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RESEARCH ARTICLE

Flattening the Curve of Moral Imagination

Ondřej Beran*

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Abstract: In this paper, I discuss some moral dilemmas related to the COVID-19 crisis and their framing (mainly) in the public debate. The key assumption to engage with is this: that we need primarily to take into account the long-term economic consequences of the proposed safety measures of social distancing. I argue that the long-term economic concerns, though legitimate, cannot suspend the irreducibly moral nature of the demand placed on the decision-makers by those who are vulnerable, at risk, or in need of medical treatment. This is discussed in relation to two points: 1) The political endeavour and rhetoric of "flattening the curve" is not necessarily short-sighted, but expresses the acknowledgment of a legitimate expectation placed on elected representatives. 2) Not being able to prevent harm (to those who are in real need, or otherwise vulnerable) may lead to a genuine moral distress, even if it is not clear whether it was in one's, or anybody's, powers to prevent the situation, or even if the best possible outcome has been otherwise reached. The second point may be understood as a part of the broader context of the established criticisms of utilitarianism.

Keywords: COVID-19 crisis, economic concerns, moral dilemmas, moral luck, remorse.

* University of Pardubice
https://orcid.org/0000-0003-2553-5872
Centre for Ethics as Study in Human Value, Department of Philosophy and Religious Studies, Faculty of Arts and Philosophy, University of Pardubice, Stavařov 97, Pardubice 532 10, Czech Republic.
ondrej.beran@upce.cz

Introduction

The surge of COVID-19 in spring 2020 caught many countries unprepared. Or, more precisely, the character of its spread, along with not always transparently distributed information and not always smooth international coordination, made it practically impossible for most countries to be "fully" prepared.

During the first weeks of the outbreak in the European countries and the U.S., the measures taken aimed at the effect described by the phrase that has rapidly become popular: "flatten the curve." These measures sought to slow down the increase in cases of COVID-19 so that the capacities of healthcare systems would not be overwhelmed.

There were various predictions of the clash between the expected progress of the epidemic and the real capacities of healthcare systems. From the outset, there were reported cases of healthcare facilities being overwhelmed. The reports also assumed that some patients may have died while not getting all the necessary treatment. Relatedly, medical authorities and healthcare workers needed to practise emergency triage, prioritising those patients who had better prospects of recovery.[1] Mostly, these were younger and less afflicted patients.

The underlying logic of this reasoning is straightforward: distributing medical capacities and material in such a way that would save as many lives as possible. At the same time, medical personnel could not fail to see that many who could not get access to ventilators or other medical material that was in scarce supply were in danger. The standard options of treatment would have increased their chances of recovery, though less than for those patients who were given priority. Although this practice of providing healthcare and making such far-reaching decisions in real time, under extremely difficult conditions, has been complex and far from straightforward,

[1] See, for example, Jason Horowitz, "Italy's health care system groans under coronavirus—a warning to the world," *The New York Times*, 12 March 2020, https://www.nytimes.com/2020/03/12/world/europe/12italy-coronavirus-healthcare.html; or Sam Jones, "Spain: doctors struggle to cope as 514 die from coronavirus in a day," *The Guardian*, 24 March 2020, https://www.theguardian.com/world/2020/mar/24/spain-doctors-lack-protection-coronavirus-covid-19.

it is often understood as a form of applying roughly utilitarian reasoning. Many have understood the triage practice during COVID-19 pandemic as a case in point. This practice purportedly illuminated the fact that the problems before which the pandemic was placing us centred round the principle of saving as many lives as possible.

Perhaps the most (in)famous philosophical reply to the pandemic was Giorgio Agamben's short critical point against the wave of societal restriction and social distancing regulations, which he views as an illegitimate form of "biopolitics."[2] However, philosophers reflected also the above aspect of the COVID-19 crisis. This interest is quite natural, as the triage practice points towards difficult moral dilemmas.

I will focus here on this latter angle of philosophical interest in the situation, in particular on related criticisms of the social distancing regulations, backed by different reasons than Agamben's. As the point of departure for my discussion, I would like to use H. Orri Stefánsson's (2020) particular reading of this medical dilemma. In section 1, I summarise the parts of Stefánsson's argument that are relevant for my discussion. I then raise some objections, in two directions. In section 2, I argue that some strawman elements partly compromise Stefánsson's criticisms of what he takes to be common moral reasoning about the COVID-19 crisis. In section 3, I present a more general reflection on the crisis, beyond criticising closely Stefánsson's position only. I will strive to show that the crisis represents a different kind of moral problem, relating to issues of remorse and moral injury. Section 4 offers a few concluding remarks.

Stefánsson's paper is unusual in that it represents a philosophical articulation of sentiments and attitudes relatively common among "laypeople," including high-profile authorities and opinion-makers. However, as far as

[2] Agamben (2020); Castrillón and Marchevsky (2021) assembled an interesting critical discussion about this piece. Žižek (2020a, 75) succinctly points out that while we may rightly be suspicious about some forms of social control inherent to the pandemic regulations, this suspicion "does not make the reality of the threat disappear." Later on (Žižek 2020b, 28f), he notes that Agamben's criticisms offer little to distinguish themselves from the populist new Right. He argues that Agamben missed the chance to say anything about the new forms of inequality, the situation of workers or precariat, or about the current forms of capitalism.

I can see, distinctly *philosophical* articulations of this position are rare to meet. In itself, Stefánsson's argument represents a particular and perhaps somewhat crude version of the utilitarian reading of the pandemic. It is *a* version, not necessarily something any utilitarian would subscribe to. After all, it has turned out that various utilitarian analyses of the Covid-19 crisis lead to very varied recommendations. The two distinct utilitarian ideas that find a particular expression in Stefánsson's paper are the following: 1) We should be worrying about the long-term results of the adopted regulations. There is, or has to be, an objective way of calculating these results, such as applying the metric of QALY (Quality-Adjusted Life Years). These calculations of the maximisation of the overall good have an unmistakeable economic dimension. 2) This calculation covers, more or less, the range of all the meaningful or legitimate moral worries regarding the pandemic. If we take any other kind of concerns, reaching beyond the need to identify and apply such an impartial principle, as *moral* concerns, it is a confusion.

