

# Different approach to medical decision-making in difficult circumstances: Kittay's Ethics of Care

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## ABSTRACT

The onset of the COVID-19 pandemic has necessitated advances in bioethical approaches to medical decision-making. This paper develops an alternative method for rationing care during periods of resource scarcity. Typical approaches to triaging rely on utilitarian calculations; however, this approach introduces a problematic antihumanist sentiment, inviting the proposition of alternative schemata. As such, we suggest a feminist approach to medical decision-making, founded in and expanding upon the framework of Eva Kittay's Ethics of Care. We suggest that this new structure addresses the issue of medical decision-making during times of resource scarcity just as well as pure utilitarian approaches while better attending to their significant theoretical concerns, forming a coherent alternative to the current bioethical consensus.

## INTRODUCTION: COVID-19 AND BIOETHICS

Bioethics is an always-evolving discourse. New thinkers propose novel approaches; legal developments force critical revisions; established theories are retested and refined. However, the Western ethics community has settled on some remarkably stable intellectual commodities within the marketplace of ideas. Most every college course on bioethics will discuss the three most mainstream Western theories: utilitarianism, deontology and virtue ethics. As the literature shows, though, the three can often be in conflict—the theories each have distinct and competitive values and methods. But, for the most part, they coexist within the discourse, with a particular emphasis on utilitarian calculations in our society; this runs so deep as to even inform our moral intuitions. As we know, the COVID-19 pandemic has forced us into a situation of medical scarcity far beyond what our health-care systems are used to. We have had shortages of crucial medical supplies like ventilators and hospital beds; healthcare personnel have been pushed to their limits. The Western bioethical consensus has coalesced, broadly, around an approach for rationing these resources that aim to preserve the greatest good for the greatest number of people—it is fundamentally utilitarian. This process of critical consolidation has not been impactless or value free.

But this current approach is not the only feasible option. And, perhaps, it should not dominate our discourse as it currently does; to adhere too closely to any single theory is to run the risk of preemptively foreclosing on insights that other ethical schemata might afford us. We have an intellectual obligation to mind alternative approaches to ethics in our pluralistic society; though ethical pluralism raises certain issues, broad intellectual interrogation

does not necessarily demand that we reduce our thought into relativism. Rather, we simply should expand our discourse and authentically engage with different thoughts. Whether we adopt the approaches or not, additional investigation is valuable. Thus, the COVID-19 pandemic seems to suggest analysing alternative ethical theories—and, furthermore, it pushes us to re-evaluate our approaches to medical decision-making in periods of resource scarcity more broadly, with relevance to future pandemics or disasters. In this paper, we suggest one such alternative framework, an Ethics of Care (EoC) that is developed out of Eva Kittay's work in her book *Learning From My Daughter: The Value and Care of Disabled Minds*; we further propose that this alternative system maintains the requisite applicability to this pandemic and equipoise with the standard approach as well as better resolving theoretical and practical concerns raised by pure utilitarian methods.

## BACKGROUND: UNDERSTANDING THE CURRENT CONSENSUS

In order to compare EoC and the current utilitarian approach, we first must better understand the predominant ethical system's values and flaws. Emanuel *et al* suggest six recommendations for rationing care (table 1); their article in the *NEJM* is a signal of the consensus view of the bioethical establishment.<sup>1</sup>

Some of these principles are sensible during a period of scientific flux—for example, the suggestion that we are responsive to evolving scientific data. But others—like maximising benefits and recognising research participation—are more controversial. The authors write:

In the context of a pandemic, the value of maximising benefits is most important... Priority for limited resources should aim both at saving the most lives and at maximising improvements in individuals' post-treatment length of life. Saving more lives... is consistent both with utilitarian ethical perspectives that emphasise population outcomes and with nonutilitarian views that emphasise the paramount value of each human life.<sup>1</sup>

Even though the authors correctly note that saving lives is a broadly shared value, it does not necessarily follow that non-utilitarians will accede to this specific method, to maximising outcomes.

