INTRODUCTION
Challenges for Bioethics in Times of Crisis – The Need for Bioethics in Pandemic Situations

We will discuss in this lecture the need for ethics in times of crisis. Many people believe that ethics and bioethics and the call for respecting some principles are bureaucratic obstacles to obtaining a rapid response from the population - for example, to achieve vaccines in record time, to immunize the population, to establish unpopular but necessary measures, such as closure of borders and non-compliance with fundamental principles of the European Union, establishment of public policies aimed at herd immunity or, conversely, closure of most activities considered not essential in the economy, to ensure social distancing and self-isolation of the population. These measures are understood as derogations from ethics or bioethics when targeting medical research on human subjects performed faster than required by the standard procedure, or the implementation of innovative therapeutic practices that have not previously been studied by clinical trials to certify that there are no known side effects.

Those of us who emphasize the importance of human rights and respect for certain rules - including ethical standards - will say that suspending the application of the European Convention on Human Rights, for example, by a number of states, including Romania, may involve a number of risks in terms of respecting these rights in the current period, but also after the end of the pandemic.

From ethical point of view, we should take into account that this period will be overcome at some point, but a number of changes in respect for civil liberties could extend

into the post-pandemic period and there may be attempts in some states to impose authoritarian regimes, especially where there is no democratic tradition, and this could be a risk for post-pandemic society. In this context, care for individuals must be correlated with respect for ethical rules, norms and standards, even if they may suffer some derogations during pandemic. The bioethicists' concern during this period should be precisely the analysis of these derogations and signalling of the slippages from the bioethical principles and from the ethical values of the Occidental civilization, of the free world.

Many of the health workers will say during this period: "I have lives to save and not necessarily to respect all ethical principles" because, there are situations when respecting ad literam all the ethical principles applicable in normal situations can lead to losing lives - because in emergencies, lifesaving is foremost.

A principle that we can accept from bioethical point of view in general is that the emergency situation derogates from a number of principles and that, in case of conflicts between ethical principles, beneficence or non-maleficence are much more important than respect for autonomy, especially when it comes to public interest. This is valid not only in collective emergencies, such as the state of emergency caused by the current Coronavirus pandemic, but also in individual emergencies. A person who suffered an accident, a cranial-cerebral injury for example and he/she is in coma, cannot wait before a life-saving surgery, until him/her or his/her family would sign for an informed consent.

In this situation, we normally talk about the presumption of pre-eminence of life and about the fact that life-saving therapy can be done assuming that there is the person's consent, provided there is no directive in advance - in those jurisdictions where this really works - and for the person to assert their desire of not benefiting from a life-saving

therapy. This is the case, for example, with the DNR (do not resuscitate order).

Derogations from certain principles, such as that of autonomy, are not uncommon for researchers in the field of bioethics when it comes to emergency situation, and this is all the more true in this time of crisis, as we are not just talking about a public health crisis generated by a pathogen that endangers the entire human society, but also of a serious social and economic crisis.

We say that there is a competition between principles, for example, between the principle of beneficence and non-maleficence, when we speak of the introduction in production and distribution of some innovative therapies applied in order applied to avoid the deterioration of the patient's situation.

A number of rules should be used when, for example, an innovative therapy has not yet been fully tested but it is intended to be applied on human subjects based on a derogation from general rules for drug testing and for approval for human use of certain drugs. For example, these exceptions should take into account the compassionate use of drugs, i.e. when the person is in a terminal stage and that therapy can be considered as the last chance to cure or prolong the patient's life.

The compassionate use of insufficiently tested therapies - *compassionate treatment*, as it is called in bioethics - is a derogation from ethical standards of biomedical research, in emergency situations, which is usually unacceptable, but which during this period was approved by the Committee on Bioethics (DH-BIO) of the European Commission. Such derogations produce windows of opportunity - also called *overtone windows* - regarding the social acceptability of practices commonly considered undesirable. Generally, derogation from ethical standards is a depreciation of the quality of medical services, and restriction of civil liberties for public health reasons are moments of democratic deficit that must be

compensated and balanced by a very good public communication of health authorities with citizens.

A number of ethical rules are applied without prior deliberation in the form of professional conduct of medical staff who guides their professional activity according to a series of mandatory minimum standards, which cannot be derogated from in any situation, regardless of whether we are talking about actions even in emergency situations. For example, it is not possible to derogate from the principle of beneficence or from that of non-maleficence, but here are certain conditions - which we will present in this volume - such as whether triage should be performed on whether or not people benefit from mechanical ventilation or other innovative life-saving therapies, when the number of patients requiring, for example, mechanical ventilation exceeds the number of devices available in the respective emergency unit or in the nearby units. The conflict of values between beneficence and non-maleficence should be resolved in favor of beneficence when choosing the best and diminishing the negative consequences, but at least situations that aggravate the patient's situation - such as in-hospital infections with Covid-19 - should be avoided, if they are due to the lack of specific protective equipment for doctors or of safe routes for infected and suspected patients.

