The Ethics of Killing in a Pandemic: Unintentional Virus Transmission, Reciprocal Risk Imposition, and Standards of Blame

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ABSTRACT The COVID-19 global pandemic has shone a light on several important ethical questions, ranging from fairness in resource allocation to the ethical justification of government mandates. In addition to these institutional issues, there are also several ethical questions that arise at the interpersonal level. This article focuses on several of these issues. In particular, I argue that, despite the insistence in public health messaging that avoiding infecting others constitutes ‘saving lives’, virus transmission that results in death constitutes an act of killing. Whether this killing is wrongful depends on several factors. I consider one intuitively plausible view – namely, that in many cases, killing via unintentional transmission is not wrongful, because the parties in question have implicitly waived their rights against this harm, often via reciprocal-risk imposition. I argue that this view is mistaken, but that its central insight can be better captured by identifying the appropriate standards of blame that we ought to apply during a pandemic. I conclude by showing how these conclusions can be fruitfully applied to certain institutional questions, such as helping to justify restrictive government mandates.

1. Most of the public and academic discussion on ethical issues arising throughout the COVID-19 pandemic has centred on institutional contexts – for example, issues like fairness in allocating scarce resources (e.g. ventilators);¹ the ethics of government restrictions (e.g. lockdowns, mask mandates);² and various ethical issues arising in vaccine development, access, distribution, and compliance.³ Given the urgency and practical value of addressing these issues, this focus has been entirely warranted. A consequence of this, however, is that certain other ethical issues that have arisen at the interpersonal level – which are admittedly much less urgent and policy-oriented, but nevertheless significant – have been sidelined or obscured.

   Indeed, one of the most central ethical issues throughout the pandemic concerns its very transmission. After all, the virus is not a purely naturally occurring phenomenon, like a natural disaster; it is spread largely through direct human transmission, which is the result of human actions. Most of these actions involved unintentional transmission from those who were asymptomatic but knew of the risks of exposing others and put themselves in close proximity with others anyway.⁴ While the health effects in most of these cases were relatively mild, many cases led to serious (and sometimes enduring) complications. Tragically, far too many resulted in death.
This raises a host of ethical questions. Are these best described as acts of killing? If they are, are they wrongful? And if so, how should we judge those who commit these acts? These questions will be my focus in what follows. In Section 2, I argue that one common way of framing unintentional transmission, favoured by many public health organizations, is deeply misleading and obscures the moral status of the act: avoiding transmitting the virus to others is not a way of saving lives, but of avoiding killing. In Section 3, I consider certain intuitively plausible approaches for justifying exposing others to risks of transmission. I focus here on arguments concerning mutual risk imposition: while it’s true that I impose risks on others, they impose risks on me too. I argue that, despite its appeal, this view is inadequate to provide a justification for risk imposition in most ordinary cases. In Section 4, I argue that the impulse toward permissive or forgiving attitudes toward unintentional transmission is better captured not by evaluating the justification of acts, but by evaluating the blameworthiness of the agent. Finally, in Section 5, I conclude by noting how these points have salience for several issues relating to institutional and governmental policies, such as lockdowns, mask mandates, and obligatory quarantines. And I show how the points raised in this article have application beyond the current pandemic.

Before proceeding, let me issue a few clarifications. First, I will focus on cases of COVID-19 transmission that result in death, although much of what I say will extend, mutatis mutandis, to the many other harms resulting from COVID transmission. In particular, I will not address the serious and enduring (though non-fatal) harms that many have suffered—so-called ‘long COVID’. Moreover, since my focus is on cases where death is the result, I will set aside the broader question concerning the ethics of mere risk imposition. Furthermore, I focus here only on cases of unintentional transmission, setting aside the relatively rare incidents where individuals intended to transmit the virus. I also mostly set aside cases in which one does not intend to transmit the virus but does so via negligence or recklessness. This is because unintentional lethal transmission strikes me as a more ethically challenging problem, and thus more deserving of our focus. Furthermore, most of our judgements about the unintentional cases will apply, a fortiori, to negligence cases as well—although an agent’s negligence will make any claims of decreased blameworthiness for wrongdoing substantially less plausible.