Utilitarianism is generally considered a subtheory of consequentialism, where utility—in the standard Bentham/Mill formulation, pleasure or happiness—is the evaluated outcome; maximising utility makes an action good. The recommendations from the



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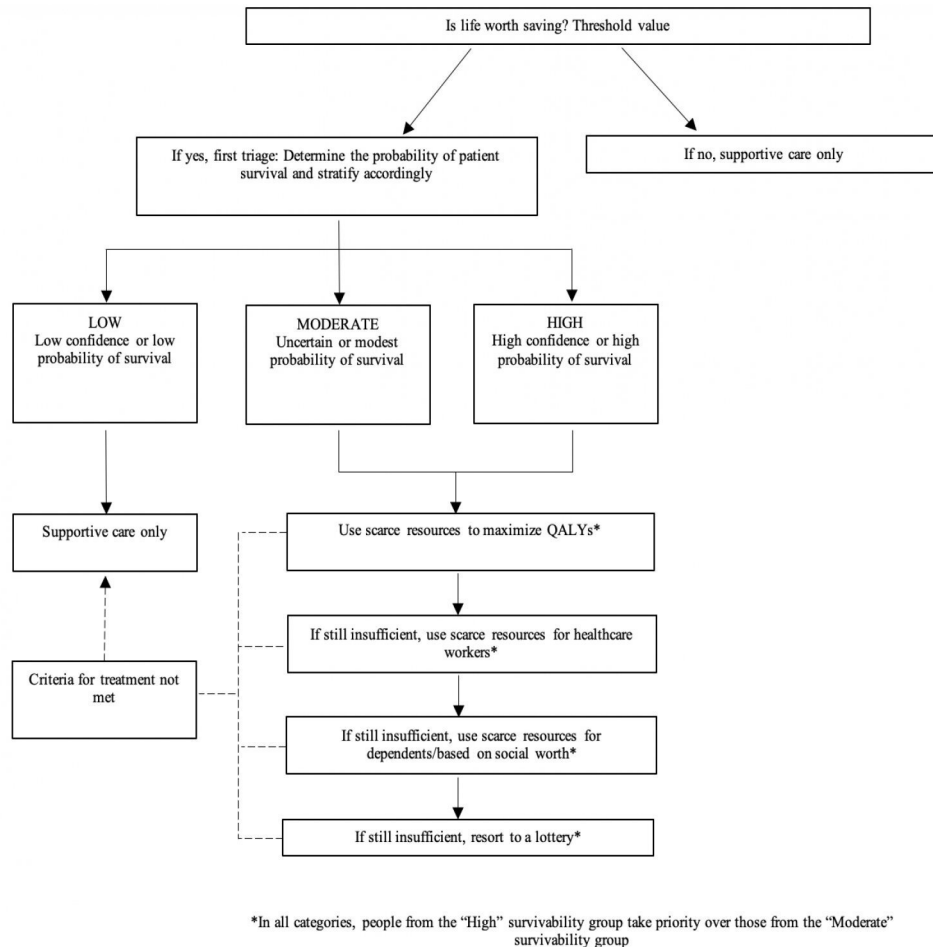
**Table 1** Emanuel *et al*'s six recommendations for allocating medical resources during COVID-19 pandemic

Recommendation	
1	Maximise benefits
2	Prioritise health workers
3	No first-come, first-served allocation
4	Be responsive to evidence
5	Recognise research participation
6	Apply same principles to COVID-19 positive and negative patients

*NEJM* are examples of utilitarian thinking in a modern vernacular: ‘Maximisation of benefits can be understood as saving the most individual lives or as saving the most life-years by giving priority to patients likely to survive longest after treatment’.<sup>1</sup> This utilitarian ethic is consistent with most other proposed approaches to crisis management, which focus on ‘calculable risks and measurable outcomes’.<sup>2</sup> The emphasis is on an intentionally rationalist approach, focusing logically on quantifiable factors that are easily compared in order to facilitate actionable responses.<sup>3</sup> Other voices within the bioethics discourse have taken these principles as a base for developing mechanisms for rationing, and we will consider two here: though they are not the only systems in the literature, they are illustrative. Savulescu

*et al* develop an algorithm that schematises how patients are assigned priorities, reducing subjective influences in medical decisions (figure 1).<sup>4</sup> Patients are triaged and, based on their likelihood of survival, are assigned priorities for treatment; limited resources are then assigned sequentially, with the most likely to benefit receiving aid before the less likely. But how exactly are patients assigned priorities? The University of Pittsburgh’s point allocation system makes these categorisations clear: this method is based on the Sequential Organ Failure Assessment (SOFA) score, which uses data on various organ systems to predict ICU mortality (figure 2).<sup>5</sup> Other methods may use different scores, but the utilitarian algorithms typically need a determinative mechanism to parse through and plug patients into the system. The University of Pittsburgh scoring approach and the Savulescu *et al* algorithm function synergistically, providing a logical and arithmetical way to determine the allocation of scarce resources.