We are therefore talking about a series of decisions with a wide ethical involvement that do not allow a time for reflection and that must be as fast as possible, and then guides of good practice, including ethical guidelines, can play an important role when they are available and could be appropriated by medical staff before this one is put in a position to make such ethical decisions. Exceptionally, such guidelines can be issued - and have been issued - during pandemic, and we will briefly address them in this volume. But they take time to be analyzed and understood, they possibly require ethical training, and it is unlikely that people in the

forefront of the fight against the virus or in the forefront of medical practice, in general, will have time to conduct an ethical debate every time they have to make a quick decision.

We emphasize the overwhelming importance of the commissions of ethics, especially of the commissions of clinical ethics in hospitals, when establishing health, therapeutic, hospital policies, and this should be a plea for a commission on ethics to endorse health policies at national level. Nevertheless immediate, operative decisions must be based on the doctor's own professional judgment, and this requires an ethical conscience, an awareness of professional ethics that the doctor, a health worker in general, should have developed based on previous competences in the field of bioethics, and less on the basis of elaborate discussions and debates for which there is no time when the right decision can save lives.

On the contrary, in bioethical research, in bioethical doctrine, the primary debate must be an academic one, it must have a certain duration, because as diverse points of view as possible representing diverse stakeholders must be presented, and thus the elaboration of an ethical guideline should include the most widely accepted, but at the same time the most advanced opinions in a certain field, or as it is said in English *state of the art* in the field of ethics in general, or in those areas of bioethics where that guideline applies.

The situation of the current pandemic is a special one, because there have been no ethical debates on the ethics of pandemics of such magnitude. This is probably due to the fact that there has never been such a large-scale pandemic affecting so many countries and individuals since 1918-19, when the Spanish fever swept Europe and the whole world during the First World War and immediately after its end, when millions of people affected by this pandemic died[1]. In our time, closer to the

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[1] Such pandemics also existed during 1968-69 (Hong Kong Influenza, H3N2), which affected 1 million people worldwide and 100,000 in the United

present, pandemics have occurred or there have been major risks of pandemic - such as SARS and other viruses that have been on the verge of producing pandemic effects - but their spread has been limited through quarantine measures taken in time, thus eliminating their global threat. We must also mention here a series of pandemics that have affected domestic animals - mad cow disease, swine flu, bird flu - all considered to have destructive potential for humanity if the virus managed to cross the species barrier. They were kept under control by destroying livestock on any farm where at least one case of infection was found. None of these threats to global public health required such drastic measures, and as such they did not bring with them major humanitarian and social crises such as Covid-19.

These pandemics should have generated widespread debates in the field of bioethics and there should already be good practice models, when various scenarios regarding a

States alone, and yet in the period immediately following the first wave (which took place in the spring of 1968), in the same year, the Woodstock Festival (August 1968) took place, attended by hundreds of thousands of people, compared to the 30,000 expected by the organizers. No post-pandemic social distancing measures were recorded, either during the festival or worldwide during that period. The second wave of the same pandemic struck humanity in the Fall of 1968 and lasted until 1969. We found no bioethical literature from that period to discuss the infection prevention measures addressed by the authorities at that time and, in general, there is no ethical literature dedicated to pandemics, which refers not to general prevention measures, but to direct decisions during a pandemic. It is possible that the lack of a bioethical literature on the 1968-69 pandemic was due to the collective mentality of that period - strongly influenced by the hippie movement and the postmodern revolution, including feminist, anti-war, pro-choice movements and so on. Also, the lack of Internet at that time may be a partial explanation for the less panicked approach to pandemic as long as the population received information only on official media channels, and alternative information was aimed rather at the Cold War as source of global panic and respectively the movements for the freedom of human rights, the climax of the new age movement and other events of revolutionary social nature generating solidarity during that period (“Misleading Claim”, 2020).

possible pandemic could occur, especially as there have been various tests at global level regarding the response of the population and of the authorities to such threats to public health[2].

On the other hand, if we analyse the public policies of most states, we notice two fundamental directions that we can highlight, both with ethical support, but which prove to be diametrically opposed. The first aims to stop the transmission of the virus through quarantine measures that limit human contact. This aims, in particular, to limit the effects that a large wave of patients can have on the health system which is at risk of collapse and thus not to ensure the most effective therapy for as many patients as possible. The ethical principle that governs such an approach is that of beneficence, understood in a utilitarian way.

