

Bioethics after the COVID-19 pandemic: More research, fewer committees?

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Abstract

In the face of the pandemic, *bioethics*, once again, proved its scientific utility. In France, in particular, the academic approach (= peer-reviewed, scientific publications, etc.) should be given priority over the institutional approach (= public surveys, public meetings, etc.), in hospitals, research institutes, universities, and companies, with the professionalization that this would imply (i.e. *bioethicists*).

Keywords

Bioethics, bioethicist, meta-discipline, global bioethics, COVID-19, France

Background

The first *editorial* written by Jonathan Lewis in his role as the new Editor-in-Chief of *Clinical Ethics* journal took the original form of an interview that he conducted himself with his predecessor, Søren Holm.¹ Various themes, directly linked to *bioethics*, were, quite rightly, addressed, including, in particular, the role and practice of *clinical ethics*, especially during the COVID-19 pandemic. However, their good-natured criticism of our *letter to the editor* published in the *American Journal of Bioethics* during the first wave of the epidemic² suggested that there was a need for us to explain our *propos* more clearly. We also wished to respond, at the same time, to other criticisms from other *bioethicists* that were perhaps less favorable, than those of Lewis and Holm.¹

We are entirely responsible for this misunderstanding. *Letter to the editor* is a format of scientific publication offering the advantage of rapid communication, but also implying a decrease in the quantity, or even quality, of the information communicated. This was undoubtedly the cause of these misunderstandings, because, evidently, we never wished to say that *bioethics* should be set aside during the pandemic. We meant simply that *bioethics* should be used at the appropriate time and in the appropriate manner, a position that we reexpressed in another *letter to the editor* published in the *Lancet*.³ This is, indeed, what we have tried to do at Foch Hospital,^{4,5} through an ethical theory, and precise research methodologies, focusing more on the future than the present.⁶

Global bioethics

Bioethics is practiced in a heterogeneous manner.⁷ Philosophy, law, medicine, biology, and other academic disciplines (e.g.

anthropology, sociology, etc.) share the use of this new *meta-discipline*.⁸ The fact is that *bioethicists* can be philosophers (e.g., Anne Fagot-Largeault in France), jurists (e.g., Guy Durand in Canada), physicians (e.g., André Hellegers in the Netherlands), or biologists (e.g. Arthur Galston in the United States), but with a professional activity and/or academic training (e.g. Masters, PhD, etc.) converging on *bioethics* through the study of moral, individual and/or collective, local and/or societal, problems, raised by new medical and/or biological practices (e.g. gene therapy, organoids, etc.). However, one particular contemporary theory tends to be favored by all *bioethicists*, whether they are originally philosophers, jurists, physicians, or biologists: *Principlism*.

Principlism is a particular ethical theory. Its premises can be identified in the *Belmont Report*, published at the end of the 1970s,⁹ but the essence of the theory is laid out in *Principles of Biomedical Ethics*, a work written by two American philosophers and *bioethicists*, Tom Beauchamp and James Childress, published at about the same time.¹⁰ The *Principlism* of Beauchamp and Childress is an ethical theory that is both deontological (i.e. a moral evaluation of individual and/or collective

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attitudes and/or actions as a function of duties and/or procedures), taking up the theoretical elements of *Kantism* (i.e. duties and/or procedures = categorical imperatives), and teleological (i.e. a moral evaluation of individual and/or collective attitudes and/or actions as a function of purposes and/or consequences), taking up the theoretical elements of *Utilitarianism* (i.e. purposes and/or consequences = pleasure vs. suffering).¹¹

At the end of the day, *Principlism* advocates four moral principles that are, in theory, universal: *autonomy*, *benevolence*, *non-maleficence*, and *justice*. In practice, the *bioethicists* of the Latin countries of Europe prefer a deontological conception and application, impregnated with *Kantism*. Conversely, a more teleological conception and utilization impregnated with *Utilitarianism* is preferred by the *bioethicists* of the English-speaking world.^{12,13} Beyond the West, in countries not particularly marked by either *Kantism* or *Utilitarianism*, *bioethicists* tend to distance themselves somewhat from *Principlism*.^{14,15} In our view, the main problem with *Principlism* is that it is a more absolutist than Universalist ethical theory that is, by definition, indifferent to cultural diversity and the concrete needs of humanity. Another contemporary ethical theory taking into account certain conceptual evolutions might be more appropriate: *Global Bioethics*.