These two points are the object of my critical focus, though not in a way neatly falling apart into separate sections. I will not be arguing straightforwardly against 1); I do not aim to present a refutation of utilitarianism here. My critical comments will concern rather some neglected difficulties relating to the identification of the good results. My truly central target is the tacit assumption 2).

Stefánsson's arguments are illuminating in how straightforward and clear-cut they are. They also represent a characteristic feature of the current debate.[3] Their examination may thus bring us a relevant insight reaching

[3] As suggested before, the above-referred "debate" is generally public, rather than specifically philosophical. Thus, for instance, two former governors of the Czech National Bank predicted that the losses of the domestic economy, caused by the protective measures, will be ten or more times higher than is the aggregate cost of the QALYs (within the Czech healthcare system) of the lives saved. See https://archiv.ihned.cz/c1-66738020-byvali-sefove-cnb-tuma-a-hampl-nechame-v-zajmu-ochrany-zivota-umrit-celou-ceskou-ekonomiku. Such simulations are made worldwide; e.g. Amewu et al (2020), who voice similar concerns. Gans (2020, chapter 1) provides a critical review of many such accounts of the COVID-19 crisis. There are, however, philosophical voices close to Stefánsson's position in some respects, for instance, Savulescu et al. 2020, Singer and Plant 2020, or Williams et al. 2021. From a position close to mine, Gaita (2020)

beyond this particular individual analysis of the COVID-19 situation. At first, I stick closely to particular points made by Stefánsson, which makes parts of this text a polemic directed specifically against him. However, he voices arguments and intuitions that are not unique or eccentric. I believe that it makes the criticisms I raise relevant also beyond the context of the one particular paper.

1. Stefánsson's argument

In his paper "Three Mistakes in the Moral Reasoning About the Covid-19 Pandemic," Stefánsson argues that moral reasoning about the current crisis is burdened by several problems. He notes that he is not criticising the motivations of the actual measures taken, for it is difficult to gain their overview, but rather the fallacies to which the common moral framing of the situation is prone. He explores what he takes to be the main three problems. First, he sees a fallacy in the idea that difficult choices and trade-offs in decision-making both individual and public can be avoided if the right kind of precautions are taken in time. The dilemmas faced by overloaded medical facilities and healthcare workers serve as the example motivating the flawed reasoning. Second, he identifies the mistaken temptation to bypass democratic mechanisms in making the important decisions and to delegate these to experts. Third, he warns against an incoherent application of the precautionary principle. He suspects that measures taken in order to stop the spread of the coronavirus may have such drastic effects for societies and economies that the results would be even worse than those caused by the pandemic. I will focus here mainly on the first of Stefánsson's worries. I agree with much of what he says about the second, and his analysis of the third is a bit sketchy and partly repeats the points he makes in the first section.

offers a philosophical reply to voices in the public debate in Australia. Gaita also observes that the kind of utilitarianism that we find only rarely in a clear form in philosophy has a special attraction for non-philosophers, when they learn about it as a theory. As he says, "[t]here are hardly any strict consequentialists, but many people are vulnerable to believing that they should be."

Stefánsson opens his discussion by rephrasing what he takes to be the principal motivation driving the endeavours to flatten the curve: "a commonly stated reason for why we should spread out the burden on the healthcare system over time, namely, that it would allow us to avoid making hard trade-offs" (Stefánsson 2020, 4). He is critical of the persistent temptation to picture these hard trade-offs as something that can be avoided. People tend to think, he says, that if matters are organised better, we won't have to choose whom to treat and whom not. No scarcities of human or material resources in healthcare would then have to occur. He is sceptical about this. More importantly, he identifies some of the public pundits, commenting indignantly on the perceived need to "choose whom to save and whom not to save," as inappropriately moralistic. Speaking ostentatiously about this misconstrued moral problem only obscures the urgency of the real problem, as he sees it.

Stefánsson's argument does not engage directly with the question of how to perceive the unfortunate choices faced by healthcare workers. He wants us, instead, to stop glossing over the inevitability of making such choices. For another, and graver, instance of such a choice is inherent to social distancing and other safety measures. These measures aim at 1) protecting lives now, which would otherwise be lost to the disease, but 2) taking these measures will cause a harmful economic impact in the future. Social distancing measures will necessarily slow down the economy, which will in turn result in a worsened quality of life and the deaths of even more people.[4] Stefánsson illustrates this risk by citing statistics about the various degrading social effects caused by the last economic depression. As he argues, we can anticipate an analogous development in the wake of the coronavirus crisis.

Stefánsson criticises the hypocrisy of people indignant about the need to make a choice between the lives of COVID-19 patients, while overlooking that other lives will be taken in the long run. The problem responsible for this mistaken reasoning is, in his view, that the latter victims are at present unidentified and unspecifiable (cf. also Savulescu et al. 2020, or Singer and Plant 2020). However, the need to think over a considerably longer time

[4] Singer and Plant (2020), or Savulescu et al. (2020, 626) expressed similar concerns.

span and a considerably more ramified interconnection of social phenomena makes the task of taking the current health safety precautions *responsibly* (with respect to the future) hard. In fact, it is harder than the supposedly hard trade-offs faced by healthcare workers distributing their overstretched capacities. For healthcare workers have, as Stefánsson concludes in this argument, at least some criteria helping them to navigate such decisions: for instance, the metric of Quality-Adjusted Life Years, or QALYs (cf. MacKillop and Sheard 2018).[5]

2. Avoiding the "hard trade-offs"

The primary worry underlying section 1 of Stefánsson's discussion (on "hard trade-offs") is how the *economy* will be affected. The decision to take measures aimed at flattening the curve is, for him, the "decision to almost completely shut down [national] economies and force people to stay indoors." He points out that this decision was not even supposed to reduce the overall number of infections, but only to spread it over time so that *at no point* would healthcare systems become overloaded.