But, by using SOFA scores—or any metric—patients and their treatment become increasingly dehumanised. Much of the medical and bioethical literatures have come to emphasise the value of the biopsychosocial (BPS) model, whereby the patient’s psychosocial background and subjective experience are elevated to a coequal status with the previously dominant biomechanical model: ‘the content and emotions that constitute the clinician’s relationship with the patient are the fundamental principles of BPS-oriented clinical practice, which then inform the manner in



**Figure 1** Sample utilitarian algorithmic approach to resource allocation, derived from Savulescu *et al*. The utilitarian approach to resource allocation emphasises maximising good for all; this is typically metric-based, distilling patients into organ systems and data. For example, QALYs (quality of life years) can be used to compare likely outcomes. In this system, providers use the algorithm to determine who is best served by the allocation of scarce resources.

Principle	Specification	Point System*			
		1	2	3	4
Save lives	Prognosis for hospital survival (SOFA score or other severity of illness score <sup>b</sup> )	SOFA score < 6	SOFA score 6-8	SOFA score 9-11	SOFA score ≥12
Save life-years	Prognosis for near-term survival (medical assessment of near-term prognosis)	...	Death expected within 5 years despite successful treatment of acute illness	...	Death expected within 1 year despite successful treatment of acute illness

\*SOFA= Sequential Organ Failure Assessment; note that another measure of acute physiology that predicts in-hospital mortality, such as LAP2 score, could be used in place of SOFA, and should similarly be divided into 4 ranges.  
<sup>b</sup>Scores range from 1-8, and persons with the lowest score would be given the highest priority to receive critical care beds and services.

**Figure 2** The University of Pittsburgh patient priority scoring system. This table shows the University of Pittsburgh's prognosis determination scheme for critically ill patients. Using the SOFA score, patients are sorted into categories based on likelihood of survival for application to utilitarian resource allocation algorithms. SOFA, Sequential Organ Failure Assessment.

which the physician exercises his or her power'.<sup>6</sup> Furthermore, the BPS model emphasises patient autonomy, precisely through the emphasis on discussion between physician and patient; concurrently, major groups like the American Medical Association are deontological in their position that patient autonomy is paramount.<sup>7</sup> But the utilitarian schemata explicitly reject this approach, reprioritising the pathophysiology of the patient and consequently undercutting that patient autonomy, as patients are subjected to the far less personal algorithm, and especially when it is used in place of direct clinical judgement.<sup>8</sup> This suggests that the utilitarian rationing approach to COVID-19 has generated an unreconciled conflict, implying that bioethical values are malleable: deontology in times of medical plenty gives way to utilitarian thought when circumstances are leaner, generating theoretical tension—tension that makes rationing decisions during this pandemic morally fraught.

But the shift back from BPS to biomechanical model is also a symptom of a larger concern. Carol Gilligan, one of the mothers of care ethics, writes that pandemics like COVID-19 ought to be approached 'not as a math problem with humans but a narrative of relationships that extend over time'.<sup>9</sup> Gilligan's suggestion is emblematic of the feminist approach: more attentive to the people within the frameworks, holistic and humanistic in ethical dicta, considerate of those who make up the groups passed over by the powerful.<sup>10</sup> From this feminist concern—that the utilitarian approach is inadequately sensitive to the human experience—Branicki suggests that crisis management ought to better attend to the experiences of suffering and caring.<sup>2</sup> The feminist approach is couched in a fundamentally distinct worldview: relationality, subjectivity and intertemporality are primary, as opposed to calculative logic, objectivity and temporariness.<sup>2</sup> Put in more general terms, the feminist critique of the currently predominant COVID-19 crisis management method is that it forgets the person within the patient and suggests that we all would benefit from a more care-centric approach.

