Moral Decisions/Ethics Notes:

Tseng 2021: Deontological or Utilitarian? An Eternal Ethical Dilemma in Outbreak

* Focuses on the two main ethical theories, deontological and utilitarian.
  + Hard to balance between these two ethical theories.
* Note: Ethics are not just moral choices but also the judgements behind these choices.
* Classic: Belmont Report – Three core principles
  + Autonomy
    - Respect for persons, both by informing them what is happening, and protecting those with lower autonomy
  + Beneficence
    - Respect people’s decisions, protect them from harm, and ensure well-being
  + Justice
    - Resources/efforts/contributions and merits should be ALLOCATED EQUALLY to people, no matter the race, religion, gender, etc.
    - This clearly doesn’t happen “as-is” so we can point to this as a major weakness/concern of ethical healthcare theory
* The current split of moral principles can lead to conflict/difficulty in reaching a conclusion.
  + Deontological ethics are inclined to be patient-centered; consequences are not used to justify means.
    - Is this the source of the conflict b/w people wanting others to have good care (utilitarianism) vs. wanting people to only have care if they ‘deserve’ it or have done it the ‘right way’ (deontology?)
  + Utilitarian ethics are inclined to be society-centered; this values care for the greatest welfare for the greatest number of human beings; Thus, the outcomes determine the means.
* Both deontological and utilitarian ethics have strengths and weaknesses.
  + For example: during pandemic/epidemic, both ethical theories should be considered, but it is possible for one to ‘override’ the other, which leads to controversy.
* Utilitarian Ethics:
  + Consequentialist ethical theories; maximize utility and prioritize public happiness.
    - “Doing bad things w/ good outcomes can be good!”
    - Utilitarian ethics can lead to some harmed for the ‘good of all’
  + “From a utilitarian perspective, medical resources are finite and there is a need to distribute them appropriately, to reach maximum health care benefit for greatest number of people”
* Deontological Ethics:
  + AKA Universal Moral Obligations – no harm is allowed even if it may lead to good outcomes!
  + Whether an action is moral is evaluated by the nature of the action, not it’s consequences.
* Utilitarianism has a fault in that you CANNOT correctly predict the outcome of every action, and the action itself might have a bad consequence.

Utilitarianism is seen as the preference when you have to ration care (Organ donation)

* Do people support UHC based on their support for utilitarian vs deontological ethics?
  + Providing medical care can be seen both deontologically (people need medical care and it is ethical to give that to them
  + Can also be seen as utilitarianism (people want others to have medical care because it’s a net benefit for society)
* Attacking UHC
  + Deontological: People should not be given handouts, need to ‘earn their keep’, people can get healthcare from their job – if they were part of society and being productive they WOULD have healthcare (suffering from no healthcare is a choice and consequence).
  + UHC is bad because we need high privatized healthcare spending in order to push forward innovation

Wagner 2015: NURSING ETHICS AND DISASTER TRIAGE - APPLYING UTILITARIAN ETHICAL THEORY

* This paper focuses on ‘disaster’ striking wherein normal procedures need to be modified
  + Is this triage mindset appropriate? Perhaps expansion of treatment that is cheap for manufacturers but expensive for consumers (insulin)
* Compare and contrast
  + The ‘4 ethical principles (autonomy, beneficence, nonmaleficence, and justice)
  + Utilitarian ethical theory
    - “Making a life or death decision that a patient will consume too many resources and must go into the dead or dying category runs counter to the moral intuition of most people and most nurses, as well as counter to the typical ethical principles that normally inform daily nursing practice.
* Triage is used every day in Emergency Depts. Worldwide
  + How would people react if healthcare were distributed according to the Emergency Severity Index Scale (5 level triage system) instead of ability/willingness to pay?
* In a “disaster” triage does NOT use the ESI system, because resources become SCARE quickly, thus, the goal is maximum good for most people through most efficient utilization of resources.
  + This is similar to utilitarian ethical theory!
  + The process here is in direct contrast to system used in emergency departments! If someone is doing very badly in an ED, they are taken care of first and EVERYTHING is done to try to save that person, no matter the resources.
  + In a disaster… critically ill patients with minimal chance of survival are NOT given resources, primarily comfort care and pain control.
* Covers the conflict between caring for every patient, and doing the most good for the most people.
  + What are contemporary criticisms of both utilitarianism and deontological thinking?

Benatar 1997: Just Healthcare beyond Individualism – Challenges for North American Bioethics

* Autonomy has been given lots of support and leverage (patients have a good amount vs. physicians)
* Justice w.r.t. resource allocation has less support!
  + Due to high-profiles given to technological interventions @ beginning and end of life.
  + Focus on ‘individual liberty’ and the ‘free market’ eclipses considerations of ‘social justice’
    - How can we compare and contrast these two concerns against each other?
  + Self determination, civil and political rights, free trade are HIGHLY prized
    - Socioeconomic rights, government control w.r.t. healthcare, and civic responsibilities are FEARED and UNDEREMPHASIZED
    - Concern about excessive state power, potentially subject to public accountability through the democratic process, however, seems to have been, traded for the progressive accumulation of (almost anarchic) power by private corporations that have been freed from accountability by "deregulation”
* Huge annual expenditure of healthcare (10x per capita GNP of half of worlds population)
  + Yet can’t, or CHOOSES not to provide basic minimum healthcare package?
  + Why are health expenditures so high, but outcomes so poor?
  + CANNOT treat healthcare as another commodity to be traded for profit in the marketplace
* What is/Where is consistency in the overriding of individual choices by state interest in protecting life?
  + If state interests in life can be used to override individual interest for the alleged benefit of the public good, why is this not used as an argument for the role universal access to healthcare could play in shaping a cohesive society respectful of autonomous citizens and the common good?
  + This links very closely with restrictions and bans on abortion in MO and other states.
  + “A society that has elevated the admirable concept of individual liberty to a level that (with the best of intentions for individuals) seems to undermine the concept of community to the detriment of both society at large and many of its citizens.”

Schminke & Ambrose 1997: The Effect of Ethical Frameworks on Perceptions of Organizational Justice

* Research focuses on PROCESS concerns and OUTCOME concerns
  + Relatively similar to “deontological” ethics and “utilitarian” ethics
* Shows that individual ethical frameworks do indeed change how people perceive whether or not an organization is just.
  + Ethical formalists = sensitive to procedural justice
  + Ethical utilitarians = sensitive to distributive justice.
* Distributive Justice:
  + Seen as how people feel about the distribution of outcomes
* Procedural Justice:
  + Seen as how people feel about the process by which these ethical outcome allocation decisions are made!
* Again, focuses on the contrast between utilitarian (outcome-based) and formalistic (rules/process based) decisions.

Process and Outcomes in Justice Research

* Early work in ‘justice’ morality focuses on ‘distributed fairness’ (perceived fairness of outcome distributions!)
  + In organizations, distributive justice focuses on perceptions of equity.
  + Mostly, reactions to pay equity and inequity, although also experienced in job challenge, job security, supervision, office space, and layoffs.
* Research on the fairness of outcomes shows that this perception directly affects attitudes and behaviors.
* Thibaut and Walker (1975): Even when people receive individually unfavorable outcomes, the outcome is seen as MORE positive when they believe the process by which it was determined was fair
  + Input into a decision process increases individuals perception of the fairness of the process (Lind, Kanfer, Early; 1990)
  + Procedural fairness is applicable in many settings (drug testing, selection testing, discipline, budget decisions, recruiting, etc.)
* In comparison… Distributive justice has been mostly ignored (Greenberg 1990; 1993)
* The two constructs are related but distinct.
  + Perceptions of distributive justice and perceptions of procedural justice may affect each other.
  + Research also suggests that they interact!
    - Procedural justice = stronger impact when outcome is unfair, distributive justice = stronger impact when the procedure is unfair.
    - “For example, an individual may receive a promotion she deserves, but may not feel the process allowed her adequate input prior to the decision. If she focuses on the outcome, she is likely to assess the situation as fair. If she focuses on the process, she is likely to assess the situation as unfair.”

Process and Outcomes in Ethics Research

* Individual differences exist in how people deal with/assess moral judgement in ethics
  + Several taxonomies exist to delineate these ethical frameworks (Brady 1985, Kohlberg 1984, Velasquez 1992)
  + They share the belief that stable individual differences in ethical ideology affect individual ethical judgements
* Formalist approaches: Process oriented, individuals subscribe to a ‘set of rules and principles’ to guide behavior, actions are ethical or unethical based on how well they conform to these rules!
* Utilitarian approaches: Outcome oriented, people define ethical actions as those that create the greatest ‘net social good’ (under whose calculation?, very subjective). Actions cannot be identified as ethical; only their outcomes can.
* Note that these are roughly synonymous with Deontology and Teleology (the two major ethical principles)
  + Fine grained distinction exists, such as act/rule formalism or utilitarianism, but is unnecessary at this level of consideration.
  + Originally considered to be relatively separate ends of a continuum, however, Brady and Wheeler (1996) finds that they are not, but instead independent subdimensions (can be high or low on both!)
    - Note: Must consider and measure each of these separately, and theorize as to which would generally fall in line with support or rejection of UHC

Integrated Model of Ethics/Fairness:

* Ethics research focuses on individuals and how beliefs affect perceptions of organizations
* Justice research focuses on situations and how attributions of situations affect individual perceptions of organizations.
  + Hypothesis: Different predisposition for people to view the world based on their preference towards one or another ethical framework.
  + Affects how they view general organizations and outcomes as well, including those w/ fairness of procedures/distribution of outcomes.
* There is difference sensitivity to perception of equity (Huseman, Hatfield, Miles 1987)
  + Rasinki (1987) finds that individual preferences for proportionality or egalitarianism affects how they weigh procedural or distributive justice in judging the ‘fairness’ of government policy!
  + Propose that people are most sensitive to aspects of organizational decisions that match their ethical orientations (formalism, utilitarianism, or BOTH!). Seen as a MODERATING effect of ethical framework on the relationship between organizational decisions and their perceived framework
    - Two ways it can manifest: Relationship between organizational procedures and their perceived fairness should be stronger for STRONG formalists (those who base opinions on what is right on rules of action)
    - Relationship between distribution of organizational outcomes and their fairness should be stronger for STRONG utilitarians (those who base opinions of what is right on outcomes of actions)
  + Perhaps we can frame UHC received as either the result of certain given procedures/rules of action (Formalism), or… whether or not those who received UHC had a good outcome (Utility)

Methods

* Respondents from 11 midwestern organizations w/ various business concerns.
  + Including hospital/university/govt. organizations.
* 73% response rate, with avg age 38.
* 4 main variables that affect perceptions of organizational justice:
  + Ethical formalism
  + Ethical utilitarianism
  + Procedural justice
  + Distributive justice
    - The first two are individual difference variables, the latter two are experimentally manipulated through scenarios that reflected procedurally just or unjust and distributively just or unjust organizational actions.
* Each survey pack had instructions and demographic questions, then questions presented in random order:
  + Assessment of individual ethical frameworks
  + Scenario describing a moral activity (up for promotion)
    - Both procedural and distributive justice were manipulated
  + Followed by assessment of respondent’s perception of the fairness of the process and the outcome.
  + Lastly, measures of perceptions of the respondents own organization, including perceptions of procedural and distributive justice.