None of the few sources referenced by Stefánsson talks, however, explicitly about this ideal scenario. One of these, Specktor (2020), characterises the aim of the curve-flattening measures as follows: "A slower infection rate means a *less stressed* health care system, *fewer* hospital visits on any given day and *fewer sick people being turned away*" (my emphasis). This is a realistic suggestion of reducing the burden, rather than a way of securing the outcome that "all can get the treatment they need," as Stefánsson puts it (Stefánsson 2020, 5).[6]

[5] Stefánsson characterises QALYs as a "well worked-out framework," though "not uncontroversial." For general criticisms of the QALY metrics, see e.g. La Puma and Lawlor 1990, or Marra et al 2007. In reply to the way in which QALYs were alluded to in Australian public discussion about COVID-19 ("we must 'apply scientific rigour' to the questions that 'everyone is skirting'"), Gaita (2020) stresses the risk that this metric represents for instance in the case of disabled people.

[6] An additional factor contributing to the overload is the insufficient funding of many countries' public healthcare systems. The present situation thus calls for making amends in this respect. Notably, Stefánsson classifies the present state of

For sure, only a few government officials would openly admit to the public that they expect the healthcare system to overload and people to be left to sicken or die without the full extent of needed treatment. Most of the statements they issued, whether specific or vague, thus suggested that everybody *would* get the necessary treatment. In that respect, Stefánsson's critique is perhaps right. These statements sometimes indeed evoked the "thought that we can somehow *avoid* making hard trade-offs." The "hard trade-offs" were *not* avoided, and whether they could be, in the chaos of the first weeks and months of COVID-19, will remain unclear.

I am less sure, however, whether any proclamation presenting the endeavour to avoid these trade-offs as worthwhile is a mistake in moral reasoning. In fact, the rhetoric adopted by most[7] governments was acknowledging the *legitimacy* of the expectation that they would endeavour to fight health system overload. This is a part of their responsibility to the public. A politician can hardly openly act as if indifference, or even placidity, about letting such trade-offs happen is consistent with how we understand the political representation's answerability to the public.

If political systems cannot operate on the *expressed*, if symbolic, assumptions of such goodwill on the part of politicians and trust in this goodwill on the part of voters, they will be affected in ways difficult to predict. Obviously, under particular difficult circumstances politicians may fail to represent their citizens' interests in obtaining urgently needed healthcare. Sometimes they indeed fail due to not trying hard enough, or even due to laziness or corruption. However, they can hardly be thought to represent the citizens' interests by *subscribing* to any *principle* that says it is perfectly all right not to care about representing the interests of *some* citizens.

Gaita (2004, 23ff) makes a similar point about the role of *lying* in politics. He argues that while politicians must not aspire to be saints, moral

healthcare systems in developed countries as already "ever-expansive" and therefore effectively unaffordable.

[7] A notable exception may be the former PM of Australia, Tony Abbott, who suggested that it might be better to "let nature take its course" ("'Assess value of life' of elderly coronavirus patients when reintroducing lockdowns, urges Tony Abbott," *The Independent*, 2 September 2020, https://www.independent.co.uk/news/uk/politics/tony-abbott-coronavirus-australia-covid-old-cases-deaths-a9700881.html).

values, shaped also by the concern for what saints represent in our culture, impinge on politics. Thus, though such beliefs, that no person should be treated only as a means, but always as an end in itself, "are problematic in politics, (…) at crucial points they inform it" (Gaita 2004, 25). Similarly, it may be an impossible task for politicians in the time of COVID-19 to organise the provision of healthcare in such a way that every single patient is treated as an end in itself. Yet, they must not start acting as if the experienced impossibility itself renders such concerns irrelevant, dismissed. Placing long-term economic concerns first amounts to reducing some individuals, here and now, to the *means* to other ends.

(I do not aim here at the disentanglement of the structures of trust, important for the very understanding of politics, from ubiquitous political marketing. I assume that particular cases of political decisions typically represent a complicated and inseparable mixture of both, which does not mean it is the same thing, though.)

Stefánsson also quotes (Stefánsson 2020, 5) from a radio debate in which the host asked a member of the Swedish National Council on Medical Ethics whether it is possible that Sweden will face this kind of medical dilemma. Stefánsson does not record the doctor's answer and focuses instead on the tacit assumption he saw in the host's question: that we *can* manage to avoid these hard trade-offs. He seems to dismiss the legitimacy of asking such a question in the time of a pandemic. It is reasonable to ask the question, for there are many different ways of elaborating on the issue. Stefánsson's argument *is* one of them. He himself would probably appreciate an opportunity to be asked the question and to present, in reply, his concerns and worries to the wider public. Moreover, the host's question does not necessarily make the underlying assumption that Stefánsson reads into it. It is possible simply to ask whether a situation that raises legitimate moral worries and that seems looming is likely to happen, by expert estimate.

Apart from the literally taken idea that we can avoid difficult medical dilemmas altogether if only we flatten the curve appropriately, the public debate, according to Stefánsson, exhibits another flaw in the presented moral framing of the COVID-19 crisis. He argues that the truly hard trade-offs are not, as is usually assumed, between differently afflicted patients here and now. Instead, he emphasises the trade-offs between the

present estimable victims of the pandemic and the future victims of the economic depression that the health safety measures will cause.

He phrases his polemic in terms of rehabilitating the standing of the future victims in a debate that overlooks their relevance. However, he does so in a way that suggests preferences of his own. Thus, he says that while some lives "will *or might* be saved" by the present measures, other lives simply "*will* be affected by the economic depression" (Stefánsson 2020, 6, my emphasis). The depression, by the way, was not only predicted but "already starting" (in Spring 2020). He also presents this prediction of the long-lasting and intergenerational effects of the depression as a *plain fact*. The prediction relies on an extrapolation of findings about past socio-economic relationships into, presumably, an inevitable future.

This bleak deterministic view apparently presumes that human societies cannot learn from past crises or react to repeated difficulties in ways that differ from the previous cases and prevent or mitigate more harms. It allows Stefánsson simply to measure, by the same scale, the prospects of people likely to die, here and now, if they don't get adequate treatment, and the prospects of people not yet born. The latter are in the same sense and with the same probability likely to suffer from the results of the present depression. Apart from his *certainty* of future victims, he also makes the equation between victims affected directly and *intentionally* and victims affected indirectly, in consequence of another action. Stefánsson phrases this difference as the one between victims known (identified) and unknown (unidentified), claiming that the principal reason for the apparent preference for the former is simply that they are known. However, he continues, "it should make no moral difference, all else being equal, whether a person is identifiable or not" (Stefánsson 2020, 7).

