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In the Shadow of Certainty: Scientific Orthodoxy in the Covid-19 Pandemic

Alex Broadbent (Durham University) based on joint work with Pieter Streicher

What was the role of science during the Covid-19 pandemic? That of hero, on one view, foreseeing the threat, guiding global responses, and delivering a cure, if not for the disease itself, then at least for the pandemic. That of villain, on another view, blowing the threat out of all proportion, prompting panicked, unfair, and damaging responses, and delivering a partial remedy which was oversold, overused, and may yet prove to have dangerous consequences. Neither is wholly true, and neither wholly false. The purpose of this talk therefore cannot be to decide between the two. But the inadequacy of both views leave the question unanswered: what was the role of science during the Covid-19 pandemic? Neither “hero” nor “villain” is nuanced enough. We must go deeper.

In joint work with Pieter Streicher, we introduce the notion of a *scientific orthodoxy*, characterised by: complexity; power; methodological rigidity; dogma; unity; and scientific injustice. In the talk I will explain each of these six characteristics with reference to some scientific episodes during the Covid-19 Pandemic. Not all science is orthodoxy: in fact, most is not, and this was true during the pandemic. This study shows that a small portion of science developed an outsized influence over global pandemic policy. I thus develop the idea of orthodoxy (as well as related notions like dogma) to be more than a mere pejorative, but a new conceptual tool for explaining how things can go wrong with science. The project is thus a defence of science done right against science gone wrong.

Sensitivity to Personal Responsibility: (Wrongfully) Discriminatory or Not?

Lydia Tsiakiri (Aarhus University)

Despite being ethically and legally condemned, discrimination remains a vague and frequently occurring phenomenon. An endless list of victims and perpetrators could be invoked, with most of us easily detecting its presence. After all, in its most generic definition, discrimination is essentially the disadvantageous differential treatment of the other who has or is believed to have some particular features (Lippert-Rasmussen, 2013). But what are these 'particular features' that deem disadvantageous differential treatment that targets them (wrongful) discrimination? Are they exclusively immutable features like race and sex, or could they also be self-inflicted ones like poor health status? For example, could obese people complain that they are discriminated against by the British NHS because of its reluctance to provide them access to elective surgery before they acquire a Body Mass Index (BMI) of 30 (Pillutla et al., 2018)? Could smokers complain about being turned away as job applicants from hospitals and medical businesses in the U.S.A. interested in increasing their workers' productivity, reducing healthcare costs, and encouraging healthier lifestyles (Sulzberger, 2011)? And, eventually, is a policy that treats people differentially in regard to resources/opportunities/welfare/advantages allocation because of their different degrees of responsibility for their current condition and need, i.e. a responsibility-sensitive policy, (wrongfully) discriminatory against them or not? The discussion about personal responsibility is not new. Luck egalitarianism has long explored the role of personal responsibility in different rationing conditions. At its core, the theory suggests that it is morally objectionable if certain individuals are worse off than others solely due to circumstances that are beyond their control (Parfit, 1984; 1997). Yet what is new is the discussion of personal responsibility in light of the concept of discrimination. Elizabeth Anderson (1999) has laid the foundation of such criticism, while more contemporary scholars have pointed out the threat of wrongful discrimination in association with responsibility-sensitive rationing mainly in the healthcare context. Inspired by this discussion, I examine responsibility-sensitive policies' conformity with definitions of non-moralized direct, indirect, and harmful discrimination. In essence, to provide a plausible response to the paper's central research questions, I initially examine these policies' compatibility with Kasper Lippert-Rasmussen's (2013) seminal definition of non-moralized direct group discrimination. Then, I test their compatibility with certain accounts of indirect discrimination

to explore whether they entail any unfair costs for those in need of protection and not, in fact, responsible for their condition. Eventually, I discuss whether these policies impose unjustified harm on imprudent individuals by wrongfully discriminating against them. Overall, the paper aims to suggest that under a responsibility-sensitive policy, non-moralized direct discrimination could occur and that the most prevalent accounts of (wrongful) discrimination should be mindful of the presence or absence of responsibility for a person's condition revising the list of the most fundamental elements/conditions required for them to apply.