Measures

* Ethical Predispositions:
  + Character traits version of the Measure of Ethical Viewpoints (Brady & Wheeler, 1996): Measures the extent to which respondents display utilitarian or formalist ethical predispositions.
    - Perhaps look to see if there are more updated measures?
  + Note: two factors account for 42% of data variance:
    - Utilitarianism at 26%, and Formalism, at 16.7%.
    - Utilitarianism and Formalism scores are calculated by averaging responses for both sets of items.
* Scenario-Based procedural and distributive justice:
  + Procedural and distributive justice were between-subjects manipulations:
    - 4 possible scenarios:
      * Procedurally just, distributively just
      * Procedurally just, distributively unjust
      * Procedurally unjust, distributively just
      * Procedurally unjust, distributively unjust
    - In the high procedural justice scenario – both people involved in the promotion decision are allowed input into the decision-making process
    - In the low procedural justice scenario – only the co-worker is allowed input into the process, NOT the main person up for promotion!
    - In the high distributive justice scenario – individual with a better objective performance is awarded the promotion!
    - In the low distribution justice scenario – individual with a better performance is NOT awarded the promotion.
  + Think of how to adapt these 4 scenarios to various forms of UHC, specific HBP plans (input or no input?).
  + Pilot tests were used to confirm that procedural and distributive justice manipulations were perceived as intended! This is vital to the procedure.
* Finally asked questions that assess their reaction/perception of the scenario:
  + How fair was the method the supervisor used to make the decision (assessed perception of procedural fairness)
  + How fair was the decision/How fair was Chris’ outcome? (measured perceived distributive fairness)
* Afterwards, asked questions on their own organization/workplace balance of procedural justice (are procedures fair/how fairly treated are you by your supervisor?) and distributive justice (how fair are the outcomes you receive from your organization?)

Analysis/Results

* Individual differences in utilitarianism/formalism scores used as covariates in analysis
  + Perceptions of procedural justice matched the manipulation (just = 4.6, unust = 2.7)
  + Same with distributive justice (just = 4.7, unjust 3.2)
    - Small effect of both manipulations on perception of the other aspect as well! (some spillover from related concepts?), but less significant than on the main effect expected
* No effect of demographics on our outcomes.
* Hypothesis 1: relation b/w organization procedures and perception of fairness is stronger for high formalism than low formalism scores.
  + Significant interaction between procedural justice outcomes and formalism scores
  + High formalism see procedurally just actions as more fair than those with lower formalism (especially fair!)
  + Utilitarian tendencies did NOT interact with procedural justice perception however!
* Hypothesis 2: relation b/w organizational outcomes and perception of distributive fairness will be stronger for those with high utilitarian than low utilitarian scores.
  + This interaction is significant!
  + Highly utilitarian subjects view distributively just actions as ESPECIALLY fair!
    - Formalist tendencies also did not interact with organizational outcome perceptions, as expected.
* Own Org Analysis:
  + Formalism was marginally related to perception of procedural justice, and utilitarianism was related to perception of distributive justice.
* Individual ethical frameworks ARE indeed important to perceptions and judgements of what is valuable and important.
  + What is the cognitive process by which ethical frameworks affect judgements??
  + E.g. Formalists may notice procedural aspects, utilitarians notice outcomes, etc.
  + Or… ethics can influence how information is interpreted/encoded: Formalists may give more weight to fairness aspects of procedure, for example.
* Could also be due to cognitive shortcuts, using a ‘fairness heuristic’
* Incongruence between what people prioritize means someone may thinking something is fair under criteria of formalism, but not under criteria of utility!

Love 2018: The Ethical Standards of Judgment Questionnaire – Development and Validation of Independent Measures of Formalism and Consequentialism

* This paper focuses on how to measure the ethical frameworks of consequentialism (utilitarianism) and formalism, and measuring the two elements independently!
  + Follows contemporary work and theory/statistical dependability!
* New, valid, scale to measure consequentialism and formalism being well grounded in prior research.
  + Measurement items develop in first 3 studies, fourth study addresses discriminant validity, 5-6th studies give insight onto how both consequentialism and formalism scores predict how people perceive behaviors in both consumer and religious beliefs
* Contemporary research notes that harmful actions must be categorized as ‘acceptable’ or ‘unacceptable’, tacitly endorsing deontology or utilitarianism. This confound is fine if the moral inclinations were inversely related (high deontology = low utility and vice/versa). However, this is NOT the case, and both can be high or low separately!
  + E.g. Deontologist = follows principles, thus an anti-deontologist = IGNORES principles? This is crazy, and doesn’t suggest they care about outcomes instead of principles. The hypothetical anti-deontologist would make choices based on what takes the least effort as well as utility (anti-utilitarian is much the same w.r.t. NOT adhering to principles, it’s not necessary to do so!)
* Note – Authors consider a difference between consequentialism and utilitarianism!
  + “The tendency to assess ethical situations in terms of their consequences to people”
  + The “rightness” of a choice is a function of the results (consequences) of that choice, and thus, rightness = maximization of wellbeing (based on outcomes!)

Necessary Criteria for New Measure:

* Formalism and consequentialism measured separately as two constructs, with discriminant validity b/w the two constructs
  + Formalism scale needs to capture the tendency of a person to make ethical choices based on set of rules which determine whether behavior is good/bad, consequences should be irrelevant
  + Consequentialism scale needs to capture tendency of individual to make judgements and evaluate ethical choices based on outcomes or net utility of the choice.
    - Creates the Ethical Standards of Judgement Questionnaire (ESJQ)

Old Measures

* Measure of Ethical Viewpoints (Brady and Wheeler 1996)
* Survey of Ethical Theoretical Aptitudes (SETA, Brady 1990)
  + Both used in prior research, however, there are big limits to them!
* MEV:
  + Forced choice vignettes matched with a character traits measure.
  + Biggest issue is large correlation b/w formalism and consequentialism when measured.
  + Uncertainty whether this subscale measures constructs OTHER than consequentialism and formalism.
* SETA:
  + Measures individual preference for consequentialist or formalist framework.
    - 15 statements split into several options, relating to either one preference or the other.
    - Considered superior to MEV; the sentence completion task is provided as a ‘forced choice’ suitable for capturing relative preference, but doesn’t show the degree to which either preference is favored!
  + The relationship between formalism/consequentialism is proscribed to be two parts of a continuum, they are not allowed to vary separately.

Scale Study Development:

* The ESJQ has satisfactory discriminant validity while the MEV does not
* The ESJQ consequentialism subscale has satisfactory construct validity, the MEV does not!
  + MEV formalism scale works fine however.
* Assessed the impact of formalism and consequences on ethical perceptions w/ MV-CES scale (measuring consumer ethical beliefrs)
  + The ESJQ results were a satisfactory match for predicted consequences or outcomes.
* Some of these ethical consumer issues show some deviation
  + High consequentialism score = negative correlation w/ actively benefiting from illegal activities, but not correlated with PASSIVELY benefiting from illegal activities.
  + People can support or attack different things based on their own moral reasoning!
* Formalism/Consequentialism differentiation can also be found in assessment of different religious faiths.

Conclusion

* ESJQ works well to inform research in social/moral psychology. The ESJQ consequentialism and formalism scales uniquely can predict responses on moral dilemmas.
* It is LIKELY that other personality traits interact with consequentialism and formalism to influence decision making and behaviors
  + E.g. Machiavellian consequentialism may be different from that from an altruist!
  + Consider seeing if these preferences towards consequentialism/formalism interact with or are predicted by political affiliation/preferences?
* The final measure itself is two 6-item subscales, with one corresponding to consequentialism, and the other, formalism.

Tanner 2008: Influence of deontological versus consequentialist Orientations on act choices and framing effects: When principles are more important than consequences

* Focuses is primarily on what scenarios people prefer deontological vs consequentialist morality.
  + Modification of Tversky ‘risky choice’ paradigm that manipulates the farming of outcomes (positive or negative) as well as if the outcome was due to action or inaction.
* Act vs. Omission tendencies are linked to deontological focus and PVs
  + Framing effects however, are driven by consequentialist focus!

Link b/w Deontology and Consequentialism:

* Not a vacuum where neither influences the other, nor a binary where one is in stark opposition to the other, on balance, the other element CAN be considered, just generally at a lower level of priority!
* Wants to find the influence of deontological vs consequentialist perspectives, and whether or not “protected values” (personal moral expectations) affect act/omission bias and on framing effects.

Experiment:

* Multiple items to assess deontological/consequentialist orientation
  + Expect to see that both types of reasoning have different effects on action preferences and framing effects.
  + Deontological = bias towards acts rather than omission, and insensitive to framing effects?
  + Consequentialism = sensitive towards framing effects?
* Set of items to determine what, if any, values are “protected values”
* N = 248, mostly women, avg 32 years old, primarily from Germany.

Results:

* Deontology and consequentialist are NOT opposite ends of a dimension.
  + Not mutually exclusive, or negatively correlated!
  + Hypothesized that this is an orthogonal relationship instead!
* Deontological orientation was more likely to prefer action over omission (in otherwise balanced cases)
* Framing effects were moderated by consequentialist orientation, those with higher consequentialism showed larger framing effects!
* Having ‘protected values’ is highly associated with deontology!
  + Also associated with preference action than those without PVs
* Consequentialists cared much more about framing effects (positive or negative focus on same #’s) rather than act/omission distinctions.
  + Tradeoff reluctance is an issue w/ PV’s that have consequentialist orientation, as they may believe that following the rules yields better consequences over the LONG term, regardless of the benefits/costs at that exact point and time.
* Note: Deontological rules can be framed as acts of action, or actions of omission! This is important for the framing.
* We found insensitivity to framing effects among strict deontologists (high deontology, low consequentialism). Furthermore, we found strong act preferences as well as large framing effects among people that combined both deontological and consequentialist concerns. Given that these people showed preferences for action (over omission) and framing effects, their principle may be best described as ‘‘you have a duty to act but act in way that produces better outcomes.’’

Laakasuo 2016: Are Utilitarian/Deontological Preferences Unidimensional?

* Simple study covering utilitarian/deontological preferences, across several measurement tools.
* No significant evidence supporting a single-factor model of utilitarian/deontological beliefs.
* “Deontologists argue that if a moral rule can be violated in one situation, it can be violated in any situation, and therefore stops being a moral rule. For example, “do not kill” is a classic absolute deontological rule, and thus murder is always wrong from a deontological perspective even if it saves lives. For a utilitarian, the ends justify the means whereas for a deontologist they do not.”
* Talks about ‘high-conflict dilemmas’ where a moral agent (participant) has the option to kill an innocent w/ actions to save the lives of others.
  + Considered an ‘emotionally taxing personal engagement’ as there is conflict between utilitarian and deontological tendencies
  + Is there a moral high-conflict dilemma when evaluating support/opposition for UHC? Or is this a ‘relatively easy’ choice with no moral juxtaposition for decision makers?
    - E.g. People are aware of deontological or utilitarian benefits, but the choice that needs to be made is so simple that no conflict is generated?
  + Is UHC considered a circumstance where there is a moral-high conflict dilemma? Need to determine if this is the case!!!
* Deontological responses are tied to:
  + ‘Instinctive, emotional ‘gut reaction’
* Utilitarian responses are tied to:
  + “Dark triad” measures
  + Negative correlation w/ honesty-humility and harm/care ethics
  + Decision making with less emotion involved
  + Greater working memory capacity
* Utilitarian/Deontological preferences when measuring moral inclinations CAN be seen as unidimensional (with weighted averages), opposing some other recent research saying that they are multi-dimensional!