In these considerations, there seems no room left for taking into account the complex phenomena discussed under the heading of "double effect." As, for instance, Anscombe argues in her classic paper "War and Murder" (1981, 58f), there are morally relevant differences between negative effects directly and intentionally caused and those that are foreseeable as a further effect of one's action, which is, however, led by a different intention. If foreseen consequences are just as relevant as what one intends to do, here and now, then there is nothing, Anscombe argues, that would be morally prohibited as

simply wrong as such. Not even murder is. Everything is subject to a possible requalification, measured by its potentially graver consequences in the future.

Gaita (2004, 55ff) presents an argument similar to that of Anscombe, with *torture* as the focal case. He claims that when sometimes one needs to commit evil to avoid greater evil, it is important to retain the sense that even the lesser evil is still evil, often grave. On the other hand, some utilitarian arguments tend to assume that what is necessary cannot be evil. This relegates any remaining sense of worry to the merely *psychological*, rather than the moral. Not only has this trickery of rational arguments (as Gaita sees it) managed to re-establish torture as a legitimate topic for public debate. It has also rendered it impossible to distinguish between the rational dispelling of prejudices and the moral corruption of losing from sight why something used to be morally unthinkable. This is, however, not just a local flaw of moral reasoning, as Anscombe pictures it, but—in Gaita's view—an established conception in its own right, taking morality as "an adaptable set of rules and principles that serve a purpose" (Gaita 2004, 58).

How does this illuminate Stefánsson's classification of "hard trade-offs" and their avoidance? It may seem horrible deliberately to allow for such a situation in society, which would entail the overload of the healthcare system and the need to leave some patients without treatment, or to let elderly people die in nursing homes. However, this assessment could never hold absolutely. It would always be an initial, tentative assessment, awaiting its possible requalification by other considerations. For Stefánsson, the true task of difficult moral reasoning seems to consist in tracing and considering options of this requalification.

There is a hint of sad irony about his call for equality between victims, though. The burden of the pandemic already lies more heavily on more vulnerable population groups. The elderly, the already ill, or poor people with worse access to healthcare and/or riskier employment situations suffer more gravely. Compared to the identified vs. unidentified distinction, Stefánsson seems to disregard this latter kind of difference between the various kinds of victims of the pandemic.[8]

[8] Reid (2020, 526f) suggests that issues of increased social or racial injustice are a blind spot in phrasing the pandemic counterstrategy in terms of maximising medical outcomes.

As we indicated, Stefánsson takes almost for granted the predicted economic consequences of lockdown and social distancing. However, as the pandemic was progressing, new evidence kept emerging. Not only the unregulated progress of the pandemic, but also insufficiently regulated progress proves to have more drastic consequences for societies and economies than strict lockdowns.[9] The temporary gap in industrial production, travel, etc. also resulted in (sadly, also temporary) improved levels of air and water pollution. The COVID-19 crisis motivates also more long-term considerations of restructuring economies towards a greener and more sustainable shape. In the long run, the pandemic thus may also have positive consequences for the economy, which does not enter Stefánsson's discussion. Nor does he take into account our current lack of understanding of the disease and its effects. It may turn out that those who have contracted it but survived will suffer some permanent health effects. These would again represent a factor influencing the future load on healthcare systems and, by that, on the economy. The long-term damage done to the texture of society—high numbers of healthcare workers quitting their jobs, the eroded trust of citizens in the competence and good will of their governments—needs to enter our considerations as well. Stefánsson's ambition to present a more complex reply to naive reflections thus appears itself insufficiently complex.

Oddly enough, Stefánsson also refuses to see the particular character of the situation of represented by the pandemic. Its impact on a society is

[9] Horton (2020) presents an overview of different strategies implemented by various countries, concluding that the more hesitant they were about applying strict social distancing measures, the graver were the consequences. Even mitigation ("flattening the curve") did not prove to be an efficient enough strategy. Analogously, Correia et al (2020) argue that, learning from the case of 1918 flu pandemic, there is a false dichotomy: by saving lives we are saving the economy, while the most disruptive factor for the economy is the epidemic itself. Even economic analyses presented in rather technical terms of "the value of a statistical life" suggest that "extreme measures are warranted" (USC economists Mireille Jacobson and Tom Chang for *STAT News*, 18 March 2020, https://www.statnews.com/2020/03/18/economic-rationale-strong-action-now-against-coronavirus/. This overview shows that while it is legitimate to worry about long-term consequences, predictions of consequences vary. Correia's argument, practically a counterargument against Stefánsson, is utilitarian, too.

overwhelming in a way similar to natural disasters. When an earthquake or a hurricane hits a country, the hospitals, firefighters, army, police, and other institutions simply do all they can to save all the people they can. Nobody really asks whether all these expenses might not cause even worse (economic) damage in the future. The reason is not that such calculations would not be possible, but that they are misplaced. That many people do not consider them misplaced in the COVID-19 case is a peculiar feature that the pandemic seems to share with the climate crisis. Certainly, we cannot overload the analogy between natural disasters and the pandemic. The latter is a long-term phenomenon. Short-term calamities usually provoke, after the initial shock, the spirit of solidarity and volunteering, but this drive naturally fades with time and cannot sustain the burden of a long-term hardship by itself. Let us not forget, though, that the ideas about economic caution were accompanying the pandemic from the very beginning, when it was not altogether sure, how long COVID-19 would remain here.

Overlooking the reasons why concerns such as Stefánsson's may sometimes be misplaced has to do with thinking about the nature of dilemmas in medicine in one-dimensional terms. I will discuss this in more detail in the following section.

3. Moral dilemmas and remorse

In the previous section, I tried to show that, at some points, Stefánsson seems to attack straw men. Here, I would like to look a bit more closely at one of his assumptions, which is, I believe, characteristic of a more general problematic tendency of reflecting on medico-ethical issues. Stefánsson keeps repeating that the alleged motivation for flattening the curve is the ambition to prevent the hard trade-offs in healthcare altogether. He attributes this ambition to some shortsighted, superficial moralism. Instead, he presents the true moral concern as proceeding in, as it were, organisational terms: it would be bad to get into the situation where healthcare workers would have to make the choice between patients, *if under different and more cautious arrangements it could have been avoided*, without causing more damage elsewhere. But, as it probably cannot (as he suggests), any further moral concerns implode.