To briefly illustrate the issues raised by the utilitarian approach in more tangible terms: one particularly concerning sequela is the very real possibility of ableism creeping into the utility calculations. If a system emphasises overall outcomes across the whole population, the door is opened for unjustly disadvantaging people living with disabilities. For example, at the start of the COVID-19 pandemic, several US states employed crisis-related standards of care that allowed denial of care to people with severe dementia or other disabilities not directly related to

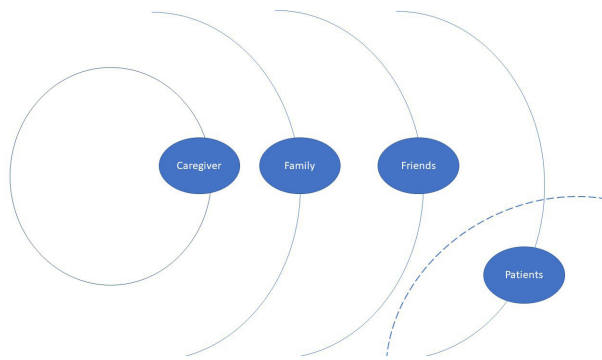
virus survival.<sup>11</sup> For the observer not deeply committed to true utilitarianism, this reallocation of human value is concerning, showing the need for an alternative approach. This plays easily into Kittay's work, which is based on care for the disabled. She summarises the concern, writing, 'some arguments maintain that the special needs of these individuals constitute a bottomless pit, diverting resources from the rest of society's needs'.<sup>12</sup> But this embodies the problematic antihumanist sentiment: it denies the dignity that the feminist philosophers insist is fundamental to humanity.<sup>13</sup> Thus, we see how the purely utilitarian approach has significant theoretical blind spots that allow for practical, visible harms.

## MOVING BEYOND OUTCOMES: THE EOC

It is worth noting that even though the utilitarian approach may be easier to theorise and implement for us Westerners steeped in consequentialism, there are many other extant ethical theories like deontology, virtue ethics and even non-Western approaches. The EoC is one of these alternatives; here, we are building on Eva Kittay's work in *Learning from My Daughter* because it both delineates a coherent theory and because it explicitly deals with caring relationships where one party is significantly dependent on another. In Kittay's text, the dependent party is her daughter, Seshia; in this paper, we are dealing with severely ill individuals. Though the two may not be completely equivalent, we suggest that the patient so sick as to need a ventilator has similar needs as a severely disabled person: total dependence on another for their life.

Broadly, the EoC is a feminist care ethic—controversially distinct from the traditional utilitarian/deontological/virtue ethical framework. This controversy comes, in part, from the different ethics proposed under this umbrella by its numerous theorists. Rather than picking a side in this dispute, we propose an alternative: that the EoC is a 'synthetic ethic'—that is, a stand-alone theory that incorporates competing theoretical aspects into a novel whole.<sup>14</sup> We can see this synthetic element in the ways that different moral theories colour care ethics. The EoC is often referred to as a virtue ethic—though many care ethicists repudiate that label. Kittay writes, 'the care ethicist (in common with other virtue theorists) would... [call] for the active cultivation of moral emotions and for the modeling of their appropriate use'.<sup>15</sup> So, there is a component of virtue within the theory. But, as Engster notes, EoC 'places greater emphasis on outcomes than virtue theories normally do'.<sup>16</sup> Furthermore, justice—a typically deontological value—itself derives from care: 'care is foundational to justice: it is the heart of justice. There can be no liberty, privacy, equality, or other values unless there is first sufficient care for individuals'.<sup>17</sup> Identifying EoC as a synthetic ethic has value beyond genealogy, however. By casting EoC as synthetic, the door opens for the absorption of other ethical mechanisms into our proposed approach: if EoC is synthetic, then we may adopt some utilitarian strategies or elements of deontological values without destabilising our theory. In practice, this allows us to develop an EoC that can address critical medical shortages just as well as the current system *and* better attend to autonomy and medical humanism.

Prior to describing the EoC, however, we must first represent its ontology. Rather than the typical approach where an action is morally delineable as right or wrong, the EoC calls us to normatively evaluate relationships in order to determine our actions. We live our lives through relationships, rather than actions severable from our surrounding world—and it is important to note that these relationships are necessarily gravitational and



**Figure 3** Gravitational field illustration. This figure represents the theoretical relationships of care between people, illustrating the multiplicity of relationships that undergird human interactions. In a medical setting, the caregiver (provider) has more demanding caring obligations to self, then family, friends and patients; similarly, patients themselves have their own obligations to others, generating a constellation of caring forces.