Lee & Gino 2014: Poker-faced morality: Concealing emotions leads to utilitarian decision making

* Emotional regulation (specifically, suppression and reappraisal) encourages utilitarian choices in ‘Emotionally charged’ (moral high-conflict dilemma) contexts and this is directly mediated by decreased deontological inclinations (are we/can we see shifts in relative utilitarian/deontological perspectives here?)
  + E.g. Use deontological/utilitarian scores as a mediator much the same way as ‘understanding’ and ‘perceptions of fairness’ in our previous research?
* Study 1: People making utilitarian choices were more likely to suppress their emotional expression
* Study 2a,b, and 3: Participants were told to either regulate their emotions (2 different strategies) or not to regulate emotion.
  + Participants who suppressed their emotions were more likely to make utilitarian decisions
  + If we see this pattern replicate itself in our own study… We can set that up by framing UHC as a great ‘utilitarian’ choice, or as a great ‘deontological’ choice.
    - Then, if we see that suppression of emotion works to increase acceptance of the ‘utilitarian’ choice, that indicates that the moral decision making within UHC is seen as a ‘moral-high conflict- dilemma’ which is UNKNOWN in the literature (and quite valuable?)
* Study 4: Reduced deontological inclinations mediate the relationship between emotional regulation and utilitarian decision-making!

Some utilitarian choices are seen as ‘necessary evils’, wherein those surveyed found 46% making those choices were ‘psychologically disengaged”

* Can we frame UHC as a ‘necessary evil’? Wherein it may be deontologically a poor choice to provide handouts, but the resulting improvements in general health (especially for hard working Americans that are unlucky and get shafted) are a worthwhile tradeoff?
* How much suffering should exist for unlucky people as an acceptable corollary to ‘punishing’ those who don’t contribute?
* When ‘Strong aversive emotions’ are tied to moral dilemmas (such as those generated by trolly problems!), people no longer prefer the utilitarian option ‘‘Doing harm is morally acceptable in circumstances that improve well-being’’) and instead tend to choose the more morally intuitive, deontological one (‘‘Doing harm is morally unacceptable’’).

Macko 2020: Contingencies of Self-worth and the strength of deontological and utilitarian inclinations:

* Paper shows that there is a correlation between self worth as measured by being ‘virtuous’ and deontological beliefs as well as ‘outperforming (competition)’ others and utilitarian beliefs
  + By increasing the saliency of ‘virtue’ as a source of self-worth, deontological beliefs/inclinations were increased, but no change in utilitarian inclinations.
  + Same was shown when increasing saliency of competition as a source of self-worth, which improved utilitarian inclinations but did not affect deontological inclinations.
* Study 1:
  + Conventionally measured relative deontological judgement correlates positively with deontological inclinations and correlates negatively with utilitarian ones.
    - Thus, deontological judgement is used to enhance a desired self-image, even when communicating with self or others!
  + Basing self-worth on competition, was a significant predictor of utilitarian inclinations!
    - Thus, we show that motivational factors (self worth perception) have some explanatory power when identifying how harm rejection/outcome maximization functions.
* Study 2+3:
  + How does manipulating salience of virtue or relative efficiency/effectiveness (competition) impact deontological and utilitarian inclinations?
  + Control group, and two interventions (one increasing virtue, one in creasing competition)
  + Strengths of deontological/utilitarian inclinations were related to contingencies of self-worth
    - Note: We need to determine whether support or opposition of UHC is mainly centered around deontological or utilitarian beliefs
    - Then, we can know whether manipulation of deontological or utilitarian levers is most appropriate!
  + Study 3 confirmed result of study 2, that virtue or competition correlate strongly w/ deontology and utilitarianism.
    - Importantly, concern for ‘appearing/feeling’ virtuous should generally predict increased deontological inclinations, and be unrelated to utilitarian ones.
  + Improvements in virtue/deontology are due to the self-perception of the ‘moral self’. In contrast, improvements in utilitarian beliefs don’t have ‘moral roots’ and living up to one’s own moral standards are UNRELATED to utilitarian inclinations!

Garrafa 2018: A Central Question within Brazilian Bioethics

* Brazil’s constitution guarantees UHC “healthcare: everyone’s right and the state’s duty”
  + This is an implementation of UHC that seems to hew to ‘deontological’ reasoning as to why it needs to be implemented!
* Brazil’s UHC (SUS) guarantees six things:
  + Universality of access at all levels of care/assistance
  + Equality of healthcare w/o prejudice and privilege
  + Comprehensive care (integration of preventative and curative actions and services for each case at all levels of complexity)
  + Community participation in the construction of guidelines/priorities for healthcare
  + Political-administrative decentralization, with regionalization/hierarchical organization only as needed.
* “Countries contradictory social reality”
  + Hard to maintain public healthcare service with minimal resources/huge poverty
    - People perhaps can be framed as understanding of a country where UHC can’t be provided due to poverty?
    - How is this contrasted to people supporting/opposing UHC in the US, were there is drastic over-spending on healthcare (not really poverty?)
* This social reality is reflected in the ‘subfield’ of “Hard Bioethics” or “Intervention Bioethics”
  + Comparison to bioethics centered in US and Europe, thought to focus on use and application of new biotechnologies in clinical research, or problems w.r.t. relationship between healthcare professionals and patients.
  + Faced with the “Hard” collective macro-problems for lower income countries (hunger, social exclusion, illiteracy, inequality, etc.), the previously mentioned issues are seen as “Soft”
  + “It sought to reflect more directly on bioethical issues associated with the global political and economic determinants fundamental for comprehending the ethical problems and conflicts that affect people’s right to access healthcare, or inability to do so.”
  + “It is the role/responsibility of the state to defend more vulnerable population groups in order to promote equity and equality”

Albert 2015: Turning Inward or Focusing Out? Navigating Theories of Interpersonal and Ethical Cognitions to Understand Ethical Decision-Making

* How theories of ethical decision making function in action.
* Does the ‘cognitive and rational’ approach (similar to utilitarian?) revolve around moral judgements of an issue when making choices w.r.t?
* Argument that ‘central aspect’ of ethics is “consideration of others”
  + The ‘nature’ of the particular moral issue can shape individual responses to ethical situations!
* Two approaches to ‘Ethical Behavior’
  + Cognitive Approach: recognize the ethical content, judgement on the issue, determine what behavior to do, then finally do it.
  + This cognitive approach underlies BOTH consequentialism and formalism (Brady and Wheeler 1996)
    - E.g. Consequentialism is ends based decision making, Formalism is ‘means based’ decision making. The two constructs here are fundamentally different elements of a ‘cognitive approach’
  + Interpersonal Approach: an additional dimension to ethical decision-making.
    - Availability of both ‘view of self’ and ‘view of others’, the other view built on expectations of others, self model based on acceptability/worth of the self.
    - Individual perception of others is argued to be one of the most important determinants of warm and agreeable behavior! (Albert & Moskowitz 2014)
    - Those who see others as hostile/unfriendly/unfair, respond in hostile, unfriendly, and unfair ways themselves!
      * Likewise with perceptions of others being friendly, compassionate, etc.
    - Baldwin (1992, 1995) argues that the view of others works in concert with view of self to determine how a person interprets and reacts to interpersonal information, which can be used to guide their behavior!

An integrated Model based on Social Consensus

* Jones (1991) argues in their model that issues vary in moral intensity (% to which an issue involves moral content)
  + 6 Characteristics; Magnitude of harm, temporal immediacy, probability of effects, concentration of effects, proximity, and SOCIAL CONSENSUS
  + Social consensus is ‘degree of social agreement that a proposed act is evil or good’
    - Perhaps directly query participants on what they believe the social consensus is for UHC??? (e.g. do you think others see it as a good/bad act?). Also includes how much there is general consensus within society about the morality of the issue (do people in favor/against UHC believe that their belief is the consensus… do they believe that a consensus exists at all?
  + When social consensus is high… clear and shared understanding of what is ethical becomes apparent. In these cases, personal judgements of ethicality (consequentialism or formalism based analysis of the issue, aka cognitive processes) are not needed!
  + Instead, widely-accepted social consensus spontaneously informs the individual on the ethical nature of the issue, High social consensus does not, however, guarantee that the individual will be motivated to perform that ethical action. The individual must be motivated to act upon that social consensus.
    - This means that perhaps people do have a positive consensus view of UHC… but that some individuals (conservatives?) are just not motivated to engage in that ethical action, as they don’t have motivation to feel strongly about that social consensus.
  + Interpersonal research shows that individuals perceptions of others is a vital determinant in behavior (albert and Moskowitz 2014). Thus, in situations of high social consensus, behavior depends on the individuals view of others!
    - If the individual perceives others positively, they will respond with positive behavior!
* If social consensus is low however… behavior seems rather different, individuals must reach their own conclusion to arrive at a moral decision.
  + When social consensus is low… consequentialism should be associated with outcome oriented behavior, and formalism will be most associated with means-oriented behaviors.
  + When social consensus is low, view of self should moderate both consequentialism and formalism (those with good view of self should have a stronger mediated effect of both)

Study 1:

* Used multiple measures of ethics behavior to see effects of social consensus, view of others/self, and consequentialism/formalism axis on ‘ethical behavior’
  + Measures of ethical behavior: Measured social consensus (charitable giving Reynolds and Ceranic 2007), as well as directly testing social consensus on various choices using a ‘pilot/holdout’ sample of the data.
  + Likert scale from 1 (disagreement that this is ethically good or bad), or 5 (agreement that this is ethically good or bad).
  + View of self measured using Rosenberg Self Esteem Scale, and view of others measured with typicality schema scale.
    - Instead of framing as, UHC is ethical or unethical based on either formalism/consequentialism, uses outside measures of ethical behavior to determine whether or not social consensus exists.

Study 2:

* Used assessment of willingness to engage in various ‘high’ or ‘low’ social consensus unethical actions as dependent variable.
  + Only ‘views of others’ affect illegal action willingness on items of high social consensus.
  + When consensus is high, a favorable view of self enhances the positive effect of view of others on ethical behavior
* For low social consensus, view of self/others didn’t influence behaviors.
* Both consequentialism and formalism independently influence behaviors in the directions expected!

Study 3:

* Within subjects exercise that isolates effects of social consensus on ethical decision-making.
* Repeated measures experiment, within subjects factor was social consensus
  + Participants asked to pretend they are a manager, with a list of tasks to do.
  + One task is recommending punishment for employees that engaged in specific behaviors, one a high consensus behavior and one low.
    - Employee threatens a person life vs employee spent an afternoon doing personal taxes on their work computer
* Ethical behavior measured as ‘punishment recommended’ for the high and low consensus behaviors , from ‘do nothing’ to ‘fired’
  + Punishment is a second order decision based on first order behavior of others.
  + More ‘severe’ punishments were considered ethical behaviors, and more means based as well.
* Also measured formalism, consequentialism, and view of self/others, as covariates.
  + Support for four of the hypotheses found (h1a,h2b, h1b, h2c)
* Integrated models combining principles from ethical cognition/interpersonal research helps explain ethical choices more comprehensively.
  + Judgements of others as well as personal judgements of others affect ethical issues
  + Can we directly activate salience of ‘high social consensus’ and ‘low social consensus’ for UHC before having people rate and assess the circumstances?
  + Note, vitally, that view of self/others is an important moderator in the effect of consequentialism/formalism on ethical perception.
  + View of self does not directly predict deviant behavior, it instead influences the relationship between view of OTHERS and ethical behavior.