What we have here is a rather familiar approach. The choices we make in relation to COVID-19 (just as elsewhere) and their underlying concerns centre round the ambition to identify and bring about the best possible scenario. If the decision-makers can reach such a scenario, they would have "clean hands" and no reason for regret or remorse. The reason is that the objectively best outcome simply is *the good outcome*, and it is unintelligible to question, criticise, or regret anything about *the good outcome*. Then, the only moral worry would be to consider whether government strategies have opted for the good outcome. For those who think of the crisis in terms similar to Stefánsson, the governments *have not*, prioritising the shorter-term effects of social distancing.

Some of my concerns presented in the previous section relate to my doubts as to whether Stefánsson identifies correctly the best aggregate result. Here, I will be more interested in the assumption (not only his) that the best aggregate result is the good outcome in the sense that it rules out intelligible remorse. If this logic held, nobody would need to blame themselves, if the need to choose between patients really has been unavoidable. Nobody would need to blame themselves, even if they *caused* a higher frequency of such situations, if only it was to prevent objectively predictable worse consequences in the future.

But consider the following: when one gets into a situation where one has to make such a choice, it is understandable that one feels blame for making *any* available decision. She feels the blame simply by virtue of *having to* make this decision. Even if such an overloaded healthcare worker has merely done what most other of her colleagues probably do, too, and for relevant reasons (triaging in favour of patients with better prospects), this does not make the self-blame unintelligible.[10] If the need has been, in better-handled circumstances, avoidable or less urgent, it adds a further shade of outward-oriented anger or bitterness to one's feeling of remorse. But it does not remove the remorse just because it is not the person oneself who was primarily responsible. Gaita (2006, 43ff) presents the analysis of an analogous

[10] Cf. the interview with Cynda Rushton (Professor of Nursing Ethics at Johns Hopkins University) on the moral distress endemic among nurses during the COVID-19 crisis; *The Hub*, 2 April 2020, https://hub.jhu.edu/2020/04/06/covid-nursing-cynda-rushton-qa/.

kind of remorse, using the example of a Dutch woman during wartime who had to refuse shelter to Jewish fugitives (who were eventually caught and killed), in order to not threaten the anti-Nazi resistance plans in which she was involved. Her take on her own actions, as reported by Gaita, is remarkable: it made her hate Hitler even more because he had made her a murderer. We can understand this as a case of what was later called "moral injury": a transformation of the person that makes her, though under the pressure of circumstances, incapable of imagining herself as a morally good person (cf. Wiinikka-Lydon 2019, 36f, 155f). Cases of moral injury show that the relationship between a tragic concurrence of events that one could not really influence and blame and remorse is very complex. Only an impoverished moral reflection would content itself with a picture of human life in which there is no room for tragedy or bad moral luck (cf. Williams 1981).

The characterisation of the moral dilemmas of COVID-19 crisis *exclusively* in organisational terms relies on neglecting an important underlying distinction. One thing is the practical, implicit need to practise triage in the real time of treatment. Under the extreme circumstances of the COVID-19 crisis, this involves treating some patients less than fully and appropriately. Another thing would be a moral *principle* stating that this is a right thing to do, as a *rule*, in order to meet the objective purpose of healthcare and medical ethics.

Applying widely the latter kind of approach seems a noteworthy aspect of *some* forms of utilitarian thinking. Undoubtedly, medical ethics benefits from identifying widely applicable general principles and procedures, which aim at maximising the number of surviving and recovered people. However, that does not mean that this is *all* that moral reflection needs to take into account in cases of medical dilemmas. Suggesting that the guilt and regret that healthcare workers experience are not moral, but psychological (neurotic) concerns is a serious misrepresentation. The purpose of finding the applicable principles and procedures is not to *dismiss* emotional responses of the moral kind to particular cases as irrelevant.[11]

[11] Utilitarian framing of medical issues sometimes gravitates towards this view. Savulescu et al (2020, 626) characterise utilitarian recommendations related to COVID-19 as beneficial in that the position from which they appear counterintuitive

However, focusing on the level of a universally applicable principle and reflecting on the pandemic only in organisational terms flattens our moral imagination in certain respects. The organisational approach requires having a metric that will allow us to make far-reaching comparisons between people, based on an empirically measurable quality. Hence the entry of QALYs. This metric allows us to assess objectively, from the *impersonal* or *third*-person standpoint, measures targeting differently various group of people, *other* people.[12] The deepest problem lurks, expectably, in the claim of the *empirical measurability* of the "quality of life." As Gaita (2020) argues, "the quality of life" is rather a first-person expression of the individual's insight. Certainly, healthcare workers have had and will continue to have to practice triage, but the principle of who yields to whom differs in how it sounds, depending on who is voicing it. It makes a big difference whether it is the person herself, who consents not to be put on a ventilator,

and *which they make possible to avoid* consists in "psychological biases," "heuristics," emotion, or intuition. An interesting example from the Czech debate about COVID-19 is the expert overview and recommendation written by a team of ethicists and legal theorists (Černý et al. 2020). The paper contains many valuable insights and information, and for natural reasons it confines itself to the highly needed identification of the appropriate principles of the allocation of scarce resources. Yet, the rationale for this endeavour does not concern only action guidance itself. The authors also perceive the importance of being capable to show and justify that the physician's decision "is not random, can be rationally understood and analysed, is transparent" (Černý et al. 2020, 6). As they say, this kind of transparency "bolsters, rather than undermines the trust of the society" (Černý et al. 2020, 8). Underlying is the worry that healthcare practice guided by anything else than such general principles would be "random" in an unacceptable manner, or at least that the public would suspect that. I am not sure to what extent this is true, or inevitable.

