Philosophy of Medicine
Perspective

Philosophy of Medicine and Covid-19: Must Do Better

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Abstract

The Covid-19 pandemic was a world event on our intellectual doorstep. What were our duties to respond, and how well did we respond? We published papers, but we did not engage extensively or influentially in public debate. Perhaps we felt we were not experts. Yet in a health crisis, philosophers of medicine can offer not only "conceptual clarification" but also domain-specific knowledge concerning structural properties of relevant sciences and their social-political uses. I set out three conditions for the kind of contribution I felt was lacking: public, critical, and timely. And I call for us to do more of it.

1. What Should Philosophers Do during a Pandemic?

What should philosophers of medicine do when large numbers of people die, government policies whiplash, large chunks of the world shut down, inequalities deepen, unemployment rockets, livelihoods evaporate, education is disrupted or terminated, social and conventional media go chaotic, peer review becomes the old normal, and science is both deified and demonized—all because of a disease?

We, philosophers of medicine, have both the advantage and disadvantage of knowing what we actually did in such a situation. The advantage is the opportunity to take instruction, and the disadvantage is the risk, temptation, propensity, or other disposition to defend actual responses that were wrong, or right for the wrong reasons. We also run the risk of unfairly and ineptly criticizing scientific and policy responses that were reasonable (or affirming the unreasonable), with the false sense of expertise that hindsight generates.

As an editor of this journal, one thing I know that we philosophers of medicine did was to publish articles in specialized academic journals. The ones in this issue are excellent, and I'm proud to have been involved in their publication. There are many more in other journals, and perhaps some of these are even almost as good. Yet most people will not read any of

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them. This kind of contribution—scholarship—is important; that's why the Editorial Team of this journal, the Subject Editors, the Governing Board, the Editorial Advisory Board, and all the many peer reviewers whom we call upon, devote so much of our mortal allotment to it. Yet it is not, I believe, the only contribution that philosophy can make to the affairs of the world. So I want to use this venue—one that is not "public-facing," but is addressed to academics in the field—to ask: what else did we philosophers of medicine contribute to the response to this global crisis on our intellectual doorstep?

2. Contributing to Public Debate

One kind of engagement that philosophers might have is with the formation and evaluation of policy: working on ethics committees, being included in response teams, and so forth. Philosophers who were in a position to contribute in this way during the pandemic were generally there because they were already engaged in this world, following a lengthy process of positioning themselves there, over a long period of time. Most philosophers, even of the applied stripe, are not directly involved in policy work, and to argue that they should be would be to argue for a fundamental change in the nature of the discipline—one that I do not approve of. My concern is with the philosopher of medicine, broadly construed, who finds themself in the midst of an emerging health crisis, wondering whether they have anything to say, whether to say it, and how.

Thus the more accessible sort of contribution that philosophers might make is participation in something commonly called "public debate." We often feel guilty about not doing this, and nervous to try; and often we don't much like what those philosophers who do participate have to say. It's not clear what we have to contribute: "conceptual clarity" sounds (and often is) patronizing, and is itself ironically unclear. Contemporary "philosophers of" tend to aspire to something different and more substantive: a kind of contribution that is not emptily formal, but is involved, in some degree, with the content of the matter at hand. Yet how are we to do this if we are not "experts"?

We are sometimes hamstrung by an eerily Kantian idea that we can contribute in the world of concepts, but not experience. But this is an outmoded idea. No longer do many philosophers believe there is an iron curtain between synthetic and analytic statements, a priori and a posteriori knowledge. We philosophers of medicine, broadly construed, surely can help to clarify relevant concepts, but this requires our having relevant knowledge of the field too. The difference between us and physicians, epidemiologists, and so on—those commonly seen as experts on health and disease—lies in the *kind* of knowledge we have. This distinction undermines the idea that there is only one kind of expert for each domain, one of the unfortunate refrains of the pandemic. We are experts in biomedical science, as much as is a biomedical scientist, but our expertise concerns a different set of facts (if that is the right word) about biomedical science.

To illustrate this point, I will focus on science. Perhaps there is no unified thing called "science." However, science as a general notion (and the word *science*) played a major role in the pandemic, and many philosophers have investigated science construed generally and, in doing so, we have come to know things. We philosophers of medicine are in a position to apply this knowledge to the health sciences in particular. And scientists don't know what we know.

We know, for example, about Thomas Kuhn's paradigm-shifting critique of the neutrality of science. So we know that "Follow the science" is not a nonsense, but the slogan of a sociopolitical intervention. We know that interests are part of the explanation, not just for scientific priorities, but also theories and even observations. So we know, too, that both asserting and denying the viral etiology of Covid are likewise political moves, even if only one side is uttering truths in the process. We know that images of the virus are social and political tools: that color pictures of coronavirus have been colored in, and that this coloring was done with some non-epistemic purpose, such as creating alarm, or luring viewers to a news program, or whatever. (I did not see any drab-colored depictions of the virus.) We know about the existence of biases that most people do not know about (publication, financial, selection, and more) and we understand them better than many of those scientists who are aware of their existence. Thus, for example, we know that scientists who promote their work are simultaneously "sharing their findings" and furthering their own careers (as indeed are we); and that this can shape their "findings," their reactions to criticism, and so forth, even when they are (as we are) insensible of the fact. Maybe it does not take a philosopher to say this, but a philosopher can say it without seeming to be, or becoming, a wholesale "science denier" because philosophers have six decades of scholarship behind them to back up what they say.