Barilan & Brusa 2007: Human rights and bioethics

* Rights are viewed here (especially that to health) as a ‘trump card’, wherein outside of extraordinary circumstances, they should not be overruled.
  + Seen as ‘major constraints’ on action
  + Can we engender increased salience of UHC as a “high social consensus”, if we portray it as something that people deserve, as a right?
  + Phrased differently, do people deserve UHC, and how much healthcare should people be granted?
* John Lock’s (conservative thinking?) original perspective: Three rights all humans are guaranteed: Freedom, Property, and Life. No-one can take my freedom, belongings, or life, ethically.
  + Perhaps can frame this issue with regards to the social consensus existing for ‘Slavery is Bad’ (high consensus), and ‘Capital Punishment is Bad’ (lower consensus)
* Vital to distinguish between moral and political expectations of members of communities granted legal rights based on democratic processes, and the real economic means of that community vs the ‘universal moral right’ to basic healthcare
* Another framing: The Positive Right to Healthcare is NOT stronger than the negative right to property:
  + E.g. Society must NOT tax the rich in order to finance medical care for the poor
  + Is this the actual perspective that people take? Is there STRONG social consensus with regards to belief in the ‘rights of property’?
* Most of these previous viewpoints are seen from a ‘deontological perspective’, from a utilitarian framing, we REJECT the idea of ‘human rights’, or see it as an ‘instrument’ used in the service of more developed values and moral theories.
* Is it possible that some opposition of UHC comes from people’s dislike of it’s increased encompassment of ‘abortion’, ‘infertility’, ‘eugenics’ and euthanasia?
* “The language of rights is NOT much help when rights themselves are at the heart of a moral conflict (supposedly equivalent rights butting up against each other)!”

Kobayashi 2018: The Impact of Perceived Scientific and Social Consensus on Scientific Beliefs

* Perceptions of both scientific and social (network and public) consensus and their impact on scientific belief, in Japanese people.
  + Study 1: Participants’ estimates of scientific/social consensus predicted their beliefs, independently of each other!
  + Study 2: Presentation of scientific/public consensus information functions as an anchor for consensus estimation, influences participants’ scientific beliefs through their perceptions of scientific/public consensus
    - Is UHC considered a moral issue, or a scientific issue?
  + The credibility of scientists itself had little/no effect on the relationship between scientific consensus and scientific belief.
* Scientific consensus (extent to which scientists agree on an issue): Predicts and influences beliefs about those issues. (Cook & Lewandowsky, 2016)
  + E.g. Those who estimate greater consensus among scientists on existence of a science fact (Anthropogenic climate change) or causality (vaccine-autism link) are MORE likely to accept/be certain of those consensus truisms.
* Note, many cases exist where the average scientific belief deviates from the known scientific consensus.
  + Thus, the perception of this consensus can provide the key to understanding/reducing these deviations in belief.
* Social consensus perception has had more research:
  + Two elements: Consensus amongst social group members, such as family/friends/acquaintances (Social Network Consensus)
  + Consensus amongst ‘ordinary’ people in society (Public Consensus)
    - Are these two elements mistaken for each other in normal individual perception and decision-making?
* Directly analyzes the effect of how social and scientific consensus are perceived (separately, together?) as well as how they influence scientific beliefs.
  + Scientists agreement on a ‘Scientific Issue’ is a ‘heuristic’ cue about the acceptability of a scientific claim. This ‘cue’ exerts informational influences!
    - E.g. Processes that change/maintain perceptions/attitudes/beliefs by providing information about reality.
    - Not the same as ‘normative influence’, processes enforcing individuals’ compliance with others’ positive expectations.
* Perception of Scientific consensus can often be distorted to favor biased cultural worldview/party identification (Cook & Lewandowsky, 2016; Kahan, Jenkins-Smith, & Braman, 2011; McCright et al., 2013)
  + ‘Gateway Belief’ model (van der Linden, Leiserowitz. 2015): Normal people perceive/form beliefs about a level of scientific consensus on the basis of externally provided scientific information (e.g. information about the actual scientific consensus!) and change beliefs in accordance with the perceived level of consensus. (e.g. less belief in early stages of COVID-19 with less consensus)
  + Perceived scientific consensus mediates the relationship between presentation of scientific consensus information and scientific belief change. Assumed that perceived consensus is the antecedent to change in belief.
* Perceived social consensus can influence scientific belief: Normal people regard group/social network as reliable sources of information, especially when given conflicting/ambiguous information from other sources.
  + Social consensus can work as a heuristic to judge whether or not a scientific claim is acceptable.
  + “Stangor, Sechrist, and Jost (2001) found that providing individuals with information about a consensus among their group members on a psychological issue (i.e., stereotypic traits of African American) changed their estimates of a level of group consensus and beliefs about the issue in accordance with the given consensus information.”
* Scientific and Social consensus are rarely examined in joint aspect, however, van der Linden (2016) looked at perceived scientific consensus on the discrimination of global warming believers/deniers with that of perceived consensus among social network members and the ‘general public’.
  + Scientific consensus was more predictive than social consensus amongst ‘general public’, but not greater than social consensus amongst ‘social network’.

Study 1:

* Hypothesis 1: Perceived scientific and social consensus predict scientific beliefs independently of each other.
  + Hypothesis 2: Perceived scientific and social consensus mediate the effects of anchoring consensus information on scientific beliefs independently of each other.
  + Hypothesis 3: Perceived credibility of scientists moderates the relation between perceived scientific consensus and scientific beliefs.
* Social consensus was assessed separately as network/public consensus.
  + Participants estimated % of scientists, social network, and general public who would agree with a given view on a specific issue.
    - Also reported scientific beliefs about issue and perception of scientists credibility.
  + Participants themselves gave a 7-point likert from strong agree/disagree on those 4 scientific topics.
* Scientific Consensus and Social Consensus are perceived separately! Although, perceived scientific consensus was positively and moderately correlated with social network consensus.
  + Social network/public consensus estimates were roughly similar.
* Estimates of social network/public consensus were highly correlated, thus, a composite index of perceived social consensus was created by averaging the two estimates.
  + Scientific credibility was a partial moderator for belief in climate change and BT personality.

Study 2:

* Causal effects of scientific and social consensus perception by MANIPULATING levels of perceived scientific and social consensus.
  + 3 conditions: Scientific consensus feedback, Public consensus feedback, and no feedback conditions.
    - Scientific and public feedback conditions estimated recent past levels of scientific/public consensus on scientific issues first, then received feedback (preset) about those same recent past consensus levels as an externally generated anchor for the following consensus estimation.
    - Then, they were asked to estimate CURRENT levels of scientific/public consensus, by splitting the times into two groups, participants would not regard the second consensus estimation as a test of their memory/comprehension of feedback information.
      * Estimating consensus before receiving feedback ‘enhances’ the acceptability of the feedback!
      * Expected that participants who got feedback indicating relatively high/low consensus would estimate a higher/lower current level of consensus than those who did not.
      * Essentially, did the experimentally manipulated perceptions of scientific and social consensus influence their scientific beliefs independently of each other?
  + No feedback condition estimated recent past levels of scientific consensus first, then current levels of scientific and public consensus without receiving feedback.
    - We could run a modified version of this w/ assessing various ethical issues (obscuring UHC as one of many ethical issues considered?), e.g. how was slavery evaluated in the 1800s, 1900s? etc.
  + Perceptions of credibility of scientists for EACH specific issue was assessed, as perception of credibility may be different depending on what the topic is (e.g., human global warming vs. earth is flat)
* Positive and Negative consensus were created by adding 20% to the mean estimated percentages of scientific and public consensus for scientific/public consensus on climate change, nuclear power, and subtracting 20% from percentages for BT personality and whale research.
* Feedback condition lead to differing estimates of scientific consensus for BT personality, Whale research, but not for climate change and nuclear power.
  + Expectations for directional effects were as expected, lower percentages of consensus for BT personality and whale research, than those in the public consensus feedback condition or no feedback condition.
  + Estimation of public consensus were significantly different for feedback conditions in BT personality, nuclear power, and whale research, but not climate change.
* The experimental manipulation of scientific consensus worked for BT personality and whale research, manipulation of public consensus worked for BT personality, nuclear power, and whale research.
  + Perceived scientific/public consensus mediated the effects of consensus feedback on scientific beliefs, independently of each other!
  + E.g. Feedback indicating low scientific consensus decreased participants’ estimates of scientific consensus, in turn, weakening their beliefs about the two issues, independently of estimates of public consensus. Public consensus feedback strengthened participants’ beliefs about nuclear power and weakened beliefs about whale research ONLY through their estimates of public consensus on each issue
* Perceived credibility of scientists did NOT moderate the mediating effects of scientific consensus!

Results

* Scientific consensus is precepted differently than social consensus, estimates of scientific consensus were moderately correlated with, but significantly different from their estimates of social network and public consensus, regardless of scientific issue!
  + The interaction effect was pretty limited, participants distinguished scientific consensus from public consensus in their perceptions!
  + Perceived scientific consensus has an independent effect on scientific beliefs!
* Social consensus does indeed add unique value in predicting scientific beliefs.
* “The present findings suggest that social consensus is perceived differently from scientific consensus and that perceived social consensus influences scientific beliefs independently of perceived scientific consensus.”
  + Communicating actual scientific consensus can help individuals improve perceptions of consensus, but can widen gap between perceptions of scientific and social consensus; this widened gap can DISCOURAGE them from changing beliefs!
* Controlling for pre-existing scientific beliefs could be very useful!
  + Assess scientific beliefs before, immediately after, and LONG after presentation of consensus information.

Farrow 2009: Weight-based discrimination, body dissatisfaction and emotional eating - The role of perceived social consensus

* Weight-based discrimination influences emotional eating and body dissatisfaction
* Perceived social consensus in one’s network can influence how favorably overweight people are regarded, and can moderate the relationship between experiences of discrimination, and negative eating/weight related cognition/behavior.
  + Recollecting weight-based discrimination contributes to emotional eating/body dissatisfaction
  + The relationship between experiencing discrimination and body dissatisfaction/emotional eating were WEAKEST amongst participants who believed that the ‘ingroup’ held a positive attitude towards overweight people.
* Thus, social consensus was able to be modified, and effective!
  + Super impactful, b/c weight-based discrimination does NOT cause people to be motivated to lose-weight, but instead associated with refusal to diet, lower self esteem, and other negative effects.
  + Providing ‘false information’ concerning other social perception of obese can affect attitudes, when given perceptions more favorable than their own, attitudes towards obese improved, and even more pronounced when this information related to perceptions of participant’s own social groups (ingroups) than when it related to perceptions of outgroups. (Puhl, Schwartz, and Brownell 2005)
* Predicted that increasing salience of being in an ‘ingroup’ (perception of self as university student) could buffer victims against negative consequences of experiencing weight-discrimination.
  + This is HIGHLY dependent on the victims’ beliefs regarding the ingroup attitude towards overweight people.
  + “Specifically, we suggest that when victims believe that the ingroup holds a relatively favourable attitude towards overweight people the benefits of group membership should be most marked.”
* Study looks at exactly the role of perceived social consensus.

Method:

* Beliefs about ingroup consensus was assessed using an 8-item attitude measure designed for this study.
  + Participants rated the extent to which an overweight person would be respected, popular, valued, liked, have friends, treated as an equal, fully accepted, and elected to a position of leadership by other university students.
  + Responses were on a 7 point likert scale, with high scores being taken to indicate that participants perceived that the student ingroup held a positive attitude towards overweight people
    - We could assess this by rating the extent to which people you know (friends/family) would use, assess, benefit from, and be in favor/opposition to regarding access to UHC?
* Perceptions of social support of those near them also was examined as a potential moderator for the effects of how ingroup perception would affect weight-stigma.