[12] From this perspective, Savulescu and Campbell (2020) suggest selective lockdown of the elderly, saying that "the benefits to others are so significant as to outweigh the loss of liberty." Lawrence and Harris (2020) criticise their proposal, pointing out the special kind of vulnerability of the elderly who are likely to suffer in ways incomparable to younger age groups. They summarise their critique by saying that "[e]quality is not about equal misery but about giving equal concern, respect and protection to all."

whether she is phrasing it as an observation about her particular case only, and so forth.[13]

Such and similar worries about the kind of reasoning that motivates the application of QALYs point towards the benefits of rethinking carefully the standing of the far-reaching, general principles. In their critical assessment of the QALY measure, La Puma and Lawlor (1990, 2920) make the following observation:

> While utilitarianism may be an acceptable ethical theory with which to make health policy at the macro level, at present, clinical practice is not primarily conducted to benefit society as a whole, the public interest, or the common good. The physician's primary duty is to meet the patient's medical needs as they together find them, the physician with technical knowledge and expertise and the patient with his or her personal history and values. Conserving society's resources is secondary or tertiary; if such conservation is brought about by considering some patients expendable or by serving opposing masters of patient and society, the seemingly imminent role of public agent must be acknowledged, appealed, and refuted.

This sheds some light on the mischaracterisation of the situated healthcare practice under stress as a matter of a rule. A macro-level rule, relevant for policy-making, is necessarily a part of the system of many counterbalanced macro-level rules of policy-making. Economic criticisms legitimately deal with

[13] Gaita's commentary goes as follows:

> Were I, now 74 years old, in a hospital and told that I could not be put on a ventilator because it had to go to a younger person, I would consent to it. I would not think of this as "above and beyond the call of duty." For me this is ethically a no-brainer, which does not mean that I believe that anyone in a similar situation should think as I do, including the young person who would get the ventilator. Certainly, I would not respond graciously if they said, "Good on you, old man. You've made the right decision, impersonally considered. You've done your civic duty in this time of critically scarce resources." If they were to add that just by looking at me they could tell that my time-quality rating must be low, I would snatch the ventilator from them.

this level.[14] However, any picture of healthcare, provided by particular doctors, nurses, and other medical personnel to particular patients, as practice either *following or failing to follow this rule* misses something. If one is motivated, in her treating of individuals as individuals, by concerns inherently directed *not* to individuals, it compromises the resulting attitude. Healthcare workers were properly worried about their capacities to treat their patients appropriately, including ensuring their own safety, which was a key factor in this consideration. Healthcare workers worrying about whether the extent of care they provided to their patients was not excessive and as such detrimental to the public economy must have been rather rare during the COVID-19 crisis. Stefánsson's discussion relies on 1) presenting these two worries as fundamentally of the same kind, which would thereby allow 2) to compare their relative significance, and which would then allow him 3) to proclaim the latter as graver.

Some commentators on the COVID-19 crisis considered ideas of the kind of 3) as outrageous;[15] in a sense, I agree. However, the original confusion may

[14] Utilitarianism may be the most common approach at the macro-level of reasoning about resource allocation, but it is not without alternatives. Perhaps the most important competitors are the various forms of egalitarianism, such as that of Daniels (2001). Reid (2020) questions the assumption that applying utilitarian principles in the case of COVID-19 pandemic would even represent the current medico-ethical consensus.

[15] Not only philosophers or religious thinkers, but also economists. In his essay "The Dismal Kingdom" (*Foreign Affairs*, March/April 2020), the Nobel prize-winning economist Paul Romer deplores the ubiquitous reliance on economists as the principle decision-making source in matters of policy. He agrees that we cannot afford to "kill the economy" altogether (see e.g. his and Alan Garber's opinion article for *The New York Times*, 23 March 2020, https://www.nytimes.com/2020/03/23/opinion/coronavirus-depression.html). Yet, in "The Dismal Kingdom" he observes that

> [u]nfortunately, asking economists to set a value for human life obscured the fundamental distinction between the two questions that feed into every policy decision. One is empirical: What will happen if the government adopts this policy? The other is normative: Should the government adopt it? Economists can use evidence and logic to answer the first question. But there is no factual or logical argument that can answer the second one.

His conclusion is that

lie in 1). That healthcare workers worried predominantly about providing treatment to their particular patients was not a sign of their having compared the two worries with a different result than (some) economists. They simply refused to acknowledge the worry about the future prospects of the country's economy as their own, inherent to their work as they needed to do it, and rightly so (cf. a similar argument made by Cowley [2008, 82ff]).

Once we have removed this worry from the picture, it turns out to be natural to rephrase the framing of the concern, as suggested at the end of the first paragraph of this section. Now, it would simply proceed in these terms: *whether or not* the need to make the choice between patients could be avoided (who knows), getting to that situation is simply bad as such. When the public was asking themselves or experts and politicians the questions about health care system overload, a particular feeling or sense was underlying these questions. It was, of course, the feeling that we need to do whatever we can to prevent as many instances of this situation as possible. The driving ambition was not to attain the objectively attainable minimum number of such situations (weighed against considerations of economic nature), because the moral problem would then disappear. For that would mean to overlook that the moral problem simply does not disappear no matter what. If a healthcare worker perceives the provision of treatment as a moral demand, following simply from the condition of the patients in need, the onerous sense of failing the demand does not disappear just because it is unclear whether it was in one's powers at all to avoid the situation. For sure, economics and economic relations *do* contribute significantly to the constitution of our moral and political relationships. We could never even understand our moral dilemmas, if we ignored how they their political and economic setting situated and shaped them. This is, however, a move of understanding, not of reduction.

The vocabulary itself that Stefánsson is using illuminates the risks of analysing our moral dilemmas in an overly reductionist manner, as fully

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> [n]o economist has a privileged insight into questions of right and wrong, and none deserves a special say in fundamental decisions about how society should operate. Economists who argue otherwise and exert undue influence in public debates about right and wrong should be exposed for what they are: frauds.

See https://www.foreignaffairs.com/reviews/review-essay/2020-02-11/dismal-kingdom.

exhausted by the description of their economic framework. Though Stefánsson is concerned with *moral* reasoning, he avoids characterising the situation in which healthcare workers find themselves as a *dilemma*. For him, it is always a *trade-off*. But while there are moral dilemmas, I am not sure what a moral trade-off would be. A moral dilemma is a situation in which it simply may not be possible to avoid doing harm whatever one does (cf. Williams 1965; or Phillips 1979). A trade-off is a confrontation of inputs that need to be settled by means of a calculation. *Trade-offs* are *hard* in the manner in which complicated mathematical calculations are hard. (Moral) *dilemmas* are *difficult* in a different sense. If we embrace the vocabulary of trade-offs, it may prevent us from seeing the moral possibility of "inescapable wrongness," in Bernard Williams' words, as relevant for understanding the situation as a dilemma.