The second approach targets much more relaxed measures because, taking into account precisely the aggressiveness of the virus, it is assumed that eventually the vast majority of the population will go through this infection and will obtain *herd immunity*, without sacrificing the economy and the well-being of the population and without the risk of major economic and social crises in the post-pandemic period.

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[2] It may not be entirely coincidental that radical measures such as closing down non-essential economic activities and self-isolating the population have been easily taken, as long as the population has been accustomed to the fact that the only accepted responses to public health threats from pandemics in the animal reign and with possible risk of overcoming the barriers between species in the sense of human infection and subsequently of inter-human transmission of the infection, were only the radical ones, of destruction of livestock. This approach contrasts with that of 1968-69, when such distancing measures would not have had a window of opportunity created by harsh reactions to previous pandemics (as has recently happened with swine flu, the avian influenza or the mad cow disease, when livestock were destroyed, regardless of the economic costs of these measures) and especially by raising public awareness of the major risks of any pandemic that could claim millions of lives.

Such an approach was initially adopted by the United Kingdom, Germany and Austria, which eventually abandoned this approach due to the large number of infected people. The only European country that still maintains this public health policy is Sweden, and it is still unclear whether we can speak of a success or a failure of this public policy.

The two approaches in public policy are tributary to major ethical approaches, such as the individualist one, which emphasizes the value of the individual, in which responsibility prevails over individuals as part of the social system, while the second approach is rather one which prioritizes community values, such as economic or social ones, the risks to global society that quarantine measures may have also being important, these being limited to strictly necessary measures to protect the lives and the health of those most at risk of disease.

Of course, saving lives takes precedence over any other ideology, discussions, debates etc. I have tried in this volume to illustrate the need for ethical debates to be known by the community of specialists and transformed into a professional ethical conscience, so that such approaches to the situation by decision makers, especially when they are advised by specialists in public health or in medicine to be infused with ethical values and that these approaches to be the basis of practice models.

These debates that we present are not intended primarily for front-line professionals, although they are also accessible to them, but are generally intended for the academic and professional community, which has the capacity to unblock ethical debates even in this pandemic situation, it has the capacity to include in these ethical debates the concrete results of the ethical practice. It is not our intention to propose ethical guidelines, but on the contrary, to try to learn from the experience that the current situation has brought to the humanity.

This volume includes lectures that I gave during the *Thursday Meetings with Bioethics and Applied Ethics* between March 12 and May 7, 2020. These lectures were initially part of the course of Bioethics and Professional Deontology that I teach at the University "Stefan cel Mare" of Suceava, Romania, later being held under the sign of the Circle of Applied Ethics and Practical Philosophy "Ekpyrosis" that I developed within the Centre for Applied Ethics of "Ştefan cel Mare" University of Suceava and LUMEN Research Centre in Social & Humanistic Sciences, with the support of the Faculty of Law and Administrative Sciences of the "Ştefan cel Mare" University of Suceava, within the Project "Ethical Competence and Academic Integrity in Scientific Research and Teaching Act" (CEIACSAD), a FDI project number 2020-0484.

Some lectures are about to be published independently, in English, in journals such as *Postmodern Openings* or the *Journal of Applied Philosophy*, but this volume contains the complete version of these lectures, with all the clarifications made during the online speeches, as well as with a series of additional clarifications that we made when preparing this volume for printing.

It is very important for me that I managed to outline this volume during the period when, because of the Coronavirus pandemic, we were all in self-isolation at home. The release of the volume on the market, in Romanian, overlapped with the first relaxation measures of the social distancing that affected us all during this period. The volume discusses the role of bioethics in crisis period and the ethical models that can be adopted during this period, but it also brings into attention a possible crisis of bioethics, as it is understood at the moment, a crisis that occurs with the social and economic post-pandemic crisis. A number of traditional topics in bioethics are addressed - such as principlism, informed consent, deontology, utilitarianism - and the concrete

ways of applying them to the pandemic situation, but also unique challenges that come from social phenomena such as virtualization of the social space, interpretive adrifts of concepts such as freedom, autonomy, equity, vulnerability, phenomena that must be taken into account when building public health policies, ethics policies and strategies for building their social acceptability.

All the online lectures I have given during this period are available on Lumen Publishing House's Youtube channel, including lectures that have not been included in this volume and which I invite readers to listen to, thus getting together in a virtual community of people interested in philosophy, sociology and especially in ethics.

References

Misleading claim: Woodstock took place in the middle of a pandemic. (2020, May 07). https://www.reuters.com/article/uk-factcheck-woodstock-pandemic-1968/true-claim-woodstock-took-place-in-the-middle-of-a-pandemic-idUSKBN22J2MJ