Global Bioethics is a teleological ethical theory, the foundations of which were laid by the American biologist and *bioethicist* Van Rensselaer Potter, in his work *Bioethics. Bridge to the Future*¹⁶ was published at the start of the 1970s. Potter suggested that such moral problems could be studied according to the effects of these medical and/or biological practices on the *quality of life* and *survival* of humanity, through an interdisciplinary approach combining life sciences and human and social sciences, and health and environmental issues. By extending the meaning of *quality of life* to include *happiness*, while taking into account the spatial and temporal variability of the objective and subjective criteria for *happiness* and *survival*, this ethical theory, in our opinion, takes into account the cultural diversity of humanity, and its concrete material and intangible needs more effectively.¹⁷

First wave of the COVID-19 pandemic

It was in March 2020, right at the start of the pandemic, that we wrote the *letter to the editor* in question.² As indicated above, our aim was not to “ban” *bioethics*, but to delimit its role differently, particularly in France: temporally, by choosing not to intervene immediately, to avoid interfering with the plans of health authorities, and spatially, to favor an academic (= peer-reviewed, scientific publications, etc.) rather than institutional (= public surveys, public meetings, etc.) approach, to respect a more scientific way of doing things, thereby increasing the credibility of the work for healthcare professionals. We also proposed

focusing on the perspective of possible future health crises, similar or equivalent to this one, as time was too short for meaningful interventions for the current pandemic.

In practice, the oncology and supportive care department of Foch Hospital asked for our support in March 2020, due to the rapid emergence of tensions in the management of cancer patients. This request led to the scheduling of the so-called “emergency” multidisciplinary team meeting (MTM), the principle of which was subsequently described in various scientific journals.^{4,5-18} The general idea was to expand the fields of competence and knowledge of “classic” MTMs,¹⁹ which are limited to only a few medical specialties (e.g. oncology, radiology, etc.), by introducing, in addition to *bioethicists*, specialists from the human and social sciences (e.g. anthropology, history, etc.), while adopting an approach that was more clinical and scientific than philosophical or legal.

The utility of such MTMs became clearer after the first *bioethics* study, performed between December 2020 and January 2021, with the oncology and supportive care department, and based on data collected during the November 2020 session of the *Groupe de réflexion éthique de l'hôpital Foch* (Foch Hospital Ethical Reflection Group).²⁰ These data corresponded to feedback from three oncologists concerning their experiences in the face of the first wave of the epidemic.⁴ By considering bioethical issues as tensions between new medical and/or biological practices and moral values and/or standards, we were able to identify and consider three key bioethical issues, through the lens of our ethical theory and with a particular research method (*a posteriori* research).²¹ This study was finally published in September 2022, as an *original article*, in the *Journal of Evaluation in Clinical Practice*.²²

One of the three bioethical issues identified was the tension between a medical standard (i.e. evidence-based medicine), that had effectively become a moral one, and new medical and/or biological practices (= diagnosis, treatment, etc.), that had yet to be validated scientifically (= clinical trials, pharmacovigilance, etc.), but aimed to improve the management of patients suffering from cancer, in this particular context.²² Through the use of an approach that was more micro-bioethical (i.e. at the local scale = hospital, institute, etc.) than macro-bioethical (i.e. at the global scale = society, country, etc.), and delimiting our ethical theory in terms of the *happiness* and *survival* of cancer patients, oncologists, and relatives, at the scale of a single hospital, the emergency MTM appeared to be a satisfactory short-term solution for the application at the start of a similar or equivalent future health crisis.²²

Vaccination campaign

In France, the vaccination campaign against COVID-19 was initiated exclusively for those most susceptible to the lethal form of the disease, including cancer patients, at the end of 2020. However, it rapidly became clear that a

sizeable proportion of cancer patients were refusing or reluctant to be vaccinated.⁵ Unfortunately, our hospital did not escape this phenomenon (5.6%, 29/522), as we explained in the first *research letter*, jointly written with oncologists from the oncology and supportive care department of Foch Hospital, in June 2021. This letter was published in the *European Journal of Cancer*, in September 2021.²³ This *research letter* was the first part of another *bioethics* study, performed between April and November 2021, to be published.