The moral concern of healthcare workers reflects the latter kind of difficulty: the need itself to decide whom one will not help to the full extent required by their condition. In this situation, one cannot help having qualms about whatever option one sees as available. These qualms do not depend on considerations of whether one has reached the threshold of inevitability. The overloaded healthcare workers did what they could under unimaginably difficult circumstances. Nobody, unless out of their mind, could think of suing them.[16] Similarly, an army officer may need to give orders such that would result in the death of some of his or her troops, in order to secure a strategically important advantage (perhaps saving the lives of many more soldiers, or civilians). However, morality does not coincide with legal invulnerability or strategic necessity. It is perfectly intelligible that army officers who did the best they could under the circumstances still have moral worries about their decision, just as the healthcare workers. It has been among soldiers that cases of moral injury have been studied most frequently. Perhaps using this conceptual lens to understand the situation of healthcare workers will be helpful, too.

No third party is thereby granted the right to morally judge and condemn healthcare workers for failing to do what they could not avoid failing to do.

[16] There are, instead, cases of bereaved citizens taking legal action against government authorities. See https://www.theguardian.com/society/2020/jun/03/lost-father-covid-19-legal-action-against-uk-government.

However, consider an attempt to placate an angry and remorseful traumatised medic by saying, "Come on, under the circumstances, nobody could sue you for the neglect of your professional duty." Such a consolation amounts to an affront. It does not do justice to the fact that the medic understands what happened, and what she did, in terms that can be and surely often are irreducibly moral. The "bad moral luck" angle, which I believe is indispensable for appreciating properly the situation of the medic, doesn't point towards a condemnation. It rather points towards pity, or abstaining from judgement by a third party (cf. Browne's [1992] discussion of moral luck).

I think that important reasons for striving to "flatten the curve" and easing as much as possible the burden on healthcare systems lie somewhere here. These endeavours rely on the intuition that "hard trade-offs" are a bad thing to happen. We cling to this intuition even when we do not see whether there can be a viable plan for avoiding them altogether. And I hope that the principal motivation for the flattening endeavours and other counter-pandemic measures on the part of our representatives and institutions was not to maximise the aggregate value *in order to* clear themselves of possible blame. The underlying intuition may have been simpler: it is not right to let people die, even when you are in such a situation that your real capacities are limited and you can only save so many people. The endeavour to avoid ending up in a situation of "hard trade-offs" is thus an expression of an important intuition. Even if you manage to distribute healthcare resources so as to objectively minimise the number of people without the full necessary treatment, having to do this—having to fail *anybody's* need—is bad enough. If the social contract between citizens and their states is taken seriously, the political representation cannot act or speak as if the fact that some citizens were not saved under the circumstances where it was not clear whether they could be saved nullifies the state's commitment to represent the interests of these citizens.

Of course, there may be hypocrisy in the rhetoric of the politicians' claiming that they would never let a single case of this kind happen. But what if they subscribed in a cavalier manner to the full legitimacy of letting it happen, when it's unclear that it could be fully avoided? Adopting such an alternative rhetoric would represent a deep, worrying deficiency in moral reasoning. This might cause a broader damage to the society. Without necessarily

calling for the kind of welfare state that is looking after all the citizens' needs, the state cannot afford to become a body of representatives who are not really representatives because they do not care at all. Incompetence can erode the citizens' trust significantly, too, but indifference cuts even deeper, I believe.

The elected representatives' and the states' political responsibility is clearly not of the same kind as moral responsibility between and towards particular *individuals*. It is rather a complex mixture of responsibilities towards individuals *qua* members of particular groups, towards institutions, towards the "nation," or simply to the future. Politicians also carry the additional burden of the unrewarding, but immensely important task to justify their responsibilities in a way that will not alienate significant parts of the public.

4. Concluding remarks

In I am not sure what the best reaction to the COVID-19 outbreak was. Others have a better insight into this immensely difficult and sensitive topic. First, we would need some clarity as to what we mean by "the best." In some readings of "the best," perhaps Stefánsson's is the right suggestion: to gauge and regulate safety measures by their predicted future economic impact. My worry is that the reasons for this suggestion may not be the kind of reasons we would like to rely on if "the best" relates primarily to what is "good" in a moral sense. At any rate, how we think and talk of "the best" shapes our ideas of what is good.

We thus need to investigate critically the assumed strong analogy between questions of different kinds. One kind of question is "Is five more than one?," or "Which *number is higher*—5 or 1?" Another is "Is it *right* to let one person die (or kill one person), to avoid the predicted death of five?" Yet another is "Now that I am in the situation where I have to choose between this one person and several others whom I could treat instead this one, what *should* I do?"

The first is not a moral question at all. The third, under some circumstances, may not be either, though for different reasons. Sometimes it is, but not necessarily as an instance of the second question. Not all moral questions are such because they allow or require their rephrasing as

questions of the second kind. The strong analogy often drawn between the value of a quantity, moral rightness, and that what one needs to do under particular circumstances obfuscates the matter. Drawing this equation helps the ambition to have the tool that would enable one to exonerate oneself of moral responsibility in moral dilemmas, whether or not they are "hard." In the same sense in which one does not need to pity the number 1 when truthfully stating that it is lower than number 5, one would also not need to regret the lives sacrificed. What gets overlooked here is that when one says "You say that I should have left the one person without treatment, but how could I have done it?," she is not asking the other to recite to her a principle which she did not have available at the moment.

All in all, the kind of difficulty that one confronts in a genuine moral dilemma does not disappear simply because one probably did the best thing that one could do, under the circumstances. Dilemmas are not trade-offs, though some situations of dilemma are also situations of trade-off.

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References

Agamben, Giorgio. 2020. "The Invention of an Epidemic." *European Journal of Psychoanalysis*. Available at: https://www.journal-psychoanalysis.eu/coronavirus-and-philosophers/

Amewu, Sena, Seth Asante, Karl Pauw, and James Thurlow. 2020. "The Economic Costs of COVID-19 in Sub-Saharan Africa. Insights from a Simulation Exercise for Ghana." *The European Journal of Development Research* 32 (5): 1353–78. https://doi.org/10.1057/s41287-020-00332-6

Anscombe, E. M. Gertrude. 1981. "War and Murder." In *Ethics, Religion and Politics*, 51–61. Oxford: Basil Blackwell.