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Expecting Participation, but on Which Ethical Framework: About Epistemic Justice in the Participation to the Participation in Medicine Discourse

Ozan Altinok (Leibniz University Hannover)

Recent work on participation in medicine by patients have demonstrated the importance of a guiding ethical framework (for participation) (Schicktanz et. al. 2012). Although within the communities of bioethics this is an extraordinarily strong concern, and starting to gain more of a foothold there are also obstacles of unexpected kinds within the practical strategies of inclusion (Tiefenthaler, Schmidt, von Koppen, 2022). In this work, taking the researcher being carried initially by the value laden concepts, and the lack of knowledge of new situations of patients' self understanding due to the institutional advantageous position, I will extend on the linguistic division of labor of Putnam (1975) in terms of using of the newly made values in the form of Williams's account of *thick concepts* ([1985], 2006), and the use of virtue ethics in the newly developing potential injustices, following the framework of Epistemic Injustice, particularly of Hermeneutical Injustice, of Miranda Fricker (2007), within participation research. Fricker (2007) defines two distinctive kinds of epistemic injustice, testimonial, and hermeneutical injustices.

In the general form, this injustice is the world being cut and defined in a way that creates concepts that are not explaining the novel morally salient situations, and not carrying the "thickness", (Williams, 1985) of moral evaluation within the concept. If we accept the claim of Fricker about the essential gap of injustice in novel situations, particularly new social settings that develop materially, a virtue-based ethical perspective can be of great help to counter the

hermeneutical injustices. This is particularly important within the framework of newly established domains of positive ethical intervention, within the boundaries of value laden concepts where they are employed at a new, looping kinds of people being intervened with (Hacking, 1995) in the making of intervention. Perhaps the central issue of epistemic injustice here (in the form of hermeneutical injustice) is the unregulated nature of the practical state of affairs through the language. The primary problem for the people who are outside the designing making of the participation research is about their inability, particularly with respect to linguistic participation in the discourse with their own concepts and meanings. Following the division of linguistic labor at the usage and making of the concepts from Putnam (1975) where concepts require different users, and in general noncodifiability of the ethical frameworks thesis coming from Williams (1985), particular attention is asked for. Among the concerns that I have pointed out, I suggest three criteria against two different obstacles. The decision-making about the criteria should involve participation of *suspected* parties within society, against the possibility of ignorance towards a kind of oppression (following *testimonial injustice* within expert communities). Including more people at first and enabling potential participants the space to be able to express their concerns with respect to definition of the conceptual landscape. This means that criteria should be included within different languages, but also with references to different conceptual relationships, such as literature, culture in general and using the concept of language and participation in the broader senses would be helpful (following the *noncodifiability of ethics*). Instead of having a strong gate keeping strategy, inviting, enabling cultivation of a language and taking the role of the ignorant party (following principles of *heuristic injustice*) as the expert in the new language that is developing in this regard are important concerns to be considered.

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Public Reason – Problems in the transfer of ideas from political philosophy to bioethics

Søren Holm (University of Manchester)

Patient involvement as (justified?) epistocracy

Ben Davies (University of Sheffield)

Patient and public involvement and engagement (PPIE) are increasingly seen as essential to ethical practice in health, including research and priority-setting. A central justification for this is that greater involvement is a way of *democratising* such practices. To varying extents, PPIE practices take involve consultation, and sometimes active involvement in decision-making, from a wider variety of those affected than traditional reliance on academics, bureaucrats, or politicians. Indeed, Frith (2023) argues that democratisation can be seen as an organising ideal for PPIE, which can help practitioners to structure their practices in a more principled way than is currently practiced. I suggest that the plausibility of this framing requires us to consider patient involvement and public involvement separately. Whatever we think of the claim that public involvement is a method of democratisation, we should be more sceptical of the claim that patient involvement is a form of democratisation. Justifications for patient involvement often rest on appeals to unique knowledge gained through *lived experience*, and on *having a greater stake* in the outcomes of particular research projects or political decisions.

Epistocracy is the idea that political power should be unequal, and distributed according to competence (e.g. Ahlstrom-Vij 2012; Brennan 2016; Jeffrey 2018). To the extent that *public* involvement can be seen as democratic, I suggest that these dual features of *patient* involvement mean that we should see it as epistocratic rather than democratic. Patient involvement is not characterised by the features that traditionally shape democracy, namely equality of decision-making power. Rather, patient involvement relies on the idea that certain individuals are better informed, and more appropriately motivated, to guide decision-making. While this may not fit the definition of some extreme forms of epistocracy – e.g., those which would deny ‘incompetent’ citizens suffrage altogether – it does fit more moderate forms of epistocracy which would weight political influence according to competence.

