeks or even days. “Why did this have to be done so much in the fog of war?” my medical ethics students would invariably ask, upon hearing about the process in the months since. “Surely, it would have been better to develop these protocols in a time of calm, when there is room for thoughtful deliberation.”
In response, I made it clear that our protocols were not constructed *ex novo*. We based them on existing guidelines that had been available for years. Many of these guidelines had had the benefit of being drafted in robust ways, that included community and diverse stakeholder input. Moreover, the specificities of a novel virus require that guidelines are tailored to emerging data, which precludes relying exclusively on existing frameworks. For instance, rationing guidelines that address a shortage of ventilators, which require critical care nursing staff, may differ in important ways from ones that deal with a shortage of infusion sites. Until the medical facts of a new disease have manifested themselves, guidelines are likely to remain in flux.

But these answers are not complete. Part of the reason why the specific COVID-19 rationing protocol groups that I served on were not convened several days or even weeks earlier was because there was reluctance on the part of officials to acknowledge the reality of impending rationing. I hasten to add that none of the protocols I helped develop were ultimately put into action—although more about that later. This reluctance, it was clear, did not stem from an inability to understand the gravity of the situation. Rather, it came from the realization that endorsing a particular rationing strategy, or even the fact that rationing was likely to occur at all, was politically precarious. It meant sticking one’s neck out. It seemed officials were taking a page out of the philosopher’s book, choosing to remain agnostic, lest they open themselves up to criticism.

**Systematic Racism Persists**

Because of the urgency with which our group of medical ethicists ended up drafting guidelines, we scrambled to include diverse community input. (Our group of medical ethicists was also not itself sufficiently diverse.) One does not need to go back to the Seattle dialysis-rationing “God
Committee” from 1961 to know that the absence of community input and deliberative democracy makes for biased and indefensible decisions.  

Sitting in a hastily convened Zoom community meeting to discuss ventilator rationing strategies with members from local minority communities, COVID-19’s disparate impact was on everyone’s mind. In April 2020, robust data was emerging that showed that, compared to White people, Black and Indigenous people were not only more likely to become infected, but also more likely to become severely ill and die. It was also clear that this discrepancy was due to systemic racism. We wrung our hands at this injustice and catalogued it as another unfortunate effect of the pandemic. One young Black woman, participating in the meeting as a community member, brought up the idea of adding priority weights to patients of systemically disadvantaged groups to combat the effects of systemic racism. The idea was intriguing, but ultimately seemed impractical—how would clinicians assess and verify something as complex as someone’s race—and so, in the fog of war, we rejected it.

In the past year, the proliferation of COVID-19 rationing protocols and the principles upheld therein have generated considerable critical attention. In particular, allocating resources on the basis of likelihood of survival to discharge from the ICU and of having more rather than fewer life-years left post-discharge—the so-called “Save the Most Lives” and “Save the Most Life-Years” principles—were found to discriminate against Black and Indigenous people in favor of White people. This is because, as a result of systemic racism, the former are more likely than the latter to require these resources in the first place and are more likely to fare worse even with the resource. Medical ethicists now endorse the addition of weightings to the priority scores of individuals disadvantaged by systemic racism. Similarly, in October 2020, in determining guidelines for the ethical rollout of the COVID-19 vaccine, the National Academy of Science,
Engineering, and Medicine, in a report requested by the Centers for Disease Control and Prevention and National Institutes of Health, urged that, as vaccine access expands, geographic areas with a greater degree of social vulnerability should be prioritized. The justification for this prioritization is that racism and poverty, both of which are captured by the social vulnerability index, have made COVID-19 more dangerous and deadly for these populations.

Mistakes…

Looking back to April 2020, it is clear we made mistakes. We failed to fully appreciate the moral import of the discrepancies that COVID-19 and racism were inflicting. We could have been leaders in addressing the impact of pernicious discrimination on the COVID-19 patient population, but we were too rigid in our approach. Three obvious lessons immediately present themselves for medical ethics. First, we must do more to combat the pervasive effects of racism, ableism, and other forms of discrimination. Second, it is entirely unacceptable for diversity, equity, and inclusion not to be built into the process of drafting rationing protocols. Deliberative processes can only be robust when they are conducted by a diverse group in an equitable and inclusive manner, so that an array of lived experiences can be harnessed and blind spots can be minimized. Finally, public trust can only be ensured through an embrace of honesty and transparency. This includes acknowledging failings and fallibility.