Browne, Brynmor. 1992. "A Solution to the Problem of Moral Luck." *Philosophical Quarterly* 42 (168): 345–56.

Castrillón, Fernando & Marchevsky, Thomas (eds.). 2021. *Coronavirus, Psychoanalysis, and Philosophy. Conversations on Pandemics, Politics, and Society.* New York: Routledge.

Correia, Sergio, Stephan Luck, and Emil Verner. 2020. "Pandemics Depress the Economy, Public Health Interventions Do Not: Evidence from the 1918 Flu" (5 June 2020). Available at *SSRN*: http://dx.doi.org/10.2139/ssrn.3561560.

Cowley, Christopher. 2008. *Medical Ethics, Ordinary Concepts and Ordinary Lives*. Basingstoke: Palgrave Macmillan.

Černý, David, Adam Doležal, and Tomáš Doležal. 2020. "Etická a právní východiska pro tvorbu doporučení k rozhodování o alokaci vzácných zdrojů při poskytování zdravotních služeb v rámci pandemie COVID-19." 2. Vydání. Ústav státu a práva AV ČR, v. v. i., Kabinet zdravotnického práva a bioetiky. Available at: https://zdravotnickepravo.info/wp-content/uploads/2020/10/Eticka-a-pravni-vychodiska-pro-tvorbu-doporuceni-v-ramci-COVID-19_podzim-2020.pdf

Daniels, Norman. 2001. "Health-Care Needs and Distributive Justice." In *Bioethics*, edited by John Harris, 319–46. Oxford: Oxford University Press.

Gaita, Raimond. 2004. "Breach of Trust. Truth, Morality and Politics." *Quarterly Essay* 16: 1–68.

Gaita, Raimond. 2006. *Good and Evil: An Absolute Conception*. 2nd edition. New York: Routledge.

Gaita, Raimond. 2020. "COVID, Quality and a Common World." *Meanjin* 79 (4): 84–99. Available at: https://meanjin.com.au/essays/covid-quality-and-a-common-world/

Gans, Joshua. 2020. *Economics in the Age of COVID-19*. Cambridge (MA): The MIT Press.

Horton, Richard. 2020. *The COVID-19 Catastrophe*. Cambridge: Polity Press.

La Puma, John, and Edward F. Lawlor. 1990. "Quality-Adjusted Life-Years. Ethical Implications for Physicians and Policymakers." *The Journal of the American Medical Association* 263 (21): 2917–21. https://doi.org/10.1001/jama.263.21.2917

Lawrence, David R., and John Harris. 2021. "Red Herrings, Circuit-Breakers and Ageism in the COVID-19 Debate." *Journal or Medical Ethics*. https://doi.org/10.1136/medethics-2020-107115

MacKillop, Eleanor, and Sally Sheard. 2018. "Quantifying life: Understanding the history of Quality-Adjusted Life-Years (QALYs)." *Social Science and Medicine* 211: 359–66. https://doi.org/10.1016/j.socscimed.2018.07.004

Marra, C. A., S. A. Marion, D. P. Guh, M. Najafzadeh, F. Wolfe, J. M. Esdaile, and A. H. Anis. 2007. "Not All 'Quality-Adjusted Life Years' Are Equal." *Journal of Clinical Epidemiology* 60 (6): 616–24. https://doi.org/10.1016/j.jclinepi.2006.09.006

Phillips, Z. Dewi. 1979. "Do Moral Considerations Override Others?" *The Philosophical Quarterly* 29 (116): 247–54. https://doi.org/10.2307/2218821

Reid, Lynette. 2020. "Triage of Critical Care Resources in COVID-19: a Stronger Role for Justice." *Journal or Medical Ethics* 46 (8): 526–30. https://doi.org/10.1136/medethics-2020-106320

Savulescu, Julian, and James Cameron. 2020. "Why Lockdown of the Elderly Is Not Ageist and Why Levelling Down Equality Is Wrong." *Journal or Medical Ethics* 46 (11): 717–21. https://doi.org/10.1136/medethics-2020-106336

Savulescu, Julian, Ingmar Persson, and Dominic Wilkinson. 2020. "Utilitarianism and the Pandemic." *Bioethics* 34 (6): 620–32. https://doi.org/10.1111/bioe.12771

Singer, Peter, and Michael Plant. 2020. "When Will the Pandemic Cure Be Worse Than the Disease?" *Project Syndicate*. Available at: https://www.project-syndicate.org/commentary/when-will-lockdowns-be-worse-than-covid19-by-peter-singer-and-michael-plant-2020-04

Specktor, Brandon. 2020. "Coronavirus: What is 'Flattening the Curve,' and Will It Work?" *Live Science*, 16 March 2020, https://www.livescience.com/coronavirus-flatten-the-curve.html.

Stefánsson, H. Orri. 2020. "Three Mistakes in the Moral Reasoning About the Covid-19 Pandemic." *The Institute for Futures Studies*, Working paper 2020:12. Available at: https://www.iffs.se/en/publications/working-papers/three-mistakes-in-the-moral-reasoning-about-the-covid-19-pandemic/

Wiinikka-Lydon, Joseph. 2019. *Moral Injury and the Promise of Virtue*. Cham: Palgrave Macmillan.

Williams, A. O. Bernard. 1965. "Ethical Consistency." *Proceedings of the Aristotelian Society*, Supplementary Volume, 39 (1): 103–24.

Williams, A. O. Bernard. 1981. "Moral Luck." In *Moral Luck*, 20–39. Cambridge: Cambridge University Press.

Williams, Bridget, James Cameron, James Trauer, Ben Marais, Romain Ragonnet, and Julian Savulescu. 2021. "The Ethics of Age-Selective Restrictions for COVID-19 Control." Blog of *Journal or Medical Ethics*. Available at: https://blogs.bmj.com/medical-ethics/2021/01/27/the-ethics-of-age-selective-restrictions-for-covid-19-control/

Žižek, Slavoj. 2020a. *Pandemic! COVID-19 Shakes the World*. New York: OR Books.
Žižek, Slavoj. 2020b. *Pandemic! 2. Chronicles of a Time Lost*. New York: OR Books.