This is a striking conclusion, since epistocracy has typically been criticised as elitist and dangerous. I consider whether there is an alternative framing that vindicates the mainstream reading of patient involvement as democratic rather than epistocratic. I then consider whether, if patient involvement is properly understood as epistocratic, opponents of epistocracy in traditional politics must oppose it, suggesting that this need not be the case. In other words, while patient involvement is more epistocratic than democratic, this need not be a problem in all cases.

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The Diversity of Solidarity in the Debate on Self-Tracking in Healthcare – Discourse Analysis and Ethical Evaluation of a Contested Concept in Digitalized Healthcare

Niklas Ellerich-Groppe (University of Oldenburg)

Solidarity can be understood as a core principle of healthcare, that serves as a prominent normative reference point for many European healthcare systems. However, not least the increasing digitalization puts to test this popular concept. This can be seen convincingly in Germany, where the concept has a long socio-political and socio-ethical tradition. Here, the debate on the use of self-tracking-technologies in healthcare provides an impressive example for the disruptive power of digital technologies. Thus, “[t]he permanent gathering and evaluation of self-related data in one’s daily life [...] by using digital technologies”

(Heyen 2020, 124) poses fundamental challenges to solidarity as normative foundation of the German welfare state. While some emphasize the possibilities for new solidary contributions (e.g., data donations), others warn against eroding solidarity due to individualized risk profiles in health insurances. However, the concept of solidarity involved in these debates is often still less than clear, especially regarding its normative implications. Against this backdrop, I examine how the concept of solidarity is used in the public media discourse on self-tracking and healthcare in Germany and evaluate the applied notions of solidarity from an ethical perspective.

To this purpose, I apply a methodological approach combining moral-philosophical analysis and discourse analysis. First, I offer a conceptual analysis of solidarity. To this end, I draw on pertinent conceptions of solidarity in bioethics, political philosophy and sociology and identify four basic elements of the concept of solidarity. Then, I introduce four normative criteria, that have to be fulfilled for a morally substantial use of solidarity: openness, inclusivity, freedom from domination and normative dependence. In a second step, I pursue a discourse analysis of the German leading media discourse (newspaper articles; print and online; n=317). Starting from the heuristic framework of solidarity, I provide a systematic matrix of seven notions of solidarity in the media discourse on self-tracking in German health care. In a third step, I discuss these different notions of solidarity against the backdrop of the four normative criteria of solidarity.

In this way, I can show, that the public debate on self-tracking in German healthcare is pervaded by heterogeneous notions of solidarity, that meet the normative criteria of a morally substantial use of solidarity only partially. Thus, my presentation can contribute to a theoretical clarification of a prominent bioethical category and evaluate its political significance. On a methodological level, I can underline the value of a combination of methods from bioethics, political philosophy, and political theory, for a more comprehensive analysis of (ethical) challenges in postmodern societies. In this way, my contribution unites bioethics and political philosophy not only in terms of contents but can be located at the intersection of both disciplines also from a methodological perspective.

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Why Public Health is not about Public Goods

Lovro Savić (University of Oxford)

According to Jonny Anomaly (2011), public health should only be concerned with the provision of health-related public goods. Call this the *Public Goods Account*. Anomaly insists that by focusing on the concept of health-related public goods, *Public Goods Account* offers several important benefits. First, it appears to be an account of public health that is both clear and simple. Second, it captures the original and traditional mission of public health by distinguishing public health from other related, but nevertheless distinctive (health care) activities. And third, it is compatible with a wide range of normative positions and, therefore, avoids the issue of political disagreements.

In this presentation, I argue that the *Public Goods Account* cannot serve as an adequate account of public health. The main reason is that its central concept, that of *health-relatedness*, is too vague and imprecise. According to Anomaly, there are two ways to understand health-relatedness. According to *Public Goods Account*_{Medicine}, to say that public goods are health-related is to say that the public goods are associated with medicine. According to alternative, *Public Good Account*_{Outcome}, something is a health-related public good in so far as the benefits it produces has a positive population-level effect on peoples' health.