Result:

* When participants saw that their ingroup held a positive attitude towards overweight people, then weight based discrimination was less strongly associated with negative behavioral/cognitive outcomes.
  + Knowing what the ingroup attitude is regarding various considerations is an important thing to assess!

Goldberg 2019: Perceived Social Consensus Can Reduce Ideological Biases on Climate Change

* Conservatives in the US generally have less belief than liberals that climate change is happening, human caused, and needs policy to limit climate change.
  + Are these ideological differences in climate change beliefs, attitudes, and preferences, smaller when people have close friends and family members who care about climate change?
  + Note: This is a very clear and simple analogy to bring with regards to support for UHC! Many parallels between these two issues.
* Nationally representative survey sample used to test if perceived social consensus predicts a SMALLER differences in climate change beliefs between liberals and conservatives.
  + Social consensus does indeed play an important role in climate change beliefs, attitudes, and policy preferences for people ACROSS the ideological spectrum, but ESPECIALLY amongst conservatives!
* Consensus does indeed in science that global warming is real and happening (97%), however, the social consensus of many Americans do not match this scientific consensus (30% say climate change not happening, or 42% think it’s not human caused).
  + Political party/ideology has a strong influence on public opinion about climate change
  + 92% of democrats believe it’s real, only 51% of republicans do, with those numbers rising to 95% of liberal democrats, and 40% of conservative republicans!
* Does perception of social consensus affect the extent to which people believe in climate change?
  + Are conservatives/liberals more likely to believe in climate change when they perceive a social in-group consensus about what to believe or about which pro-climate policies to support?
  + Research demonstrates importance of in-group messages in shifting normative beliefs (Ehret, Van Boven, and Sherman, 2018). Respondents more likely to endorse pro-climate policy when endorsed by elites from their own party!
    - Both for liberals and conservatives!
* Inaccurate beliefs can also lead to ‘pluralistic ignorance’ – most people thinking tha others hold the opposing viewpoint, when they do not, leading people to self-silence!
  + Exists for alcohol consumption, sexual behavior, and climate change beliefs.
* Does the effect of perceived social consensus change across the political spectrum?
  + Core psychological/personality differences exist between liberals/conservatives, and generally suggests that social consensus might play a MORE important role amongst conservatives.
    - Generally, greater value placed on conformity/in-group loyalty, thus plausible to expect greater effect of social consensus.
    - Republicans are generally more responsive to messages from their ‘in-group’ than Democrats are (Benegal & Scruggs, 2018)
    - Ideology and political party, while not the same, are strongly correlated.

Method/Results

* N = 16,168, between 2008-2017
* Participants were asked questions regarding global warming. Including beliefs, policy preferences, norm perceptions, political party, and ideology.
  + 4 conditions about perceptions of social consensus on climate change within their friends/family.
    - “What percentage of people who are important to you (friends/family) believe that human-caused global warming is happening?” (0-100%)
    - “How important is it to your family and friends that you take action to reduce global warming?”
* Ideology was significantly negatively associated with the belief that global warming is happening, human caused, and worth worrying about.
  + Also had a significant negative association with support for regulating carbon as a pollutant and for regulating utility use in general.
  + Also had a significant negative association with ‘whether or not they think people should be doing more/less to reduce global warming’, aka the need for public action.
* Perceived social consensus was significantly and positively associated with the belief that global warming is happening, human caused, more worry about global warming, more support for carbon regulation, more regulation for utilities, and more need for public action.
  + Significant interaction, those with low social consensus, ideology had a negative and significant (but weak) relationship on global warming is real, but this relationship was substantially weaker for those with high social consensus.
* The “Social Influence” model, wherein ideological biases are weaker because of social influence, is more supported than “Social Projection” where people may project their own views onto what they think their social group members believe.
* Perceived social consensus is associated with higher % of people believing that climate change is real and human caused, which holds for both worry and climate policy support!
  + Social consensus is particularly important for predicting the views of conservatives.
  + Thus, norm-perception could be a useful mechanism for social change!
* The effect of social consensus on ideology was STRONGEST when the respondent perceived that their friends and family thought the respondent themselves should take action on global warming!
  + Unanswered question – How much ‘consensus’ is seen as enough to be ‘persuasive’, does this value change based on individual differences?

Greene 2007: Why are VMPFC patients more utilitarian? A dual-process theory of moral judgment explains

* Neurobiological background/rationale for what cases and contexts can lead to increased proportion of utilitarian reasoning (vs deontological reasoning)
  + Engaging in morally repugnant but utilitarian reasoning can elicit a strong negative emotional response, which results in disgust or less interest in the action itself.
* Inducing positive emotion can lead to more utilitarian approval, as a sort of ‘vaccine’ or an ‘antidote’ to the negative thinking or feeling.
* Additionally, people with frontotemporal damage or dementia should tend to be more utilitarian in thinking.
  + Lastly, you can provide greater amounts of cognitive load, which makes it more difficult to use utilitarian judgement.

Lincoln 2011: Ethical Decision Making: A Process Influenced by Moral Intensity

* This research focuses on understanding the process of ethical decision-making, especially what external factors can influence it.
* Our current identification of factors necessary for what is a good/bad choice is the axis of “moral judgement”
  + The evaluation/decision of an action as good or bad
  + This is different under deontological/utilitarian thinking!
* Moral ‘sensitivity’ is related but different:
  + An individual’s ability to recognize that a situation contains a moral issue.
  + The belief that your actions can harm and/or benefit other people (either through utility, or respecting their rights)
    - Or the idea that a situation ahs moral content, and thus, that a ‘moral’ perspective is valid (e.g. what fruit do I eat? No moral sensitivity here)
* Moral “motivation”, or the intention to choose what is moral over a non-moral choice that provide perhaps personal benefit
  + W.r.t. how this relationship has to do with our choices, we can only query moral judgement, not anything else?
* Looking at other aspects of morality… what affects our choice to support UHC?
  + Magnitude of Consequences: How much can the individual be harmed or benefit from the decision-makers action?
    - How can we query this? Do we ask how much people would individually benefit from each of our categorical considerations?
  + Temporal Immediacy: What is the length of time between an action and it’s consequences?
    - E.g. Do we query people what do they think the relative ‘lag-time’ is between these choices being made and the outcomes? Is this perception different amongst people?
  + Proximity: How ‘near’ is the decisionmaker to the individuals affected by the consequences?
    - Could be different depending on perception of how wide-ranging the issue is.
* Empirical work here is VERY limited and historically lacking (May & Pauli, 2002)
  + Social consensus and magnitude of consequences have significant evidence supporting them (Chia & Mee, 2000; Barnett, 2001; Butterfield, Trevino, & Weaver, 2000; Frey, 2000; Harrington, 1997; Singhapakdi, Vitell, & Kraft, 1996)
  + Social Consensus is seen as a strong predictor of moral judgement!
* Look at potentially assessing ‘moral awareness’ using a simple moral awareness questionnaire adapted from Rest 1994
  + “Do you believe that there is a moral or ethical issue involved in the above action/decision?”
    - From Complete Agree to Completely Disagree (7 pt scale)
  + We can query this before and after the intervention, and perhaps the degree of moral awareness changes or is a mediator for the effect?
* Additionally, we can query directly magnitude of consequences and temporal immediacy
  + Asking “possible harm/benefits resulting from this choice would be ‘minor’ to ‘extreme/severe’.
  + Asking “Any negative or positive consequences of this decision are likely to occur ‘after a long time’ to ‘immediately’
* Proximity measured by “This specific decision would positively/negatively affect, ‘my group’ to ‘people outside my group’…?”
  + Can we manipulate these the same way we manipulated social consensus scores?
* This study concluded that Social consensus is STRONGLY associated with moral awareness, judgement, and intention.
  + When people assess that something is moral, form a judgement, and decide intentionality, they are STRONGLY affected by what others believe.
* Other dimensions of moral intensity affect specific parts of the ethical choice-making process.
  + Proximity relates to moral awareness, and magnitude of consequences and probability of effect are both closely linked.

May 2002: The Role of Moral Intensity in Ethical Decision Making

* Moral intensity is related to recognition of moral issues/evaluations and intentions
* Ethical judgements are determined by both deontology and utilitarianism (Mayo and Marks 1990)
  + Same evidence was found by Vitell and Hunt 1990
* Moral intensity dimensions tend to influence judgements of moral evaluation.
  + Judgements here are operationalized as the degree of agreement one has with given statements of ethicality of behavior in a scenario.
  + Recent research has shown that students and practicing managers are comparable in their sensitivity to ethical issues in business decision making (Lysonski & Gaidis, 1991). Furthermore, Randall and Gibson (1990) show similar.
* Magnitude of consequence, probability of effect, and proximity/temporal immediacy were all correlated enough to form an aggregate “probable magnitude of harm” scale.
  + 11 items in the 4 subscales.
* Probable magnitude of harm is STRONGLY correlated with the idea of ‘moral recognition’
  + E.g. If there is a probable magnitude of harm/benefit, then it is relatively easy for people to see it as a moral issue.
  + Thus… the reason why social consensus bowls over in our intervention, is that perhaps people don’t see a huge difference in relative harm/benefit to themselves w.r.t. UHC?
* The more morally intense an issue is, the easier the moral evaluation process is.
  + The less individuals care to think about its’ moral evaluations because the correct course of action is ‘clear’ to them.
  + E.g. perhaps the reason we can see changes so easily, is that this is not considered as morally intense as an issue?
    - We can directly measure moral intensity in order to assess this.

Germain 2020: Will COVID-19 Mark the End of an Egalitarian National Health Service?

* British NHS Has generally used a ‘egalitarian/deontological’ approach to residents of providing healthcare as equitably as possible based on health-status, instead of ability to pay.
  + Covid-19 has pressured the system to allocate resources in a utilitarian fashion.
  + This puts pressure on society to assess value of individual health economically.
* Healthcare resource distribution is seen here as essentially moral, as compared to other elements, as they have the potential to alleviate risk of illness, suffering, and absolute harm, to a greater extent than many other resources (T Schramme, 2009)
  + Can we lean on this framing in order to increase or decrease the relative intensity of perception that healthcare distribution is a moral issue?
* Note that the British NHS is seen as explicitly formed for ethical purposes, wherein “level the healthcare “playing field” by providing more care to the least favoured and most vulnerable , as well as equal access to services for all other types of patients” (WH Beveridge, 1942)
  + The usage of resources cannot be ‘spread out’ fairly, you can’t rotate to share a ventiliator, and same with hospital beds
  + Thus, the system is currently ‘first come first served’ which is NOT egalitarian.
* The NHS thus ‘maximizes’ healthcare outcomes by favoring individuals with greater chance of survival, by using a ‘ranking’ system of relative likely benefit.
  + E.g. is indirect ‘age based’ rationing (due to comorbidities, and less likelihood of recovery in intense care) ethical, and is it OK to let older people who have ‘had a good amount of life’ to sacrifice their healthcare resources in order to help the youth, who are MORE likely to recover from their infection?
  + Preventative medicine access was reduced, in order for these resources to go directly to individuals at greater risk. (A Rimmer,“Covid-19: GPs Can Stop Health Checks for Over 75s and Routine Medicine Reviews”, 2020)
* Deontological rationale is all well and good, but under intense pressure, many medical systems default to a form of utilitarianism instead!
  + Whether or not this is morally acceptable is another matter.
  + Clinicians tend to follow deontological principles in healthcare, but this may run counter to governmental guidelines in the NHS, and they MUST adjust their assessment and resource use to maximize the ‘greater good’ from the NHS’s point of view.