proximal (figure 3). Kittay argues that the people closest to us have special moral importance as they are motivators to care, but that we cannot be indifferent to distant others—‘I may not have a duty or responsibility to care equally for all, but I do need to acknowledge the equal right all have to receive care’.<sup>18</sup> This includes the relationship with the self: like Buber’s *I-It* or *I-Thou*, there is a self-directed caring relationship. Care reflected back on the self: *I-I*.<sup>19</sup> Notably, also, two people in orbit of each other have co-obligations, though perhaps of different qualities—this is the genesis of patients’ care obligations. The end result, like in Nel Noddings’s paradigm, is ‘chains of caring’: we are yoked to each other at an ontological level.<sup>20</sup> To offer an analogy, Kittayan care is like electromagnetic fields, with stronger field lines closer to the centre (the subject) and radiating outward; other bodies (other people) generate additional radiations from themselves. In line with this analogy, we suggest calling the moral obligations acting on us ‘caring forces’, which vary in magnitude—and allow us to make actionable normative judgements by comparing the forces’ respective pulls on us. There are even potential caring forces between us and those we have not yet met, generating Kittay’s acceptance of care obligations for distant others contra Noddings.<sup>21</sup> The fundamental metaphysical distinction between EoC and utilitarianism is the inescapable presence of caring relationships from which moral acts flow; they may then be evaluated.

Care is a theoretically complex entity. It is found in attitudes and labour, and it forms virtue. Per Kittay:

As labor, caregiving requires attending to the needs of another... the attitude of care is the open responsiveness to another—so essential to understanding what another requires—is needed if the work is to constitute caring labor... Care... is also a virtue to be cultivated, disposition to make the attitudinal shift.<sup>22</sup>

Further, Kittay suggests that ‘care in the fully normative sense is care as it ought to be practiced if it is to do what care is supposed to do’.<sup>23</sup> The implication is that care is bifunctional: it is both an abstraction and an application. Care is a normative goal as well as a process of achieving that goal. Unlike Aristotle and his list of virtues and vices, Kittay suggests that care is *the* virtue for this ethical system. But there is another, subtler interpretation of her description: care can be either effective (fully normative) or ineffective (care that does not necessarily do what it should).

The EoC emphasises that all relationships are caring—simply in different levels of quality. Goodness is fundamental to existence; what matters is whether we apply our own capacity for goodness for the benefit of others.

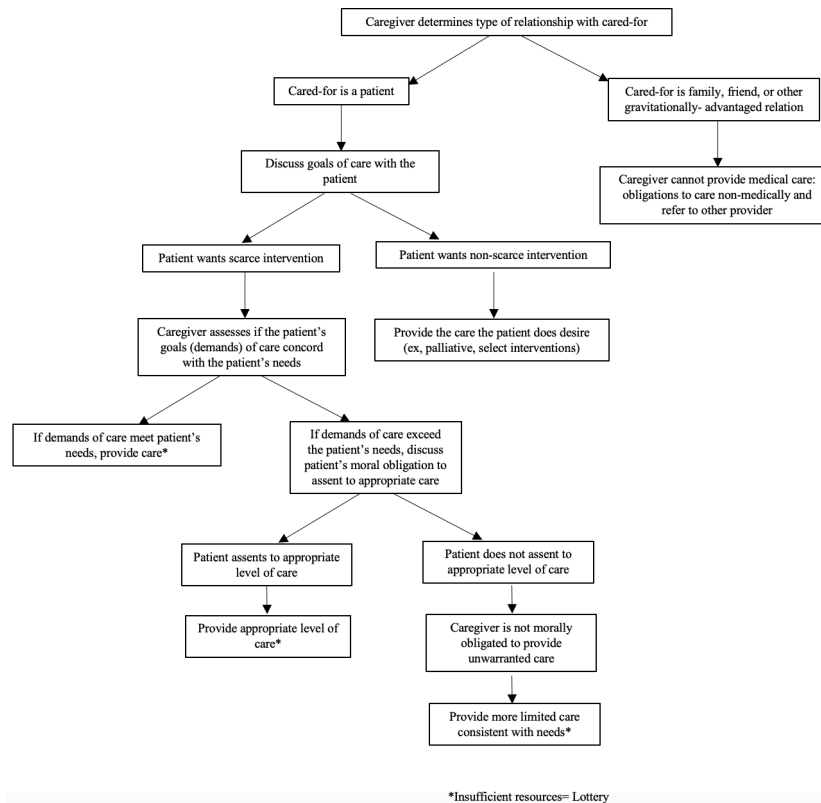
Care quality is directly related to its closeness to maximal care. Kittay defines three main criteria, all of which must be satisfied for full care:

1. intention to care, based on concern for the caree,
2. active uptake of care by the caree,
3. benefit to the caree.

