Wandering Virtues, Moral Confusion

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INTRODUCTION

The COVID-19 pandemic has become an ego-dystonic period for physicians, posing competing moral needs and perceived obligations. This essay will review some of the traditional understandings of physicians' bioethical responsibilities and a description of the realities of the medical world that have challenged those understandings.

Within the many traditions of bioethics, there are commonly referenced principles, rules, and virtues that would animate the ethically refined physician.[1] Many physicians have taken the Hippocratic Oath, written in the 5th Century BCE.[2] Broadly speaking, the Hippocratic Oath obligates physicians to be grateful to those from whom they have learned, to apply their knowledge for the benefit of their patients, to avoid harming their patients, to maintain a certain moral purity, to avoid impropriety, and to maintain confidentiality. What this Oath suggests is that physicians must acknowledge and maintain a certain "art of medicine" and direct that art to the best interests of their patients. There are, however, many gaps in the "oath." It does not explicitly address the multiple ethical issues that occupy the beginning and end of life, ethical issues in managed care, the role of health insurance companies, nor the expanded role and prominence of Departments of Health. There is no implicit or explicit obligation to an overarching public health focused on improving population health.

To whom and to what are physicians obligated? The "good" of the patient? The "good" of the population? If so, which population?

DIRECTION OF OBLIGATIONS

It can be assumed that we, as physicians, perceive a primary obligation towards our personal patients. In the case of group practices, this obligation might extend to the well-being of our group's patients. Emotionally and ethically, however, we stratify these obligations. I (Dr. Felder) have a greater obligation to my own patients than to other patients cared for by my immediate colleagues. I have no particular obligation to patients cared for by other physicians with whom I have no professional relationship. Though, perhaps if a patient's actions directly, imminently, and significantly existentially threaten others, it provides the philosophical justification for overriding our obligation to the individual patient. What I am really touching on here is the limits of my ethical obligations, in direction and extent. Primarily, I am obligated to my patient. Only after that might I have obligations to others, in ever-expanding concentric circles. The primary care physician is not a public health physician with some broad obligation to society at large. This is neither mentioned in the Hippocratic Oath nor the Principles of Biomedical Ethics.[1,2] Rather, I have an obligation to the well-being of my patient.

During the COVID-19 pandemic, the direction of obligation has not been so clear. The presumed primacy of patient autonomy, as well as my obligation to my patients' best interests, are valued in the breach. We, as physicians, are often asked to donate personal protective equipment to other practices or institutions, instead of offering it to our patients. We are expected, at times, to pressure our patients to make medical decisions that will benefit others or that align with demands and rules of specific institutions, without considering the impact that those decisions may have on our own patients' health and autonomy. Specifically, when we require patients to be COVID-vaccinated in order to attend university or require a clinical professor to be COVID-vaccinated even when teaching "virtually", we are, essentially, saying that our patients' right to self-control and autonomy has been exhausted in favor of some other overriding principle or goal. When patients "agree" to the demands of others under threat of loss of employment or university enrollment, this "agreement" is hardly consistent with "informed consent", a fundamental expression of patient autonomy. This ought to trouble us. To the extent that physicians are party to this process, it reveals a lack of clarity regarding to whom our primary allegiance is owed. Am I obliged to respond to the needs of my patients, the Department of Health, the government, the requests of health insurance companies, or theoretical-future patients? If one ranks any of those "obligations" above the obligation to my patient, the burden of philosophical justification will be a heavy one.

Many other questions arise. Do physicians have an obligation to be vaccinated themselves or do they have the right to make decisions in accordance with their own personal values? Can physicians act upon views that differ from their parent medical organizations? Who will be authorized within an institution itself to make the very difficult moral

decisions and by what metric will those decisions be made? How do we understand the role of government and the rise of what appears to be a strong paternalism? Is strong paternalism justified? Has the COVID-19 pandemic reshaped our answers to these questions?

PSYCHOLOGY CHALLENGES VIRTUE

One of the greatest challenges to our ethical commitments comes from the psychological experience of caring for and about our patients. The inherent emotional strains of the COVID-19 pandemic have been dramatically different from any we have previously experienced. Virtually nothing was previously known about this infection. While we are accustomed to knowing much more about medical issues than our patients, this is no longer necessarily true. It can be threatening, humbling, and unsettling to our typical experience of relative expertise based on our sophisticated and academic fund of knowledge.

It can also be a lonely world as our interactions with colleagues now occur infrequently. I do not visit patients in the hospital or at home. Nor do I attend conferences. With COVID-19, cure is often impossible, and care can be elusive. How difficult it has been to counsel patients and families when their terribly ill relatives are hospitalized and the families are unable to visit. Patients are sad, hopeless, and helpless. Families want to hold their loved one's hand only to find that it is behind an impermeable synthetic barrier of infection control. Medicinal healing precludes a healing touch. We feel distant and disconnected, powerless, humbled, ineffective, unable to predict, lonely, burnt out, and frustrated. We are confused by our expanding real estate of medical uncertainty. We are, sadly, outraged by the widespread carnage that has resulted, in part, from our patients' personal and value-driven, yet unwise medical choices.

We have become all too familiar with our emotional experiences of negative judgment and frustration, anger, disappointment, and dislike. Many of these have been directed at the health insurance companies, the Departments of Health, the government, and, even, our patients. When the immunocompromised patient, who chose not to be immunized, calls demanding treatment, it can be challenging at the very least. When the insurance companies and public health officials believe that video "medicine" is as good as "in-person" health care, it can be hard to believe that we all have the same commitment to providing for the best interest of our patients. Depending on our moral development and social graces, we make the effort to retain our smile and provide help.

What we are observing is the contagious and insidious nature by which our psychological experiences invade our moral virtues. We experience a myriad of emotions including resentment, helplessness, loss of professional autonomy, loneliness, and confusion. These partly stem from our changing roles, a new (and perhaps manipulated) corpus and direction of ethical obligations, inadequate scientific knowledge, the narrowing knowledge gap between physicians and patients, and the experience of medical uncertainty. We experience our own transference, countertransference, and projection.

For many of us, these emotions and experiences chisel away at our aspirational virtues such as courage, self-effacement, empathy, non-judgmentalism, and care. It has become difficult, in some cases, to experience love and compassion when viewing our patients, as well as to experience solidarity when viewing (or thinking about/considering) our colleagues and leaders.

In the end, we will need to revisit some well-established metaethical questions. From where do our ethical principles come? How binding are they? What do we do when they conflict? How do we interact with others who possess a different "metaethical reality"? To whom do we look in times of moral uncertainty? What are the principles and methods of moral justification? How do we refine our character traits and moral virtues?

We will need to remind ourselves of the goals of medicine. We will want to continually remind ourselves of those moral beliefs and virtues which we hold most dear and simultaneously find a system for holding ourselves accountable. We are humans with foibles and challenges that can certainly be overcome by the enormous moral strengths that can be brought to bear.

References

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2. Miles SH. *The Hippocratic Oath and the Ethics of Medicine*. Oxford University Press, USA; 2005.

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