2.

Since the onset of the pandemic, much of the public messaging has employed language suggesting that by wearing masks, staying isolated, and social distancing, one can save lives. The hashtag campaign ‘#StayHomeSaveLives’ was promoted by AdCouncil in the United States and used by dozens of popular media companies. A key part of the UK government’s public health campaign involved the slogan, ‘Stay home. Protect the NHS. Save lives’. (Lest one think this is a uniquely Anglophone phenomenon, the French Health Ministry also said, ‘plus que jamais, pour sauver des vies, restez chez vous [more than ever, to save lives, stay home]).

I do not doubt that this is an overall effective public-messaging strategy. Saving others’ lives tends to be a useful motivational tool: it evokes the idea of superheroes, selfless public service, and other acts of heroism. Moreover, it’s natural to speak of institutional guidance and government mandates in terms of saving lives. Those researching the effectiveness of
stay-at-home orders or universal mask wearing tend to tally the effects in terms of lives saved. It makes sense, then, to extend the language we use to speak about institutions to the actions of its citizens in complying with them.

And yet, this is a deeply misleading way of describing our actions in complying with these restrictions. To see why, consider a roughly analogous case. We would think it odd to say that finding oneself a designated driver instead of driving home drunk is a way for one to ‘save lives’. It is true, of course, that fewer lives are likely to be lost by opting for a designated driver. But finding a designated driver is not best viewed as a way to save lives; rather, it is a way to avoid potentially killing others. Generally, saving lives involves preventing harms that originate from natural sources or agents other than oneself: I save your life when I prevent you from drowning or when I thwart your attacker. But by not driving drunk, I do not prevent a harm originating from elsewhere; rather, I prevent myself from being the cause of that harm. We should view pandemic precautions the same way. My wearing a mask, practicing social distancing, or isolating at home is not a way for me to ‘save lives’. Rather, it is a way for me to avoid potentially causing another’s death – that is, to avoid killing someone.

Some might find it difficult to accept the idea that I kill you by unintentionally transmitting a lethal virus that results in your death. But it is important to note that whether my act constitutes a killing is just a function of my role in the causal story. Given what I have said above, it seems hard to deny that I cause my victim’s death (in the relevant sense). We would surely say this if, holding everything else fixed, I transmitted the virus with the intention of causing death – say, to punish my nemesis. To be sure, the fact that a death is brought about entirely unintentionally can affect the moral status of the act. But it does not alter the basic causal story – it does not, in other words, make this not an act of killing.

Of course, most cases of unintentional transmission are not acts of killing, but they involve imposing only a risk of death on others, since the infected person ultimately recovers. And one is seldom in a position to know, ex ante, whether the risk of death will eventuate; like most things, the circumstances surrounding infection are rife with uncertainty. But this does not change the fact that, when the risk does eventuate, the act transforms from a mere risk to an act of killing. In other words, it is the resulting harm that ultimately defines the agent’s action. This is certainly true in analogous cases: by driving, I impose a risk of death on pedestrians; when that risk eventuates – when I hit one with my car which causes their death – we say that I have killed them. This point is worth emphasizing here, since most of us cannot help but impose at least some risks on others throughout the pandemic, and it seems largely beyond our control whether those risks indeed eventuate. Indeed, one might say that we are only in control of whether or not we risk transmitting the virus, since whether it results in death is too far beyond our control to be relevantly tied to our actions. But again, we do not reason this way in cases of gunshot wounds, car crashes, and other instances where the harm may or may not prove lethal. I will say more about the role of moral luck later, but it will suffice here to note that these worries do not directly affect whether the act is one of killing or not – although it may be relevant in our assessments of whether the act is wrongful (as I will argue, however, there are reasons to doubt this is true in general), as well as whether one is blameworthy.