The main goal of this presentation is to argue that both views are inadequate. First, I provide an overview of the concept of public goods and two understandings of specifically health-related public goods. Secondly, against *Public Goods Account*_{Medicine}, I recount and offer a further defence of the Bernstein and Randall's (2020) and Dees' (2018) claim that, once understood as those public goods that are 'associated with medicine', health-related public goods are not necessary for a public health activity. That is, there are paradigmatic examples of public health activities that produce public goods that are *not* associated with medicine. I also advance a novel claim that, understood in the same way, health-related public goods are not sufficient for a public health activity, either.

This is because there are plausibly some activities that produce public goods that *are* associated with medicine, but we have good reasons not to class these activities as genuine public health activities. Therefore, insofar as it is understood as *Public Goods Account*_{Medicine}, *Public Goods Account* is implausible.

In the final part, I introduce *Public Good Account*_{Outcome} and demonstrate that it is equally problematic. To show this, I argue that there are public health activities that produce positive population-level effects on peoples' health, but these outcomes are either not *pure* public goods, or they are not public goods *tout court*. I also demonstrate that there are a number of legitimate public health activities that produce outcomes that indeed constitute public goods, but these public goods are *not* health-related in the sense that they either *do not* produce

positive population-level effects on people's health or when they do, they do so imperceptibly and non-substantially. This includes public health activities that are concerned with allergies and ultra-rare diseases.

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Intuitions about Just Public Healthcare Versus Liberal Political Theory

Thaddeus Metz (University of Pretoria)

If I were allowed to present at the Bioethics Meets Political Philosophy Conference, I would make the case that strong intuitions about how the state ought to allocate healthcare are incompatible with one major, neutralist strain of liberalism, which has been advanced by Karl Popper, John Rawls, Ronald Dworkin, and many others over the past 75 years or so. In a nutshell, I would maintain that we cannot easily avoid making judgements of which lives are good (or bad) when distributing medical treatments in public hospitals, which tells against the principle that the state should not take sides on which lives are good (or bad) when adopting policy/law and instead should merely enable people to choose their own ways of life in autonomous fashion. This tension, I submit, between aiming to improve patients' quality of life and solely protecting liberal rights has not been appreciated in the literature.

After spelling out the basic tenets of neutralist liberalism and indicating why it has been so appealing to political philosophers, I would then discuss three respects in which it appears that state decisions about how to allocate healthcare probably must rely on conceptions of the good (and bad) life.

One point would concern *which types of treatments should be offered* to patients. I would contend that reattaching a missing pinky toe, removing a vestigial tail, offering therapy to those whose romance is fixated on humanlike dolls or dead bodies, and enabling people to procreate are all properly offered by a public hospital but that doing so would flout neutralist liberalism.

A second would address *how to prioritize amongst types of treatments*, contending that a liberal approach of first treating diseases and injuries that particularly threaten autonomy, while admittedly promising, fails to capture the full range of intuitions. Consider, for instance, the urgency of offering palliative care to those suffering from gravely incapacitating diseases, i.e., where an autonomy-rich life is no longer possible.

A third point would take up *who should receive a certain type of treatment*, say, one that is life-saving when not everyone's life can be saved. On this score, I would maintain that, while

answers remain hotly contested in the bioethics literature, salient ones appear to express or depend on a conception of the good. They include the views that: human dignity means that we should randomize or accept a first-come first-served approach; those with children should come first; those responsible for needing their lives saved should come second; those who would not live for much longer anyway should come second; and those who would not have lives worth living should come second. (I would need to consider whether the 'fair innings' principle, that those who have already lived a long and healthy life should come second, is neatly able to avoid appealing to a conception of the good. Even here, though, my hunch is that, if health is plausibly different from statistical regularity or normal functioning, then normativity looms.)

The talk would not prescribe how to resolve the tension, viz., whether to reject neutralist liberal theory or revise judgements about how those working in public medical facilities should allocate healthcare, but instead aim to establish the point that one must choose between them.

Mapping the Epistemic and Social Virtues and Vices in Pandemic Policy

Angus Dawson (University of Singapore)

During the recent COVID-19 pandemic, whilst policy decision-making was usually in the hands of a small number of politicians and/or officials, many countries chose to involve different kinds of advisory committees (ACs) in the broader policy process. In this paper I reflect upon my own experience as a member of many such committees and seek to articulate and reflect upon various possible norms for the work of such bodies in the future. In this work I draw upon the literature from social and virtue epistemology, the theoretical literature on trust and trustworthiness, and a general tradition of pragmatism. My argument is that ACs are a particular kind of social institution, governed by a diverse range of norms, and that there are clearly better and worse ways of both constituting and conducting such ACs. This paper seeks to offer an initial taxonomy of the different domains relevant to the work of ACs and provide some provisional thoughts on related sets of norms expressed in terms of epistemic and social virtues.

