**Post-modernism and utilitarianism during the COVID-19 pandemic: Throwing ourselves under the bus**

**Abstract:**

The novel coronavirus pandemic is both shaped by and an agent of the post-modern, post-truth, utilitarian times we live in. It is associated with an overload of both information and mis-information with an increasing loss of the distinction between the two. The disconnect between governance and the health care professions and the lack of a consensus within health care professionals have left us ill equipped to offer a unified response to the pandemic. Further, the difficult decisions that we have to make in allocating scarce resources during this crucial period has thrown open health care’s divides – between health care providers and patients and within health care professionals. With the global lockdown - economic, social and gender disparities have been highlighted in an unprecedented manner. There are no easy ways out of this crisis, however, I advocate for inclusivity and parity in decision making to navigate bioethical and moral pitfalls.

**Keywords:** COVID-19, SARS-COV-2, bioethics, utilitarianism, health care divide

We live in post-modern, post-truth times, where reality is subjective and facts – the last bastion of rationalism, science and evidence based medicine – can be tailored to meet our needs [1] [2]. This is obvious to the point of being a trite truism – to say so means that I may as well say that the grass in green (it usually is) and the sky is blue (again, it usually is).

The novel coronavirus (how easily those phrases roll off the tongue, now), the causative agent of the COVID-19 pandemic is both a product of and an agent of these interesting, post-modern times. The sheer information overload that has emerged in the wake of the WHO declaring it a Public Health Emergency of International Concern on 30th January, 2020 has been overwhelming and exhausting [3]. Conspiracy theories abound - the virus was genetically engineered in a lab in Wuhan, no- in Seoul [4]. The sound waves generated by clapping or banging pots and pans is virucidal [5]. Drugs and vaccines appear to generate some hope – hydroxychloroquine, for example – and just as quickly fall from grace as randomised controlled trials fail to find evidence for their safety or efficacy [6]. I am not placing these post-truth events on a common platform or equating them with each other. However, there is a common theme underpinning all of these – we are clearly desperate for an answer (and a cure) and are clutching at straws.

One would (and certainly I did, initially) expect medicine to demonstrate resilience against unproven theories and myths about the novel coronavirus. We are after all, built on millennia of evidence and experience. We can fact-check these theories and guide efficient public health programmes and policies to contain the pandemic [7] [8]. We are the heroes nobody asked for, and the gods walking the earth. We believe we have control over life and death (a common fallacy). In truth, medicine has been, and perhaps always will be about relieving the suffering of the patient, and helping them reconcile to their illness. On our worst days – we go home and examine whether we have lived and practised according to the central tenet of bio-ethics – *Primum non nocere* – first, do no harm [9].

Perhaps the post-modern approach to a pandemic isn’t a surprise in hindsight. The medical profession has been shaped by and founded on utilitarianism – the good of the many outweighs the good of the few [10]. This may be why it has been so easy for doctors to reconcile ourselves to the lockdown across the world and in India to contain the spread of the coronavirus – despite the human rights crisis it has unleashed, despite the plight of migrants and refugees who are trapped at border zones without food or shelter or employment [11] [12].

What is also surprising (and perhaps shouldn’t be) is the disconnect between governance of countries and the medical profession. This is further compounded by the lack of a consensus on disease control measures and health care policy within the medical profession [13] [14]. How can we advise the government and our patients when we aren’t sure of what to do ourselves- the novel coronavirus is of course, novel to everyone and no practising doctor today was alive and practising during the last major pandemic –influenza in 1918 on the tail end of World War II [15]. We are all in this together and we are all new to this virus [16].

What does utilitarianism mean for the medical profession during the COVID-19 pandemic? It means that we have several, hard decisions to take [17]. We have to decide which of those infected to admit and treat and whom to send home [18]. Italy sent infected patients over 80 years home, while grappling with the shortage in intensive care resources – a form of triage with questionable ethical basis [19]. We have to decide which of the non-infected patients should be treated now and which can be deferred until the pandemic is better controlled. This means that severe mental illnesses, including dementia do not have access to elective services such as out-patient consultations, psychotherapy and cognitive retraining [20] [21]. We assume that they can afford to wait, and will survive the pandemic, and will come back to the hospital afterwards.

With regard to self-regulation within the medical fraternity – there are other, no less hard decisions to take. Doctors and nurses are working with potentially infected and confirmed cases of COVID-19 equipment without adequate personal protective equipment (PPE) [22]. We have to make the decision to self-isolate to avoid passing on the risk of infection to friends and family [23].

There are other decisions to make where the answers and ethics are less clear. Most hospitals have put interns and resident doctors on back-to-back duties while older, more senior faculty are rested or given administrative duties to minimize their exposure [24] [25]. Some hospitals allot more duties to single or unmarried or childless doctors and nurses – while those with small children and ageing parents at home are given less duties [26]. The gender gap has widened in the wake of the pandemic- the personal protective equipment and duty rooms are clearly designed for men than women, for bigger builds than smaller builds [27].

Much as we would like to say that duties are allotted on the basis of evidence based medicine - the power imbalance within the medical profession has predated the pandemic and will likely outlast it [28]. Does this mean some lives are worth more than others? Or, from a salutogenic perspective, does this mean that some demographic groups are more resilient than others and therefore can be exposed more to risk. There is preliminary evidence that younger adults and women are more likely to survive the novel coronavirus infection than older adults and men [29 [30] [31]. Does this justify the health care administrative decisions we take? And what are the costs of these decisions to doctors and nurses over the years? Further, in choosing to ignore these pressing imperatives – has the health care profession thrown itself under the bus?

Finally, what is the ethical basis of the utilitarian decisions we have decided to take to contain the COVID-19 pandemic, and how shall we justify this, years later in books on history and public health [32]. For this comes eerily close to the practise and defence of eugenics in Nazism and Fascism – which were too, of course, founded on utilitarian principles and spurred the need for bioethical principles and the regulation of medicine in the first place [33] [34].

The ethical quandary to consider while bridging health care’s divides (between patients and health care providers as well as within providers) during the global response to the COVID-19 pandemic is: [35] [36]

*Quis custodiet ipsos custodes?*- who guards the guardians? [37]

There are no easy answers to this, or even, a single homogenous response available. However, I have this slogan for inclusivity from identity activism to offer as a moral and ethical guide:

*Nihil de nobis, sine nobis* – nothing about us without us [38]

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