Based on these criteria, care must be deliberate; caring actions carried out with impure intentions are tainted. Additionally, there are not one but two moral actors involved. The carer proffers care, but the caree must take it up for it to be valuable. Proffering care does not oblige the caree to graciously accept it, Kittay notes—and can even raise questions about caring too much or not truly aiding those ostensibly being served.<sup>24</sup> These stipulations illustrate the synthetic identity of care ethics: the deontological attention to intent is balanced out with the consequentialist importance of outcomes. Effective care is care that contributes ‘to the well-being, restoration, or flourishing of a being or subject’.<sup>25</sup> By participating in the process of care and facilitating reciprocal engagement—by satisfying the three criteria for effective care—the carer provides that equal and opposite caring force, matching the pull of the caree with their own provision of care. Then, at least in the hypothetical, the caring relationship may foster true flourishing—flourishing, to Kittay, meaning having one’s true needs met or maximising well-being. But, Kittayan flourishing does not require perfect virtue: rather, we aim to support flourishing as well as we can, keeping in mind the limits to what we can achieve. ‘Care is guided by regulative ideals... that we cannot fully realize but for which we should strive nonetheless’.<sup>23</sup>

Moving from theory to bedside, we have constructed an algorithm that applies these caring principles to our current pandemic situation (figure 4). In order to make practical ethical decisions as carers in times of medical scarcity, we are confronted with four main considerations: first, we must determine the kind of caring relationship at play. Is it medical or familial? Second, we should discuss patients’ needs and desires for medical care. Third: assess if the patient’s demands match their needs. Fourth, and finally, we ought to consider the role of moral luck. The emphasis during this decision-making process is on engaging in discussion with all of the stakeholders about these different concerns: what they think about their care and what we do to care for them. The goal is to reach consensus, actualising all parties’ autonomy through addressing the issue at hand together.

Additionally, the algorithm is constructed from the side of the clinician, in keeping with the usual structure of these sorts of guidelines. This brings up one theoretical concern: Kittay notes a requirement of subjectivity in care, meaning that the clinician has an obligation to consider the patient’s perspective. To her, the caree’s ‘genuine needs and legitimate wants’ and sense of well-being are necessary for care.<sup>26</sup> This raises the question about those whose perceptions are morally warped or those who cannot experience (or communicate) their perceptions. Kittay’s legitimacy qualifier becomes important for the morally non-normative—following in Nussbaum’s footsteps, there are some capabilities that are required for flourishing, like bodily health or integrity; someone who thinks that causing pain to others is necessary for flourishing, for example, is simply not recognising their legitimate, genuine needs and instead misunderstanding true flourishing.<sup>27</sup> Kittay addresses cases of those who cannot experience or communicate flourishing. The approach is



**Figure 4** The Ethics of Care approach to allocation of scarce resources. Caregivers and patients must both accept their gravitational relationships and obligations to others and engage in dialogue about goals and needs of care. When patients' desires do not match their needs, they should be gently reminded of their relationships with other patients; if, after all deliberation, patient needs are equivalent and resources are still scarce, all are entered into an unweighted lottery.

antipaternalistic, with an acceptance of indeterminacy, periods when it is unknown if the care is taken up or valuable. Kittay writes:

When one's mind is underdeveloped, or temporarily impaired, the actions of the carer may only later be acknowledged as caring by the cared-for... Sometimes we get it right; sometimes we get it wrong. We can only hope that on balance we succeed in our efforts to care.<sup>28</sup>

Furthermore, Kittay invokes hypothetical consent—'If the cared-for could understand, then she would endorse my actions as care'—with the caveat that the carer has an obligation to continue to assess the care they are offering from the perspective of the caree.<sup>29</sup>

Now, with the flourishing of the patients in mind, let us examine our algorithm in more detail. We suggest that the emphasis throughout the process of medical decision-making includes a parallel dictum to really investigate the patient's thoughts, and then allowing the patient's perceptions to help guide the process of care; if the patient is unavailable or indisposed, their family or guardian should also be consulted. Then, if there are no surrogates available, the clinician must act with substituted judgement. The first step from the clinician's side, though, is to determine the quality of caring relationship. The gradation in strength of caring forces acting on the provider necessitates this interrogation, so that the provider may refer their family member to another physician so as not to disadvantage their other patients—this is a question of justice. Then comes the explicit discussion with the patient/guardian,

designed to help both parties understand the goals of care. If a patient does not desire the scarce intervention and instead wants another less resource-intensive treatment—or none at all—then it is caring and good to provide what they desire, which concurrently reduces the need for medical resources.