- The AC should be carefully constituted. For example, membership of the AC should reflect a diversity of relevant expertise and perspectives. Appointments should not reflect narrow and ideological political interests. The aims of the AC and terms of reference should be clear and relevant. Too often the process of appointment is lacking in transparency, and the AC's authority can be undermined by a lack of foundational legitimacy.
- The business of the AC should be conducted in an appropriate manner. Members of the AC must be willing to adopt a set of virtues towards evidence, discussion, and policy proposals, such as openness, listening, questioning, respectful engagement, willingness to put to one side one's own prior commitments etc. There are virtues attached to each member of such institutions (being the right kind of person) as well as a set of virtues attaching to the social institution itself (conducting business in the

right kind of way). Too often certain personalities dominate the discussion, or a certain set of ideas remain unquestioned (e.g. about evidence) etc.

- Policy proposals that emerge as outputs from the AC need to be open to discussion, critique, and revision with the broader public not just politicians. Advice should make it clear what the reasons are for policy proposals and options that were rejected. The relevant virtues are not simply the intellectual virtues, discussed in some virtue epistemology, but more virtues of social engagement, linked into social and political action.
- The commissioning parties for the AC, such as the politicians, in turn, are required to exhibit various virtues towards the AC. For example, they, not the AC, are responsible for decision-making. The advice should be accepted in good faith, as an input into decision-making. They should not blame the AC for political difficulties or misrepresent the advice that the AC provided.

Trading Off Lives and Livelihoods

Greg Bognar (Stockholm University)

During public health emergencies, such as the recent COVID-19 pandemic, governments have to make trade-offs between civil liberties and the protection of public health. Such trade-offs are indirect, since there is no accepted way of quantifying the value of civil liberties. Thus, policy makers compare the expected losses in economic activity and the expected losses in terms of lives and health instead. There are different ways to quantify the costs to health and life: for example, policy makers might calculate lost earnings and the extra costs of medical care (“cost-of-death method”), use the value of statistical lives approach (VSL), or quantify health losses in terms of quality-adjusted life years (QALYs).

A lot of the debate on the trade-offs between liberty and public health focuses on the details of these methods. A more general objection, however, targets the aggregative nature of the trade-offs that use them. This feature is thought to be especially problematic for two reasons. First, aggregative views fail to consider harms and benefits from each person’s own (intrapersonal) perspective. As a result, they violate the separateness of persons: they allow sacrificing the interests of some (e.g. members of vulnerable groups) for the benefits of others (e.g. business owners) as long as the overall benefits are greater. Second, aggregative views count morally irrelevant goods and harms (e.g. the profits of business owners) even when the trade-offs involve lives. These objections warrant rejecting aggregative approaches and use non-aggregative or partially aggregative methods instead.

The aim of this paper is to show that the rejection of aggregative approaches is premature, because the two objections that are used to motivate it are in conflict with one another. If some harms and goods are considered irrelevant (and hence completely discounted), the requirement of justifiability to each person is violated: under many distributions of risks and expected harms, the interests of some will be sacrificed for individually smaller expected benefits of others. This violates the separateness of persons as it is usually understood. Thus, justifiability to each person requires to count all harms and benefits. But this leads to the same kind of counterintuitive trade-offs that motivated the move away from aggregative approaches in the first place, and which are claimed to be in violation of the separateness of persons. Therefore, non-aggregative and partially aggregative approaches have no obvious

advantages over the aggregative approaches that have traditionally been used in making trade-offs in public health and other social emergencies.

Boosting and Giving Back, in Solidarity

Zohar Lederman (University of Singapore)

During the peak of the Covid pandemic wealthy countries including Israel, France, Germany, Sweden, UAE, and the U.S., secured third doses of COVID-19 vaccines to further boost immunity even while other countries such as the Democratic Republic of The Congo had less than 1% vaccination rate. The stated goals were to reduce infection, severe disease, and death.