...And How Not to Fix Them

One lesson that should not be drawn from these mistakes is that experts such as medical ethicists should not be making these difficult decisions. The lesson is not that we should retreat into the world of philosophy, where conditionals are the currency. Indeed, the opposite is the case. Medical ethics needs the courage to make difficult decisions and put forward concrete recommendations, even in the face of fallibility.
When experts who are in positions of power embrace a sort of “pragmatic agnosticism” regarding rationing decisions—“pragmatic” because this agnosticism is more of the expedient than of the deeply held variety—these rationing decisions do not thereby disappear. Rather, they are offloaded onto others who are often in much worse positions to make such decisions. Bedside clinicians faced with a critical care resource shortage, for instance, can hardly be expected to ignore the immediacy of their own patients’ needs and adjudicate the demands of the whole system. Such a process is fraught with implicit bias. It also risks eroding the trust relationship between a provider and her patient. Moreover, forcing clinicians to engage in beside rationing is not only an injustice to patients who may receive unjust allocations of treatments, but also a grave moral injustice to clinicians, who become responsible for making calls they are not equipped to make and thus should not have to make. And yet, while the pandemic was raging in the United States, there were reports of clinicians forced to make *ad hoc* bedside rationing decisions, due to a reluctance to implement so-called “crisis standards of care,” where formal rationing protocols are set into action. These included *ad hoc* decisions regarding how to allocate time, staff, and equipment such as dialysis machines. Butler et al\(^\text{13}\) describe how “even before a declaration of crisis capacity, clinicians encountered varied and sometimes unanticipated forms of resource limitation that could compromise care, require that they make difficult allocation decisions, and contribute to moral distress.” It also included case-by-case decisions regarding whom to admit to a hospital or whom to accept as transfers when beds, staff, and equipment were running critically low.\(^\text{14-17}\)

The offloading of responsibility in medicine is a phenomenon that extends beyond rationing in a pandemic. Paternalism was once the standard approach in clinician-patient relationships and its demise over the past decades has undoubtedly been a good thing. However, as others have
observed, the reigning focus on patient autonomy risks becoming fanatical.\textsuperscript{18,19} When a medical provider merely catalogs medical facts and declines to make treatment recommendations on the grounds that she wants to preserve her patient’s autonomy, while also recognizing that one option is preferable to another for the patient, then this does nothing to support the patient’s autonomy. Rather, it offloads the responsibility of decision-making onto someone who does not have the benefit of many years of medical training and experience, and who is not equipped to evaluate the benefits and burdens of various option.

Public health authorities and government bodies have similarly off-loaded decision-making responsibility onto parents of young children during the pandemic. For example, throughout, parents have been given little official guidance on whether sending their children to daycare is recommended, and instead are exhorted to “weigh the pros and cons” of exposing their children and family members to COVID-19, facilitating children’s social development, and being able to continue working, in the context of a rapidly evolving, once-in-a-generation epidemiological situation.\textsuperscript{20} (As a comparison, in Germany, governments instituted a tiered system that coupled the level of operation of day care centers to local caseloads, dynamically adjusting these tiers as new data became available.\textsuperscript{21}) Even now, as anyone 12-years and older can be vaccinated, guidance for unvaccinated young children, particularly those under 2 years, is lacking. Parents are told unhelpfully that while severe illness in children is rare, it is serious.\textsuperscript{22} Seemingly, the expectation is that parents, stretched thin by the dual roles of full-time childcare provider and full-time employee, should also obtain a degree in epidemiology.\textsuperscript{23,24}

It is true that even experts, such as medical ethicists, medical providers, and public health officials, in possession of the best available data, with the best tools and abilities to glean meaning from such data, do not know with certainty whether one recommendation is preferable
to another. But this does not absolve those experts from throwing their doxastic weight behind
the best recommendation available at the time. The alternative is that not only do they condemn
less well-informed individuals to potentially worse courses of action, they also place the
responsibility of identifying these courses of action onto individuals who are worse equipped to
discern them.  

**Taking Responsibility**

Of course, this call for experts, such as medical ethicists, to take greater responsibility must
include 3 crucial aspects. First, the body of experts must itself be diverse, and processes must be
equitable and inclusive. For too long, the dominion of decision-making, in medical ethics and
elsewhere, has been concentrated amongst White males.  

Moreover, decision-making must
include robust, representative community input. Only by embodying diversity at each step of the
decision-making process will decisions have legitimacy. Second, the decision-making process
must be transparent. The clout of decisions and recommendations will derive from whatever
powers are vested in the expert body, but their legitimacy stems from the principles, facts, and
reasons upon which they are grounded. As such, the justifying principles, facts, and reasons must
be accessible to anyone who wishes to examine them. Finally, we must embrace the
normalization of fallibility. Complex situations like pandemics and medical states are many-
headed hydraz; no sooner has one adversary been neutralized than two more appear in its stead.

With COVID-19, the clinical and public health circumstances are constantly developing, thus
demanding updated recommendations. Only if we normalize the expectation that the
recommendations are the best that are available *at the time*, and that they may change in the
future, is the public likely to trust them.
Conclusion

Medical ethics, unlike pure philosophy, is not well-served by remaining in a world of conditionals. Rather, like medicine and public health, it has an obligation to embrace assertion, even when such assertions may well turn out to be wrong. Blind spots and errors should be fended off by ensuring diversity and inclusivity of the decision-making body. Moreover, transparency and robust community engagement are crucial for the legitimacy of decisions. When the decision-making process is grounded in legitimacy, medical ethics must have the moral courage to embrace fallibility.
References