If the patient does desire the scarce intervention, however, the physician must then assess whether the patient needs such an involved level of care—this is where the synthetic component of the EoC peeks through again. The provider feels caring forces from multiple patients and needs a way to parse through them to maximise their expenditure of care, as there are limits to what we can all offer. At this point, the provider may look at the relevant utilitarian metrics like predicted length or quality of life, as both find an implicit place in Nussbaum's capabilities list. And, practically, providers need some methods for comparing and evaluating needs; utilitarian grading schemes can, thus, have a role to play, but they are within a framework of care, rather than being the framework, evading the concern about dehumanisation that accompany pure utilitarian calculations. However, if the patient does not medically need the intervention that they desire, the patient must first be reminded of their moral obligations to those around them; it is not caring to gobble up an unnecessarily large quantity of care for oneself. If this discussion leads to the patient changing their mind and assenting to the appropriate and lower level of care, they are then provided it. If not, the EoC suggests that the physician is not obligated to provide that supranecessary level of care and may morally provide only what is medically necessary. Caring too much is wrong: it is unjust by redistributing care from other stakeholders

in need, violating that central bioethical principle. Then, finally, if there are multiple people with the same magnitude of caring forces after all of this winnowing, we suggest resorting to moral luck, in the form of an unweighted lottery.

Kittay, following Aristotle and Bernard Williams, notes that moral luck is an inherent part of moral life—we are limited in both our materials and our knowledge. ‘Understanding care from the perspective of the completion of care presents the hard reality that whether or not our action will hit its mark ultimately depends not on us, but on the cared-for and on conditions not in our power to effect’—like overwhelming numbers of patients from a novel virus.<sup>30</sup> Kittay argues that moral luck is an inevitable part of EoC—for her, a carer can offer everything necessary for care, but it can fail without active uptake—and we suggest that moral luck has an even larger role in determining who has access to care in certain situations. In fact, we propose that Kittay’s empowerment of moral luck helps us avoid falling into the trap of hubris: perhaps it is fallacy to try and weigh likely outcomes when we know that these predictions are merely inductions and thus are vulnerable. Though cases of equal care obligations may be small in number generally, this is an important consideration for a pandemic, where resources may become far more limited. We suggest the unweighted lottery formulation of moral luck for two reasons: first, that both caregivers and carees may find some comfort in the knowledge that they are not being judged as individuals, either because of their ability to care or because of their medical pathologies and second, this chance-based approach is most consistent with the value of justice built into the EoC, as it is a impartial way to choose between multiple people with competing claims.<sup>31</sup>

At all levels of this ethical schema, the emphasis is on authentic interaction—with the providers who directly care for the patients making decisions in discussion with the carees themselves, always trying to find a mutually caring approach that maximises the autonomy of all involved. Additionally, the EoC I-I relationship determines that the caregiver is not obligated ‘to stray from her own moral compass in her willingness to become “engrossed” in the other’: this is captured in the first consideration, where the provider determines whether they are best situated to actively enter into the caring relationship, based on the forces of caring active in their orbits.<sup>32</sup> As Kittay describes, there is a danger in caring too much, both for the individual caring relationship and between caring relationships, raising issues of justice. Therefore, autonomy for both patient and provider is valued more than in a purely utilitarian paradigm.

However, there is a theoretical concern to be addressed: many mainstream care ethicists consider the application of a broad rule to run counter to the spirit of the avowedly particularistic theory. Kittay writes, ‘What a care perspective adds to virtue theory and sentimental ethics is the understanding that these motivational forces also make us more alert to what is required in this particular circumstance’.<sup>33</sup> Furthermore, the variegated individuality of care frameworks, born from differing theoretical goals, has made the project of developing a widely applicable theory even more complex. But the fecundity of care theory need not be an insurmountable obstacle: we do not suggest in this paper that our framework supersedes others, but rather that it is a new member of the chorus of ideas. Steven Steyl explicitly argues why care approaches ought to invest intellectual work into developing theories of right action. He surveys a number of arguments, which are outlined in table 2.<sup>34</sup>