De Hoyos 2016: Issues on Luck Egalitarianism, Responsibility,

and Intercultural Healthcare Policies

* Briefly considers some of the ethical issues regarding various moral theories on the distribution of healthcare.
  + Utilitarianism: Usually good, but ‘fails’ when considering some suffer extreme diseases and need very expensive/rare treatments
  + Liberalism/Deontological viewpoint: Addresses some of these concerns, as it focuses on ‘health rights’ that people have. However, this doesn’t do well with ‘pandemic’ style proportional issues, or consistent basis type issues such as diabetes or hypertension.
    - Due to requiring broad access to resources since it has wide population prevalence.
* Interesting framing: Healthcare needs are ALWAYS greater than available resources, since “we can always live a little longer or take better care of those who are ill” (Callahan D . Ethics and population . Hastings Center Report 2009)
  + Thus, considering this, utility seems like ‘common sense’.
  + Focuses entirely on consequences on ethics, and evaluation of different courses of action according to their aggregate outcomes.
    - However… run into challenges with measuring these outcomes, as there is debate on what is ‘good health’, not just living longer but having good quality of life!
  + Utilitarianism generally defaults to increasing coverage for common, cheap to treat diseases.
    - This fucks over those who have complicated and expensive treatments (e.g. Orphan Diseases, rare cancers, etc.)
    - This way of thinking generally ignores the value of cultural diversity and different forms of life/ways of living.
* From a Deontological perspective… we consider the equitable good needing distribution not strict healthcare resources per-se, but ‘the capability for each individual to develop their own life plans w.r.t healthcare’
  + Thus, since healthcare is necessary for life and liberty, it cannot be dependent on differences in availability of goods, like apples, etc.
  + However… this vague interpretation does not inform us as to what degree access to healthcare is egalitarian.
  + What we are distributing is not RESOURCES, but RIGHTS.
    - Thus, most liberal theories on this subject establish a minimum quantity and quality of healthcare to enable the individuals’ functioning.”
* However… this also has negative ‘knock on effects’ w.r.t. treating the elderly, as treatment for elderly is MUCH more expensive, and it’s relative benefit e.g. QALY and life expectancy is unclear. (Sen A . Why health equity? Health Economics; Williams A . The “fair innings argument” deserves a fairer hearing! Comments by Alan Williams on Nord and Johannesson . Health Economics 2001)
  + For our current day issues, most bad illnesses are ‘chronic illnesses’ (diabetes, hypertension, heart disease, etc.), These are diseases that are perfectly treatable, and patients may have a good quality of life; but treatment requires the cooperation and participation of the patient in changing his life and eating habits.
  + If the patient doesn’t make these changes…
    - Requires MORE treatment as disease gets more acute
    - Longer hospitalizations, diminished quality of life, and INCREASED healthcare costs for others.
  + The “Deontological right” to pursue the values that align with your own desires for functioning are great… but a population that does not take care of its own health will often incur greater expenses, which could overload the capacity of the public healthcare sector and potentially block the capabilities of others.
* “Luck Egalitarianism”: e.g. if you suffer from bad luck, when the bad luck wasn’t the result of a gamble or risk that could be avoided… luck egalitarianism concludes that redistribution is appropriate.
  + Hence, unequal access to education based on unequal wealth would be unfair because a child would not have been able to control any of those circumstances; in contrast, unequal access to education due to differing efforts on the part of students would be tolerable, and there would be no claim for retribution
  + “A newborn has no control over the decisions made concerning his health, and therefore not to give him access to good healthcare services would be unfair. Someone born with a severe disability had no influence on it and therefore suffers from brute bad luck and is justified to receive greater resources to have equal opportunity to develop his life plans.”
  + “On the other hand, even though basic health needs have to be met to protect the individual’s capabilities, some considerations of the responsibility of individuals toward their own health can be made, because some illnesses are caused not by brute bad luck but by the individual’s own conduct, and such individuals need not be compensated in all situations.”
    - Can we assess how much the perception of ‘personal responsibility’ relates to how much individual support or detraction one has for UHC?
* Healthcare systems have a duty to accommodate specific needs and beliefs INSOFAR as doing so does NOT affect the equal opportunity of others to access these services
  + Interesting perspective… we should DIRECTLY ask other people if they think a transition to UHC will affect their ability to access goods and service equitably (level one), or even if they think it will be ‘equitable’, do they think with UHC their access to healthcare overall will STILL be worse than what they have?

Kahane 2018: Beyond Sacrificial Harm: A Two-Dimensional Model of Utilitarian Psychology

* Frames one consideration of utilitarianism as “impartial concern for the wellbeing of everyone”, which can easily be ignored as a consideration.
  + Creates the “Oxford Utilitarianism Scale”, indicating two different aspects of utilitarianism.
* Concerns about utility: Can conceptually place no constraints on maximization of aggregate well-being
  + If killing a disabled child means better good overall, then utilitarianism (contrasting against ‘common sense morality’) requires the child be killed.
  + This is considered the “Negative dimension”, in which we are permitted (even required) to use/harm/kill individuals to promote the greater good
    - “Instrumental Harm” axis, or “the conditions under which people find it acceptable to cause harm for a greater good.”
    - Do people who oppose UHC oppose it based on this dimension? E.g. Do they oppose it because they think ‘taxation’ in order to fund UHC, or some individuals receiving ‘less’ or ‘different’ care in order for others to have care, doesn’t meet their threshold for ‘instrumental harm’?
* Utilitarianism has a ‘positive dimension’, wherein utility is seen as a form of impartial beneficence
  + For those in wealthy countries, this would generally expect the very rich to self-sacrifice and give income to charity.
  + Many find this level of sacrifice too demanding. However, this is the inspiration for ‘effective altruism’
  + Historical measurement of utility has focused on the negative aspect, not the positive one!
* Conceptually, pure utilitarianism is a little silly, as the pressures on average humans are unreasonable
  + E.g. Uncompromising demand for impartiality and self-sacrifice
  + Demanding the sacrifice of ‘innocent’ others for the greater good
* Positive Dimension of Utilitarianism: Impartiality
  + Treat the well-being of everyone as equally important, no priority given to oneself, family, friends, etc. Demands sacrifice of self-wellbeing if there is even a tiny net gain in the well-being of others RE: what they have lost.
  + Complete impartiality requires more than ‘commonsense’ morality(e.g. modest altruism, heroism only in extreme circumstances/emergencies)
  + Diverges mostly w.r.t. how MUCH we should sacrifice, as well as for WHOSE sake we should sacrifice.
* Negative Dimension of Utilitarianism: Harming/Breaking Rules
  + E.g. While some may endorse the impartial moral GOAL, if you are forbidding yourself from taking certain MEANS to achieve it, then you are ignoring a vital aspect of utilitarianism.
  + E.g. Tell the truth, keep promises, and refuse to harm innocents… ONLY IF these acts are likely to lead to a better impartial outcome.
  + Willingness to cause instrumental harm is a form of rejecting putative moral rules.
* Defines utilitarianism as ‘greater focus on impartial maximization of well-being across different moral contexts (positive dimension) as well as giving less weight and space to values other than well-being, or moral rules that could constrain the promotion of well-being (negative dimension).
  + Perhaps use this split-scale as form of measuring whether or not these two different dimensions of utility have differing impacts?
  + We can also query whether or not people are explicitly aware of endorsing utilitarianism/deontology?

Kvaran 2013: The effect of analytic and experiential modes of

thought on moral judgment

* This researcher found ways to prime utilitarian responses, using a “mode-of-thought” priming technique, to place subjects in either ‘experiential/emotional’ or ‘analytical’ mindset.
  + Links well with previous research that system 1 thinking is linked to lower utilitarianism, and system 2 thinking indicates greater rates of utilitarianism.
* Mode of Thought Manipulation
  + Analytic thinking was primed by asking a short math problem prior to the presentation of the dilemma-scenario (e.g. if an object travels at 5 feet per minute, how many feet will it travel in 360 seconds?)
  + Experiential thinking was primed by showing participants a word before each trial, and asked to simply write down the feeling they most associate with this word prior to the presentation of each dilemma-scenario (“When you hear the word crying what do you feel? Please use one word to describe your predominant feeling”)
    - All answers were written on a physical answer sheet, while controls were presented with a screen showing a fixation cross for 10 seconds.
* 30 Moral Dilemmas were selected and presented as 10 personal, 10 impersonal, and 10 nonmoral. Participants were asked to make a judgement about what they would do in each case. Yes responses were linked to utilitarian judgement, and no responses were nonutilitarian judgements.
* Mode of thought had a significant effect (priming utilitarian judgement or experiential judgement)
  + The experiential judgement had no significant difference from the control.
* This research shows first time that behavior manipulation of system 2 thinking results in a change in rate of utilitarian judgement!
  + Some gender differences appeared, wherein males were more affected by experiential priming, as they tend to be analytical
  + Females were more affected by utilitarian priming, as they tend to be more emotional?

Tremoiliere 2012: Thinking about death makes people less utilitarian

* Primed mortality salience for the purpose to reduce utilitarian responses.
* Authors found that the effect of mortality salience on utilitarian conflict judgements is comparable to extreme concurrent cognitive load.
  + Interestingly, portrays the possibility that private judgement/public debate on controversial moral issues can be shaped by mortality salience effects (e.g. Healthcare, assisted suicide, etc.) since this OFTEN involves matters of life and death.
* Mortality salience priming used ‘classic’ Greenberg et al. 1990 method.
  + Asked to briefly respond to two of the following questions
    - ‘Briefly describe the emotions that the thought of your own death arouses in you’
    - ‘Jot down, as specifically as you can, what you think will happen to you physically as you die and once you are physically dead’
  + The control/pain scenario, participants were asked similarly phrased questions about extreme pain (used to contrast the effect of aversive emotions more generally against death specifically).
  + In the 1st study, Mortality Salience clearly suppressed utilitarian judgement.
* Plausible that mortality salience EITHER takes up mental load and cognitive resources (and thus less utilitarianism), OR that mortality salience motivates people to switch to an intuitive, experiential mindset.
  + Again, whenever mortality concerns are salient, emphasis on moral values outweighs the rational and utilitarian calculations.

Capraro 2019: Priming Intuition Disfavors Instrumental Harm but NOT impartial beneficence.

* Looking at the 2-Dimension new concept of Utilitarianism, splitting it into instrumental harm, and impartial beneficence, seeing if the idea that increased intuitive/experiential judgement affects both dimensions equally.
  + It has been found that greater intuition has lead to weaker utilitarian thinking, but that was only looking at utilitarianism as a monodimensional construct.
  + Utilitarian decisional tendencies do NOT constitute a singular dimension, but instead are split into Instrumental harm (IH) and Impartial beneficence (IB).
* Priming occurred by making salient how emotion (or reasoning) leads to ‘good decision making’ and ‘satisfying decisions’
  + I actually really like their methodology here, it’s very functional!
* In their initial study, results were very clear, there was an interaction between the prime, and the scores on the category of dimension (IB or IH). Endorsement of IH was higher when deliberation was primed, and no difference in IB was found in either condition!
* Study 2, modified the priming a small amount (to make clear it was about superior decisions, not ‘more satisfying’ ones.)
  + Results were very similar to study 1, and did not reach critical P value
* Study 3, modified the prime to be shorter and more evocative.
  + The results were consistent with study 1, with STRONG significance, and clear indication that this basic effect is ‘real’ and ‘reliable’
* Major limitation – what are the underlying motivations behind participants, wherein intuition promotes non-utilitarian choice in the IH dimension, but not the IB dimension?