The World Health Organization (WHO) and most bioethicists^{1, 2} have opposed these decisions, citing three ethical arguments. First, fairness requires that high-income countries share resources by first ensuring that people in every country have minimal protection. Second, utility requires optimizing benefits for everyone and more benefit accrues from vaccinating the unvaccinated than from boosting the immunity of people who are fully vaccinated. Third, prioritizing the unvaccinated benefits everyone by reducing the risk of future SARS-CO-2 variants that could be impervious to the protections afforded by third doses.³

While these arguments are compelling, other considerations may be sidelined. Adverse effects of the pandemic stretch beyond mortality and morbidity, and encompass the well-being and interests of all relevant stakeholders, rich and poor alike, as well as the loss of trust in local healthcare institutions. Further, solidarity does not necessarily entail increasing vaccination rates; it could rather involve being boosted while giving back.

In this paper I join the few bioethicists⁴⁻⁶ brave enough to allow for some degree of prioritization by countries of their own citizens in vaccine allocation. Like them, I will argue that an ethical defense of limited vaccine nationalism is possible which appeals to nonideal justice and combines getting with giving.

My proposal, however, differs in substance. For future pandemics of a similar nature, I propose a global campaign, tentatively designated Get one give one, in solidarity, to corral governments and individuals receiving boosters to give back. Donating dollars to Gavi Donate (gavi.org), or to the WHO Foundation <https://gogiveone.org>, an amount equivalent to the cost of at least one dose for each dose purchased or used (the Moderna vaccine against Covid for instance costs less than 5\$ US per dose) might help offset advantages given to boosted individuals. It creates a middle option, rather than a binary boost-or-not choice.

While not an ideal solution, a campaign to Get one give one, in solidarity may bring additional benefits.

1. Donating just takes a click. Yet its benefits are lifesaving and allow people to return to normal life sooner.
2. Donating expresses solidarity, of citizens of one country standing together with citizens of the world against a common threat. Solidarity is both good in itself and potentially spreads, inciting more acts of solidarity across the globe.

3. Donating en masse may lead to global partnerships and goodwill and strengthen international alliances.

Ethics should unquestionably guide global vaccine allocation. Preventing countries from administering third shots is not, however, the only way to move closer to global justice. When ideal-world ethics fails in the real world, it may be time for alternative, innovative alternative solutions.

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The Birth of Public Health as Civic Health: A Republican Viewpoint

Oriol Farres Juste (Autonomous University of Barcelona)

Tracing the historical origins of the concept of public health is enlightening. As trivial as it may sound, the truth is that political concern and occupation for the health of populations haven't always existed. Often, we take the present for granted, considering it necessary and inevitable, almost natural. This is what philosophy refers to as *naturalization*, overlooking the contingent nature of our cultural constructs, including the most widespread, pervasive, and effective ones. Public health was invented, or more accurately, it had to be invented. We have the exact date and place of this event: July 27, 1377, Ragusa (now Dubrovnik, Croatia). This marked the first instance in history when a 30-day period of isolation was established for both goods and individuals arriving by boat to the city. This isolation took place on islands (Mrkan, Bobara, and Supetar) off the Dalmatian coast, across from Ragusa. The Venetians soon followed suit, adding ten days to the thirty, creating the more familiar "quarantine."

Let's ask ourselves: What drives a community to organize politically to address disease and promote health? And why did this happen in Ragusa and shortly thereafter in Venice? The combination of *republican institutions* and *rhetorical interactions* forms the framework in which civic management of public health emerged in 14th and 15th century Venice. It happened in a Republic. Power, in this institutional design, is dispersed and exercised through deliberations, debates, and other rhetorical devices. It is not absolute but subject to law and language. The Venetian Health Magistracy was not exempt from this civil requirement, which is the true essence of "public" in any republic. Beyond idealizations, this

institutional design was conceived to safeguard the citizens' liberty against arbitrary abuses of the State, against its *imperium*. Republican public health must, therefore, be civically protected, just as the proto-physicians of the Magistracy were accountable to the *provveditori* and *sopra provveditori*. Similarly, these officials were held accountable to the Senate, and the Senate, in turn, was accountable to the *Maggior Consiglio* (the main assembly of citizens).

Civil society is "free," in this specific republican sense of the term, when it self-governs. In other words, if the state is defined as an external and arbitrary power, then in a republic worthy of the name, there is no real state. However, if it refers to the civic body itself, it is free, a "free state" (Skinner). In normative terms, Venetian public health is not only pioneering due to its organizational and technical advancements but also because of its respect for civility. As a political discipline, it should never forget to whom it owes its existence: the citizen. Rationally reconstructing this republican desideratum and reclaiming its spirit is not an inconsequential lesson for our democracies, by any means.