We find Steyl’s arguments to be compelling, both individually and as a group. Kittay describes a continuum of theoretical approaches to care ethics, from the purely descriptive to the fully

**Table 2** Summary of Steyl’s arguments in defence of theories of right action in care ethics

Reason	Summary
Sociological	To most people, normative ethics without theories of right action are unpersuasive
Justification	Care ethicists assess right and wrong, so a theory explaining the difference is required to justify their normative claims
Pragmatism	Care theorists aim to voice the experiences of caregivers, implicitly constructing normative models as parts of their projects
Differentiation	A theory of right action would differentiate EoC from other ethical frameworks

EoC, Ethics of Care.

normative; she settles on her EoC occupying the latter position; to maintain Kittay’s theory as an actionable approach, we have superimposed this theory of right action to make her method more clearly applicable and philosophically sound. This fits particularly well with Steyl’s justification argument.

But we suggest an additional reason as to why our algorithm does not overly generalise the deeply particular nature of mainstream care ethics. Our approach is constructed around the COVID-19 crisis and other pandemics that generate similar scarcities. As such, it would first need revision in order to be translated into other realms of patient care, yielding some amount of specificity at a macro level. More individually, we maintain that our project is still sensitive to the particular situations that patients and providers find themselves in. We emphasise discussion between patients and providers in our algorithm precisely because this deliberation allows both parties to recognise and respond to the individual needs of each other; this emphasis on discourse allows our system to be flexible, in the spirit of the care ethics tradition.

And on a final, more abstract point: Baumeister and Sommer suggest that men and women operate in two different social spheres, with women ‘mainly orient[ed] toward and invest[ed] in a small number of close relationships, whereas men orient toward and invest in larger sphere of social relationships’.<sup>35</sup> This dualism is replicated in the metatheoretical conflict between utilitarianism (as in Emanuel *et al*’s article) and care ethics (along the lines of Nel Noddings’s work). Noddings focuses on primarily the close social relations; the utilitarian on the anonymous masses. But again as Baumeister and Sommer note, these dual constructions are not so firm: men and women can and do think in cross-spherical ways. And this is what we hope to add to the care ethics discourse: a middle ground approach that appreciates the particularism bound up in human intimacy that is also tempered with the attention to the Other that powers much of feminist scholarship. Kittay’s willingness to attend to distant others while being mindful of the weight of personal relationships allows us a chance to pull those two spheres together, in a synthetic movement that we suggest combines both approaches’ benefits. So even though our approach does stray from some of the particularism of EoC, it incorporates a view of all people that allows EoC to be more applicable to bioethics—a subfield that requires ethical consideration of the non-intimate Other.

## CONCLUSION: EXPANDING THE BIOETHICAL DISCOURSE

We have now seen the distinct differences between the utilitarianism and EoC systems, both ontologically and practically: one focused on cultivating relationships, the other on biomechanical weighing, raising questions about autonomy, values and the role of humanism in medicine. In this vein, we have aimed to take

Branicki's feminist discontent with the utilitarian approach for COVID-19 pandemic management and combine it with Steyl's arguments for a theory of right action to yield the impetus for this project as a way to expand Kittay's EoC. We suggest that pure utilitarianism is not the best approach, even if it is the ostensible consensus. It is not that the utilitarian cannot develop a calculus that includes attention to the human within the patient, but acting on that—acting with care—requires a new system of implementation. The EoC focuses on maximising the flourishing of others and selves, using discourse and the mutuality of moral relations and moral luck if needed; in our paradigm, it is also synthetic, invoking elements of other moral theories in the care effort. We contend that EoC, while particular, can also be normatively decisional through attention to relationships.

Thus, we have started to develop a system by which medical resources may be rationed while maintaining care for all patients. By using utilitarian calculus and appealing to justice when necessary, this system is able to parse between competing moral claims while being more attentive to the people receiving care than pure utilitarianism. Recognising that people are more than collections of biological mechanisms and attuned to their relationships and to the world around them, we hope that this new approach helps to rehumanise the existing approach to COVID crisis management. Thus, our final contention is that Kittay's EoC meets the standard approach's applicability to our situation, and is better—perhaps more caring?—to the people who inhabit it. By taking up the feminist call for crisis management that is humanistic and practical, its value lies beyond just a thought experiment, or an abstract philosophical thought—it suggests, perhaps, that we ought to reinterrogate our moral intuitions.

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