Markowitz 2021: Values-based Foundation for a U.S. Single Payer Health System Model

* This author provides strong deontological perspective on how the issue of UHC should be viewed.
  + Also a pretty good overall summary of UHC’s benefits w.r.t. systems (quote some of this later if we need to ‘bulk up’ in sources?)
* 70% of the US believes that the healthcare system needs either “fundamental changes” or to be “completely rebuilt” (YouGov Poll, 2017)
  + Clearly, single payer would address at least the relative difficulty of access to same services that currently exists.
  + We see extremely higher rates of infant mortality for non-hispanic black women vs non-hispanic Caucasian women (10.75/1000 vs 4.63/1000) [National Center for Health Statistics, 2016]
* Deontological Perspectives: What is owed, what are duties?
  + Duties of justice – guaranteeing that people can get what they deserve.
  + Duties of beneficence: We can improve the condition of others in the world, thus we must.
  + Non-maleficence: Ensuring no harm occurs to the ill, infirm, or disenfranchised.
* Common moral, ethical, and religious teachings that Americans claim to care about, APPEARS to support UHC! (portray this argument as a potential paradox w.r.t. why UHC hasn’t been implemented?)
* Barriers and Opposition to Policy Change
  + Difficult to ‘honestly’ assess the position of people on the other side
    - “Some liberals presume that the sole motivation behind conservative resistance to UHC is crass selfishness”
    - Some conservatives view a movement towards UHC as a “power grab” by ‘takers’ whose only motivation is to enjoy a ‘free ride’. (Craig, 1984)
      * Is this deontological or utilitarian?
  + Do some people legitimately believe in Social Darwinian “Survival of the Fittest”?
    - E.g. The government should care for those who are strong, hoping that others can do the rest, given that it isn’t their responsibility to do everything.
    - “Society will benefit if the rich are made richer, and what falls from the table will be enough for the middle class … the wagon train will not make it to the Frontier unless some of the old, young, and weak, are left behind” (Cuomo, 1984)
      * Is this a deontological or utilitarian argument?
  + Perhaps there is a legitimate belief that NOT all are equal? (Bloom, 2009)
    - Again, can we test these various hypothesis w.r.t. why people oppose UHC?
  + Perception that there are NOT enough resources for everyone to obtain all the healthcare that is needed and desired?
    - Is there a way to directly query w.r.t. if people think there ISN”T enough pie to go around, or moreso that they would have to sacrifice significantly in order for others to even have some?
    - E.g. Bauzon (2015) states that not EVERYONE can have the best basic care, since there isn’t enough to go around, thus, how do we determine ethically and morally how to ration this?

Bauzon 2015: Classical Distributive Justice and the European Healthcare System: Rethinking the Foundations of European Health Care in an Age of Crises

* Can too much healthcare distribution jeopardize the sustainability of state government? (Thus, if so, it’s irresponsible to provide it)
  + In a world where it is impossible for ALL to receive equal access to the best of basic health care, we MUST critically examine the plausible scope of the state to limit access to this healthcare.
* UHC also ‘restricts’ the freedom of patients to decide how much health care, and what quality healthcare is worth what price.
* The “right to healthcare” cannot be seen as an argument for absolute claims to healthcare support
  + “Hypothetically… For a healthcare system to ensure equality in health care for all, the government would have to forbid persons from using after-tax resources to purchase better basic health care.”
* Frames the argument as balancing the ‘abstract claims of human rights’ against the ‘realities of healthcare distribution’.
  + The challenge – everybody is perceived as possessing an entitlement to (almost) free access to basic healthcare.
  + “If all are provided an equal amount of health care or an equal amount of funds for the pursuit of health, some will have too much and others too little”

Crisp 2017: Right or Duty: A Kantian Argument for Universal Healthcare

* Changes the framing of healthcare as not a welfare right (which has obligation to pay for it) into a duty from the Kantian framework/approach to ethics.
  + Rights are either liberty rights, or welfare rights. Welfare rights require action or expense in order to provide, whereas Liberty rights merely require that no outside party interferes with the right (e.g. Free Speech).
* Healthcare THUS is a welfare right, as saying that it’s guaranteed without financial support doesn’t really mean anything.
  + “Conservatives who oppose “big government” are understandably cautious about the granting of welfare rights, because they always involve the question of who will pay for them”
  + Is the focus here on the relative utilitarianism (e.g. that what’s provided might not be at a good cost rate)
  + Or is it instead deontological (e.g. NOBODY should be forced to expend resources [being taxed] in order for OTHERS to have healthcare)
* Hypothetically, an argument would be that everyone should be responsible to pay for their own healthcare, JUST AS they would pay for any market good.
  + However… healthcare is NOT a market good like others, subject to supply and demand, but instead due to it’s complexity and base cost, many can be excluded entirely.

Longoni 2020: Artificial Intelligence in Utilitarian vs. Hedonic Contexts: The “Word-ofMachine” Effect

* Individual differences in utilitarianism and hedonic thinking interacts with preference for/resistance to ‘AI based recommendations’ – as compared to traditional word of mouth or other human recommendations.
  + The “lay belief” that AI recommenders are superior to human reviewers.
* Salience of utilitarian attributes determines preference for AI over humans.
  + This is robust to attribute complexity, number of options considered, and transaction costs!
  + This effect reverses in utilitarian goals if a recommendation needs matching to a person’s unique preferences.
  + Eliminated entirely when looking at human-AI hybrid decision making
* Humans think AI are more competent when assessing relative utility value of things (hardness, cost, etc.). Alternatively,
  + But think AI recommenders are WORSE at assessing hedonic value (e.g. Will it make me happy? How does this taste?)
* Hedonic and Utilitarian attitudes are activated by a brief paragraph, requesting people to focus on either the ‘hedonic’ attributes of it (smell, luxury, spa-like vibe, etc.) or the ‘utilitarian’ attributes (practicality to use, objective performance, chemical composition, etc.) for Shampoo.
  + Then stated that there were two options they could choose, one recommended by a person, one recommended by algorithm.
  + Significant difference (2 to 1) for utilitarian recommendations by machines, and still a 3/2 split for hedonic recommendations by humans.
* Replicated again with recommendations for ‘real-estate’ properties
  + For us… we would provide either ‘traditional’ private health insurance as one option, or ‘UHC’ as the other option, and we would have either human or AI recommendation (and then see what people choose?)
  + Again, a strong split effect either way!
* Word of machine effect RE perceptions of utilitarianism or hedonic attributes, are indeed made more salient when asked to assess them w.r.t. a human made or AI made product!
* Preference for AI or Human when utilitarian attributes are seen as more important!
  + Participants are directly asked whether they care about utilitarian aspects, or sensory/hedonic aspects, with regards to a winter coat (generally trended towards being seen as utilitarian)
  + The actual higher utility scores here predicted very cleanly the increased preference for AI recommendation.
* How does this relate in a Medical Context?
  + Consumers perceive AI as less able than a human physician to tailor a medical recommendation to their unique characteristics and circumstances (Longoni, Bonezzi, and Morewedge 2019); and thus choose human recommenders at a higher rate, compared to AI ones. EVEN if utilitarianism was seen as more salient!
  + Uniqueness Neglect, seen here as the concern that AI cannot provide for people as well, drives resistance to medical AI
    - Uniqueness neglect is higher in individuals that see themselves as more unique!
    - However, uniqueness neglect effect is eliminated when AI is seen to provide care that is framed as a personalized study, to people that are not the self (e.g. evaluating how the AI doctor is providing care for other people), or when it’s seen as a system that ‘supports’ rather than ‘replaces’ human providers
  + Can this be applied similarly w.r.t. concerns that people don’t want UHC because they feel it will flatten their experience, and thus they will not be able to get the ‘unique’ care they need, that they could get under current private conceptions?

Zaleskiewicz 2020: Market mindset impacts moral decisions: The exposure to market relationships makes moral choices more utilitarian by means of proportional thinking

* Market relationships lead to greater utilitarian moral choices
  + Through the mechanism of ‘proportional thinking’
* Primed participants with market relationships, leading to more utilitarian choices in ‘classic’ IH utilitarian situations.
* Priming market mindset lead to more utilitarian moral choices and more focus on the proportion of survivors to victims
  + Market mindset effect only holds when the number of deaths and saved lives were clearly specified.
  + This effect is NOT due to suppressed emotions.
* Theoretical model about why some people use deontological reasoning and in other situations they use utilitarian reasoning (Greene, Sommerville, Nystrom, Darley, and Cohen, 2001; Greene, Cushman, Stewart, Lowenberg, Nystrom, & Cohen, 2009; Greene, Nystrom, Engell, Darley, & Cohen, 2004; Greene, Morelli, Lowenberg, Nystrom, & Cohen, 2008)
  + According to this model, moral-decision making is inherently associated with emotions; when emotional experience is sufficiently strong, people’s judgements and choices are congruent with deontology (e.g. intense negative feelings regarding killing one person to save several lives)
  + When emotions are LESS intense, cognitive considerations prevail and decision-making becomes consistent with utilitarian philosophy.
* Market Mindset: When people engage in market relationships, they care how much they receive from their investment, and whether repayment is of comparable value.
  + Generally characterized by rationality, logical thinking, efficiency, self-control, and equivalent exchange.
  + Often based on clear, comprehensible, and easy-to-recognize rules.
* Considered in opposition to ‘communal’ relationships, wherein benefits are given without the donor or recipient feeling the recipient has an obligation to repay.
  + Generally characterized by values such as ‘helpfulness’, ‘friendship’, ‘generosity’, and even ‘altruism’
* “Assuming that the tension between utilitarian and deontological moral decision-making reflects the distinction between calculating which choice maximizes the overall good on the one hand, and behaving with regard to a general rule irrespective of consequences on the other, we might predict that activating the market mindset that promotes proportional thinking will be supportive for the utilitarian philosophy”
  + People primed with market mindset not only make utilitarian moral choices more often, but their willingness to make such choices increases with the ratio between numbers (representing how many survive and how many will be killed)
  + Perhaps we can give explicit numerical framing on benefits of UHC w.r.t. relative survival, relative death, average life-span, average cost spent, etc. – Then we can manipulate these values and see if the proportion of support changes?
* Priming was done with images
  + Market mindset primed with an image where one person hands a pizza box to the other, with money handed from them back
  + Communal mindset primed with image where one person gives a gift, with no hand-back
  + Control condition, had two characters with no actions.
    - Then asked to imagine real life situation like the pictures, and then describe that picture in as much detail as possible.
    - Manipulation check (on communal vs market vs neutral mindset) indicated that the intervention was effective.
* Priming was done in experiment 2 with images, but also added a caption describing what was happening.
  + Same image, but one showing the groceries given as a gift, the other shown as groceries being delivered by an app-worker.
* When people are exposed to market relationships, they tend to make utilitarian choices, but also assess utilitarian choices made by others as more ‘correct’.
  + “In the present paper, we showed that when people are exposed to market relationships, they become more prone to base their considerations on proportionality, which brings them closer to the utilitarian position in their moral judgments and choices. Our research documented that thinking consistent with the market mindset not only makes people more open to utilitarian decision making, but also makes them perceive such a manner of making moral decisions by others as right and acceptable”

Aktas 2017: Moral Pluralism on the trolley tracks: Different normative principles are used for different reasons in justifying moral judgements.