As for the previous study, the data were collected in an empirical and qualitative manner, but over a period of time, from 29 cancer patients managed at our hospital who refused or were reluctant to be vaccinated, and 5 oncologists. The same ethical theory was applied to this study, but with a different research method (a research-action study).²¹ We again opted for an approach that was more micro-bioethical than macro-bioethical, delimited in this case solely by the *happiness* and *survival* of cancer patients managed at a single hospital, and refusing or reluctant to be vaccinated during a health crisis. Our results were published in August 2022, as a *research article*, in *BMC Medical Ethics*.⁵

In summary, we identified, and then tried to resolve, a major bioethical issue: vaccination policy, here in the form of a tension between the recommendations for vaccination against COVID-19 (i.e. a new medical and/or biological practice), free will (i.e. a moral value = good attitude) and the duty to protect each other (i.e. a moral standard = good action). Based on both our own data for a given population of cancer patients and the objective positive effect of introducing the *pass sanitaire* (health pass) in July 2022 on the whole French population, rendering vaccination obligatory appears to be a satisfactory solution for more effectively limiting the number of cancer patients refusing or reluctant to be vaccinated, in the context of future similar or equivalent health crises.⁵

Nevertheless, it is important to distinguish between the collective and individual scales.⁵ From our bioethical viewpoint, at the collective scale, rendering vaccination obligatory would have a positive impact on the *survival* of cancer patients reluctant to be vaccinated, rather than those refusing to be vaccinated. Conversely, at the individual scale, it would have a negative impact on the *happiness* of the most skeptical patients, increasing anxiety and social isolation, and perhaps even radicalizing anti-vaccination sentiments, without having a positive effect on the *survival* of these patients, whose cancers were already metastatic. Consequently, while imposing vaccination at the collective scale, the establishment of an emergency MTM would make it possible to improve the management of these patients, at individual level, in the short term, within the hospital. These solutions are most appropriate for countries with considerable medical resources, and a high-performance health system.

Conclusion and perspectives

Each *bioethicist* or healthcare professional is free to subscribe to or reject our theory, methodologies, or results, and to adopt, ignore, or criticize them. We have simply strived, almost systematically, to respect the following rule, which is necessary to improve the theorization and practice of a contemporary academic discipline: to publish our *bioethics* research and/or reflections in specialist scientific journals,^{2,3,4} such that they are always subjected to peer review and evaluation by our peers. That does not necessarily render them more true, but it perhaps means that they will be more likely to be considered, and then used, by *bioethicists* and, above all, healthcare professionals directly concerned by these subjects, to explain the meaning and justify the use of their medical and/or biological practices (=diagnosis, treatment, etc.).

We should also add that our department includes two ethics committees: the *Groupe de réflexion éthique de l'hôpital Foch* (Foch Hospital Ethical Reflections Group) mentioned above, which is dedicated to healthcare practices, and the *Comité d'éthique pour la recherche de l'hôpital Foch* (Foch Hospital Research Ethics Committee), which is dedicated to biomedical research practices and also includes peer review of our own empirical research in bioethics.²⁰ These two committees have played an important role since the start of the COVID-19 pandemic, but equivalent to research activities in *bioethics*. In our view, ethics committees are certainly necessary, but not sufficient in themselves. Hospitals, research institutes, universities, and companies, especially those in France, also need *bioethics* research activities, with the professionalization that that implies (i.e. *bioethicists*), if they wish to deal with the many moral issues raised by new medical and/or biological practices more effectively.

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