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Does "Genetic Inequality" Have a Level Problem?

Olesya Bondarenko (University of Cambridge)

It has recently been argued that our understanding of inequality should be extended to include individual health-related and psychological differences that arise from genetic sources (Harden, 2021). According to Harden, the genetic "lottery of birth", which individuals have no control over, results in unequal chances of possessing characteristics that are causally relevant to attaining valued health and social outcomes. With regard to the latter type of outcome, Harden draws on recent work in political philosophy (e.g. Sandel, 2020) that criticises meritocracy as a social system that rewards luck (such as being born into

privileged circumstances) masquerading as “merit”. In her view, the aims of social justice demand that individual differences (e.g. in terms of education-relevant psychological dispositions) arising from genetic lottery are investigated by scientists and ameliorated through tailored social policy interventions. Despite Harden casting her proposal in socially progressive terms (she refers to it as “anti-eugenic science and policy”), commentators have worried that the account does not go far enough in addressing the ethical dangers associated with genetic explanations of social outcome differences (e.g. Martschenko, 2021).

In this paper, I offer a critical examination of the notion of inequality that has a distinctly genetic basis. I concur with Harden that various embodied characteristics of individuals – from health-related phenotypes to psychological dispositions – may constitute a disadvantage under a particular social system and suggest suitable targets for compensatory policy. For example, having ADHD is known to be detrimental to educational attainment (Loe & Feldman, 2007), hence schools should aim to provide additional learning support to individuals with an ADHD diagnosis. However, contrary to Harden’s insistence on the instrumental value of genetic research in this context, I argue that remaining agnostic about the causes of such characteristics (whether genetic, social, or – the most likely scenario – a combination of the two) will be more conducive to the ideals of equality. If genetic causes contribute to generating forms of advantage or disadvantage, these are best conceived at the phenotypic, not genetic, level. Moreover, associating them with an unlucky draw in a genetic or social lottery can lead to stigmatisation that is counterproductive to the aims of social justice.

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Legal Permissibility of Aid-in-Dying Procedures: a Threat for the Marginalized? Lessons from Canada

Maciej Piwowarski (Jagiellonian University)

The Canadian scheme of aid-in-dying, MAiD (Medical Assistance in Dying) has caused a lot of controversy. It has been criticized for not having proper oversight and for allowing healthcare professionals to initiate the conversation about possible assisted death (as opposed to waiting for the patient request). The number of deaths resulting from MAiD procedures has also drawn attention as possibly too high (Pullman 2023). But the most troubling thing about MAiD, one that had substantial media coverage – is that people are choosing assisted death not because of terminal illness, but mainly because of the suffering that they have to endure living in poverty. Of course, to qualify for the program they have to be diagnosed with “grievous and irremediable medical condition” – in practice, that can be permanent, but not life-threatening ailment, producing symptoms that could be alleviated effectively given better medical care, which they cannot access. The people in question

simply cannot cope with their conditions in their material circumstances. The MAiD scheme, providing them with the only way out of life in misery, is seen here as malfunctioning. It seems to allow some people access to the procedures, though it should not. The line of argumentation here sometimes comes dangerously close to the idea that having even limited assisted death options is an inherent threat to the worst-off (Kim 2022).

This way of reasoning may be misguided. It rests on the preposition that those marginalized people who choose death in such circumstances must be falling victim to societal pressure and that their choice is wrong. I would like to propose the interpretation, that in many cases, continuing to live could be simply worse for the person, and that providing them with some institutionally accepted way of ending their life makes their very bad situation slightly less bad, a view that is consistent with Wiebe & Mullin 2023. At the same time, I do not want to go as far as to suggest that having people end their lives because of their socioeconomic status is something even remotely morally acceptable. But the true culprit here may not be MAiD. The Canadian system may be imperfect, or even critically flawed, but that is not the root cause of the problem here. I want to show that the issue is that there are people in such a bad socioeconomic position, that they cannot bear to live any longer, and they do not get the medical, financial or even emotional support that they require. Thus, I want to reframe this problem as a failure of the social support scheme, not the aid-in-dying one. Distributing society's resources more fairly – not narrowing assisted dying eligibility criteria – can be a way of dealing with this phenomenon.

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