* Authors asked subjects to make a choice in ethical dilemmas, and then were asked to indicate what normative principle they used for judgement in the dilemma.
  + This DIRECTLY relates to us wanting to know why and how people use various considerations to make choices on supporting or opposing the various queried items.
  + Also… we can see if the normative principle used to justify changes after an intervention, thus we can look @ the mediational relationship between these normative principles and the outcome!
  + The principles were ‘fatalism’, ‘virtue ethics’, ‘utilitarianism’, ‘deontology’, and ‘amoralism’.
* Most people chose based on deontological principles, but a non-insignificant number also chose virtue ethical and fatalistic justifications.
  + Note – we can also measure psychopathy? E.g. it’s plausible that psychopaths are utilitarian in some ways (namely, IH), but they lack on the IB thinking that supports UHC… We could show that psychopaths are utilitarian that have IH, but they don’t support UHC, and also see whether or not IB thinking supports UHC!?
* Uhlmann (2015) Theorized that people evaluate a person’s general moral character instead of individual actions.
  + “Thus a person who smothers a baby to save a group of fellow citizens might be judged to perform the right action from a utilitarian point of view but still be undesired as a friend because of a presumed defect in his character”
  + Querying on ‘virtue ethics’ seeks to capture this intuitive moral judgement aspect.
* Questions RE: grounds for judgements
  + Acting on non-moral grounds: “Moral reasons did not play an important role in my judgement”
  + Virtue-ethical principle: “Someone who intentionally harms an innocent person cannot be moral”
  + Deontology: “Intentionally harming an innocent person is against fundamental moral rules and is thus unacceptable regardless of it’s intended consequence”
  + Utilitarianism: “Moral action is what ensures the well-being of the maximum number of people”
  + Fatalism/Fate: “It is wrong to interfere with consequences that arise as a result of the natural course of events no matter what the ensuing harm is.”
    - Participants were asked to choose one of the five justifications for their choices in each of the dilemmas (order randomized!)
  + The guiding principle can also be seen as being rated, the importance of each principle from 1-5!
    - This was what was done in the expansion, Study 3
* Psychopath was measured using the psychopathology subscale of the “Dark Triad” scale (Paulhus & Williams, 2002)
  + Can we present and directly frame various paragraphs on the reasoning behind supporting or opposing UHC?
    - E.g. we can say… do you believe that more Americans would be better off if healthcare was only provided to those who work? Most of those that do not work will find it more difficult to access healthcare (Utilitarian Opposition)
    - Alternatively… Do you believe more Americans would be better off if healthcare was provided without requiring work? Some will choose to not work, if it is not necessary for them to have healthcare (Utilitarian Support)
    - Do you believe Americans have a right to healthcare access, and that the government should enact programs to ensure continued access to healthcare (Deontology Support)
    - Do you believe Americans have a right to healthcare access if they are a member of the workforce, and that the government should enact programs to ensure hard-working Americans have access to healthcare (Deontology Oppose??)
  + Unsure how we would test and calibrate these options, but would LOVE to see a final product for it.

Reynolds 2017: The Recognition of Moral Issues: Moral Awareness, moral sensitivity, and moral attentiveness

* Brief review looking at how individuals can recognize whether or not an issue has moral bearing.
* Moral Awareness: An individual’s determination that a single situation contains moral content and legitimately can be considered from a moral point of view.
* Moral/Ethical Sensitivity: A broader cognizance of moral issues (e.g. measuring through exposure to moral issues) and captures the individual’s ability to recognize and consider a set or range of moral issues.
* Moral Attentiveness: The extent to which one chronically perceives and considers morality and moral elements in his or her experiences
  + Thus, Moral awareness is about an event an individual experiences, Moral sensitivity on the individuals’ skill at regularly achieving this moral awareness, and Moral attentiveness captures the innate tendency to perceive issues as moral issues.
  + I think moral awareness is specifically what I want to look @ with regards to our various issues and calibration considerations.
* Cognitive depletion is a biological factor that can reduce an individual’s ability to be morally aware
  + If this is something we want to manipulate… we can have them write essays without the letters A or N (remove the letters from a keyboard?) (Gino et al, 2011)
* Conversely, mindfulness exercises can improve relative moral attentiveness (Brown KW, 2003; Ruedy NE, 2010)
* In general, consequentialists (utilitarians) respond to moral issues involving harm, whereas formalists (deontologists) recognize issues involving harm and issues involving violations of behavioral standards.
  + NFC and moral identity positively shapes moral sensitivity.
* How an issue is framed, and the relative competitive context in which it is understood is key to shaping individual reactions to moral issues, especially w.r.t. moral awareness (Butterfield KD, 2000)
  + Similarly, when subjects were primed by their environment to think of the issue in moral terms (i.e. their information package included a label marked “ethics”) they were more likely to demonstrate moral sensitivity (Sparks JR, 2015)

Lutzen 2006: Developing the Concept of Moral Sensitivity in Healthcare Practice

* Simple paper that goes over the concepts for a questionnaire that queries how much moral sensitivity a given individual expresses.
  + Few missing values though, which indicates good likelihood it can be used in practice!
* Splits perception into three sub-units
  + Moral Burden: caused by problems or situations that have moral values. This is the ‘negative’ domain of moral sensitivity. High sensitivity can result in moral burden
  + Moral Strength: the courage to act and the ability to provide arguments with the intention to justify these actions on behalf of another instead of defending oneself.
  + Moral Responsibility: Indicates primarily a moral obligation to work according to the rules and regulations, and insight into their purpose.

Savulescu 2020: Utilitarianism and the Pandemic

* CANNOT be egalitarian in a pandemic, as pressure on the healthcare system is too high, prioritization of needs is fundamentally required.
  + Utilitarianism falls within this ideal of optimizing limited resources; how can utilitarianism be put into practice w.r.t. limited resources?
  + Triage: Which patients should get a ventilator w/ limited supply?
  + Lockdown: How should countries decide when to implement stringent social restrictions, balancing preventable deaths from COVID-19 with causing deaths/reduction in wellbeing from other sources?
* Utilitarianism here isn’t the ONLY relevant ethical theory, and a purely utilitarian approach has issues, but a utilitarian framework can help individuals think critically about the cost and benefits of various services.
  + Societies may choose to embrace or reject utilitarian ideas, BUT this MUST be done with a CLEAR understanding of the values involved and the price they are willing to pay
* Utilitarianism is seem by some as a ‘pejorative term’, meaning ‘using a person as a means to an end’ or indicative of an ethical dystopia
  + “Whenever a utilitarian solution to a dilemma is adopted, there will be more well-being or happiness in the world. Typically, some people will be better off. Of course, there may be good ethical reasons to deviate from a pure utilitarian approach, for example to protect rights or promote equality. However, considering the alternative will help societies to identify and consider the necessary cost of these other ethical values. Utilitarianism is not the end of ethical reflection, but it is a good place to start.”
* Moral choice is generally to maximize what is good for all; this is principle of beneficence.
  + Utilitarians hold that maximizing this is the only thing that matters. This is a VERY simple moral rule.
  + The distribution that maximizes greatest good, might not be a just or fair distribution! Principle of beneficence balanced against the principle of justice.
    - I think this is an EXCELLENT way of framing hypothetical deontological argument against UHC; the individual would hold the principle of justice/fairness above that of the principle of beneficence (e.g., don’t unfairly tax those to pay for healthcare for all).
    - Balances again against ‘principle of autonomy’ which gives weight to individual’s freedom to choose and determine (e.g. the right to NOT have healthcare and thus save the money). Individual freedoms can conflict with overall good, e.g., hanging out w/ friends when social isolation is recommended.
      * Additionally, is there a stronger/more stringent moral reason to omit doing harm, as compared to providing a benefit?
  + It is extremely challenging to balance the deaths of a lower number of people (extreme bad outcome for a few) against the small burdens for a much higher number of people (social isolation, less access to health services) with regards to utilitarian outcomes.
* Act and Rule utilitarianism
  + Act: The right act is the act that produces the best consequences.
  + Rule: The right rule is the rule that produces the best consequences.
    - E.g. laws are chosen b/c they bring about the best consequences.
  + An act that may be beneficial in each case, doesn’t mean that the rule in place may have still overall better over-riding consequences.
* Two levels of utilitarianism:
  + Intuitive utilitarianism: e.g. rules of thumb that can be deployed without major reflection (don’t kill, don’t steal, be honest)
  + “Critical Level” utilitarianism: choosing the action that will maximize the good when we have time to consider alternatives; with good access to the knowledge and facts at hand. In complex situations, we must try to rise to the more reflective and deliberative critical level.
* Utilitarian rules of thumb
  + Number: Saving the greatest number of lives is very easy to contemplate
    - Probability: Saving the individuals with greatest improvement in odds for recovery.
    - Duration: Limited ventilator time is available, so if four people need it for one week, vs one for four, the first group is prioritized.
    - Resources: Limited resources = lives, thus, the more resources a person uses, the less there is for others. Thus, we should prioritize treatments that use less resources (all other things being equal)
  + Length of life: How many QALY can be added by saving a given individual?
    - Age: Priority should be given to the younger person; or in general, treatment should be given to those who would live longer if successfully treated.
    - Age here is a de-facto measure of length, there can be older people that will still live long lives! Also still younger people who are likely to die very soon. This is why utilitarianism is not unfairly discriminatory and not ‘ageist’ in an ethically problematic way.
    - E.g. for the lockdown question; if the pandemic largely affects patients w/ short life expectancy, the benefit of a lockdown would be smaller than a different illness that affects younger people more harshly. Perhaps it’s OK to not lockdown, since the costs are borne on the elderly that have relatively few QALYs, and otherwise, the costs are borne on the young, with the total amount of QALYs affected being potentially even greater.
  + Quality of Life: Should we spend resources to give respirators to those with dementia, or in comas? Even if they have a higher chance of survival with treatment?
    - How about lesser degrees of cognitive impairment or other disabilities? This comparison is NOT straightforward however, it’s very difficult.
    - Practical cut-offs include unconsciousness or sever disorders of consciousness.
  + Social Benefit: Should we give care first to those who are healthcare workers, or other essential services?
    - This presupposes that the relative social worth of others is a metric by which we can evaluate how we would want to distribute care.
    - E.g. Pregnant women, parents of dependent children, etc?
      * If there is a risk that a principle will be abused, you should consider not using it. E.g. Social Worth metrics can be abused by rich and powerful to claim privilege and priority in treatment (even if this is net bad for society)
  + Responsibility: Smokers should receive lower priority for lung transplants, drinkers for liver transplants, etc. As these issues are at least partially due to their own hand.
    - However, this is an issue because it doesn’t ascribe to maximizing actual net good. (Friesen, 2018)
* Above rules can be used algorithmically to determine allocation of ventilation, same with scarce and expensive treatments.
  + Divides decision-making into stages, and prioritizes on the basis of different criteria.
* Lockdown: This is significantly more difficult to determine, as there is more uncertainty with regards to individual elements.
  + Utilitarianism here is highly dependent on accurate information to lead to correct decision making.
* Well-being matters MORE than RIGHTS/LIBERTY
  + Is this a way we can phrase this question to query the balance between medical utilitarianism vs deontological prioritization in the healthcare field?
  + Rights and liberty are only important insofar as they secure well-being.
  + Some favor voluntary self-isolation and greater liberty/freedoms, and this is certainly a choice that can be made, HOWEVER, it’s a “values” choice, it prioritizes individual rights over reduction in disease spread, thus if the liberty based approach is less effective, it comes at the cost of additional COVID-19 cases and more deaths.
* When people understand that there is an unavoidable need to choose between patients, they appear to recognize that securing the most benefit overall is both logical and ethical (Arora et al;, 2016)
* asdadsf