We know, too, that knowledge claims are subject to social and political forces; that having power includes having the power to say what is a fact. When the World Health Organization declares (as it did, early in 2020) that wearing a mask is ineffective in preventing the spread of Covid-19, we know that it is not merely (and in this case, not at all) reporting a scientific output, but it is also exercising agency in pursuit of a goal in the big, wide world. In this case, the objective seems to have been to keep masks available for health workers, which implies that the people were deceived in order to prevent them from doing something that could, at least possibly, have saved their lives—as argued by Eli I. Lichtenstein (2022) in this issue. We know that policies are made in the interests of the rich and powerful, even when the explicit justification is altruistic: as when Ebola in West Africa in 2014 prompted an international response, while outbreaks in other parts of the continent had not done so. The difference was that the outbreaks in West Africa were larger and appeared to pose a risk of spreading to wealthier, more powerful regions. Thus we know in advance of a public health emergency that whatever policies are adopted, they will probably not be altruistic: they will probably serve the interests of the rich and powerful of the world first, and those of the weak and poor either by chance, or not at all. In the absence of strenuous and persistent advocacy, altruistic policy happens only by mistake.

Naturally, what we conclude from these and other parts of our knowledge web differs. We might incline towards realism or relativism; we might espouse or reject a value-free ideal of inquiry; and so forth. But we are aware of the complications that give rise to these differences of opinion. We understand, I take it, that much of what was said during the pandemic about science, health, and disease, among other things, was ill-conceived. Yet, as a collective, we were not vociferous in saying so.

We can dissect the inner workings of drug approval agencies. We can show how bias may persist even through complex layers of experiment and analysis designed to eliminate them. We can parse what the psychiatric authorities have to say about mental ailments. So we can certainly make short work of "Follow the science." We can explain why treating the scalar "herd immunity" as a strategic objective is an error and that it serves certain interests.

We can unpick the obsession by various parties over single variables: one was the "R number" (see Amoretti and Lalumera 2022); another was the infection fatality ratio. We can and should make visible the absence of women from public-facing roles (at least in Britain and the US), and the lack of any notable provision for domestic abuse. We can and should resist the pillorying of experts (notably female, notably of color) who openly disputed the perceived scientific mainstream. We can illuminate the rhetoric of "fact" and "expert," of "unprecedented threat," and "threat to humanity." And so on, for a huge number of other travesties of intellectual and social justice. And we can do this, not only after the fact in academic journals, but at the time, in public debate.

Where were our critical skills? Wherever they were, they were largely invisible.

3. Doing No Harm

You may be thinking: "Sure, but Covid *is* caused by a virus; vaccinations *do* work; modelers *ought* to have been listened to. If we philosophers had come swinging in with public critiques of science, we would have fanned the flames of unhelpful, dangerous dissent. Kuhn is fine for the seminar room, but this is the real world. Publish academic papers if you like. But don't go on TV, trying to dispute with experts who—even if they, like all of us, are enmeshed in the messiness of social and political life—are fundamentally right, and whose knowledge is going to save us from widespread disaster."

I agree with part of this sentiment and I strongly reject the other part. I agree that it is quite possible to meddle: to pronounce on things that look easy from the outside, when in truth we have no idea what we are talking about. I reject the idea that deploying the body of philosophical skill-knowledge indicated above during the pandemic would have amounted to doing that.

One piece of evidence for this claim is that those philosophers who did engage publicly did not, as a rule, do so in an irresponsible or unhelpful way. There were a number of public engagements. I was involved in some of them, and I'm biased as regards those. But there were a number of others, which I'm not going to mention because I will inevitably do injustice to someone by leaving some out. In my own opinion, a few of these were unhelpful (for example, in failing the criticality condition set out below), but the majority were interesting and useful. Their usefulness came in a variety of forms, and not solely in the anointment of some discourse with a special property of "conceptual clarity." Nor was their engagement confined to the more familiar terrain of political philosophy. It was proper engagement, in a public forum, in terms of the kinds of things that we philosophers of medicine are the experts in. And, for the most part, this engagement did not bear out the alarmist fears. This shows that philosophers *can* engage without meddling. How should we do it, and how can we know when we're passing the limits of our skill-knowledge?

Specifically in relation to epidemics, the answer is partly in preparation. We should continue to build expertise in philosophy of epidemiology and public health. I'm biased; these are my specialisms. But the *reason* for this is that I've felt, ever since I learned the word, that epidemiology is much more important than people have generally realized, and that epidemiology and public health are not widely understood. The pandemic has changed the former but not, I fear, the latter. Philosophy of epidemiology and philosophy of public health can help improve understanding of these fields (including that of the scientists in them, who sometimes have quite remarkable ideas about what they are doing). Yet

philosophy of epidemiology and public health remain underpopulated areas of scholarship. And the more you know, the more you know that you don't know, and the less likely you are to meddle, and make an unhelpful contribution.

Another part of the answer is simply to learn to exercise judgment. We know that people with technical expertise can easily get it wrong by overselling their conclusions, failing to mention (or perhaps forgetting) that their model is a simplification, or that their inference concerns a specific domain. Philosophers are more likely to fall prey to different vices, such as adopting a striking position and adroitly defending it. This gets you seminar invitations, workshops, special issues, and citations; there is even the remote prospect of immortalization on undergraduate reading lists, the ultimate goal of a philosophical career. It does not, however, help people in other domains form good judgments, so it does not further public debate in a way that might ultimately lead to better policy. In our public engagements, we must modify our concern for distinctions when they are not pertinent, and our propensity to think of ways to sustain a position, or an attack, when this is simply not appropriate. We can practice our discipline as if it mattered, and then perhaps it will.

4. What We Did Not Do (Much)

I have shared my opinion that the philosophical contributions to public debate around Covid were, for the most part, good. But I am disappointed that they were not more numerous. Therefore, I call for more contributions from the philosophy of medicine, broadly construed, to public debates, especially concerning epidemics, epidemiology, and public health. I am not wholly sure what a public debate is, but I can say something about the kinds of activities I am calling for. They should be:

1. public;
2. critical; and
3. timely.

What justifies these criteria? First, publicity. When many people are chipping in with ideas about what to do, it is not always helpful to throw in one's two cents. However, there have been situations where our field ought to have been able to offer something useful. We philosophers of medicine do have relevant expertise. If many of us were uncertain what to say, perhaps this means our preparation was lacking: perhaps we have been studying the wrong things. Or perhaps it means we are not appropriately trained to engage publicly (although I fear this is sometimes an excuse), or perhaps it means something else again. Anyway, whatever the problem, we should fix it.

Second, criticality. The pandemic was a knowledge-war: those who ruled the epistemic high ground shaped policy. It is striking how a field that routinely, at times perhaps carelessly, offers criticisms of the biomedical model and evidence-based medicine, exposes the actively concealed influence of financial interests, explains the operation of various kinds of bias, rails at the epistemic injustice of neglecting lived experiences, and so on, nonetheless offered remarkably muted criticisms of science during the pandemic. Our acquiescence as a field was a betrayal of our prima facie commitments as philosophers. To dispute this is to assert that our normal criticality has been revealed as irresponsible.

Third, timeliness. Perhaps the irony of, say, publishing detailed work on the precautionary principle eight months after the time the precaution was taken can only be missed by a philosopher. No doubt such work serves the purpose of scholarship, but it

cannot be said to form part of the pandemic response if the decision upon which it might bear has been taken half a year before. Sometimes, philosophers have defined their discipline as if it were one that makes no difference beyond the philosopher: a game, a therapy, an exercise of harmonizing contradictory intuitions. I take it that philosophers of medicine do not tend toward such views, since medicine is a field that makes a great deal of difference beyond its philosophers, and this is part of why they study it.

Philosophy does not measure its value directly through its impact on other matters, and nor does anything I have said imply this. (If you disagree, feel free to submit your proof as an Analysis piece to this journal.) Yet when it does have an effect, the effect is profound. Philosophy has shaped our democracies, our science, our property rights, our rights to life and suicide. It has even, in the time of Galen, shaped our medicine. These interventions were never welcome: philosophers specialize in uncomfortable truths. So it is all the more important that we train ourselves to articulate them, position ourselves to be listened to, and take the risk inherent in raising our voices when everyone else is saying something different.

5. Must Do Better

Timothy Williamson presented a critique of philosophy in an address at a major conference under the title "Must Do Better" (Williamson 2007). In criticizing contemporary work in metaphysics and philosophy more broadly, he compared himself to the headmaster of a minor "public" (the British word for "private") school after a disappointing term. I have no illusions: I am not on Williamson's intellectual level. Nor do I intend to hold myself above the rest of the field of philosophy of medicine. But I can count the number of philosophical contributions that were public, critical, and timely, and I can get a rough sense of how influential the field was as a whole. Maybe your assessment is less dim than mine; if I have gone too far, it would not be the first time. But decisive advocacy for a position provides the opportunity to refute it. I hope the field will take this opportunity.

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References

Amoretti, Maria Cristina and Elisabetta Lalumera. 2022. "Reviewing the Reproduction Number R in Covid-19 Models." *Philosophy of Medicine* 3, no. 1: 1–16. https://doi.org/10.5195/pom.2022.78.

Lichtenstein, Eli I. 2022. "Inconvenient Truth and Inductive Risk in Covid-19 Science." *Philosophy of Medicine* 3, no. 1: 1–25. https://doi.org/10.5195/pom.2022.132.

Williamson, Timothy. 2007. "Afterword: Must Do Better." In *The Philosophy of Philosophy,* 278–92. Wiley Online Books. https://doi.org/10.1002/9780470696675.after.