This point about killing is not purely semantic; it concerns our most central moral obligations. As Helen Frowe recently put it, ‘I do not save your life if I do not infect you with Covid-19. Rather, I refrain from harming you. And the costs that I may be required to bear
to refrain from harming you are considerably greater than the costs that I may be required to bear to save you. Frowe’s point is based in the familiar distinction, central to common-sense morality, between doing and allowing harm: all else being equal, doing harm is morally worse, and harder to justify, than allowing that same harm. And this means that not doing harm is a more stringent moral requirement than not allowing harm. In other words, while we do indeed have an obligation to save lives (i.e. by not allowing harm), it is in general much weaker than our obligation to not actively harm people. There are, therefore, cases in which I am forbidden from actively harming someone, even at great cost to myself; and yet taking on the very same cost in order to save them from the very same harm would be supererogatory. For example, I am forbidden from killing an innocent person in order to prevent serious injury to myself, but I am not required to accept serious injury to myself in order to save an innocent person from death by some other means.

This distinction has implications for the various public health mandates I mentioned earlier. It is perhaps more likely, especially in liberal countries like the United States, that the government will succeed in achieving broad compliance with its mandates by presenting them as voluntary (and thus, supererogatory), rather than using the language of moral obligation – even though this establishes a confusing and, in my view, false narrative. But the flip side of this is that treating such mandates as though they are morally optional means that many will decline to comply, and they will do so with the plausible (though mistaken) cover of moral permissibility. If, for example, self-isolating is an act of saving lives, and saving lives is essentially morally optional, then it is no surprise that some might see the cost as too great to accept – and a government that demands compliance as overreaching.

3.

Transmitting the virus, even unintentionally, to someone who later dies from it is an act of killing. But not all killings are wrongful.

Killing can be justified when the goods achieved substantially outweigh the harms caused (subject to certain conditions) – what is called a ‘lesser-evil’ justification. This applies to select cases of unintentional transmission. Consider the frontline health-care workers whose efforts prevented countless deaths; the scientists who risked transmitting the virus while pursuing vaccine research; and the work of various other relevant emergency services personnel, such as police officers and EMT’s. Some of those performing this work may have, in the course of their work, unintentionally transmitted the virus to others who ultimately died. But when this work was necessary for preventing many more (or worse) harms and deaths, the resulting unintentional killings may be justified as a side effect of pursuing a more valuable good, at least taken in aggregate.

Some might also claim that unintentional transmission is not wrongful when one could not possibly have avoided infecting another person. The clearest cases of this involve those who are restricted to particular locations, such as many of those housed in long-term care facilities and the incarcerated. In both cases, mask availability and compliance, cleanliness of shared spaces, and their ability to avoid interactions with others are almost entirely beyond their control. In such cases, killings might be thought to be non-wrongful.
I am not primarily concerned here with cases in which transmission is either justified or unavoidable. Instead, I want to focus on the much more ordinary scenarios that capture the majority of cases of unintentional transmission, which generally have the following features. First, one is either a potentially asymptomatic carrier, or is only minimally symptomatic, but does not knowingly carry the virus. Those who exhibit significant symptoms are therefore excluded (as their negligence puts them in a separate category). Second, one is in sufficiently close proximity with others who are vulnerable to infection. Those who are in total isolation, or only interact with those in the previous group (e.g. fully closed ‘bubbles’), are therefore excluded, as they do not risk transmission – although this group is likely to be exceptionally rare. Finally, the cases we are interested in involve voluntary actions, both in terms of being autonomously chosen and (in some sense) morally optional. Giving a full account of voluntariness is beyond the scope of the article. I rely here only on a common-sense notion of voluntariness, which captures cases where individuals willingly enter or remain in risky venues without sufficient moral necessity. Cases where individuals are in some sense forced or coerced into risky encounters (whether physically or due to sufficiently compelling moral reasons) are excluded. Many encounters, such as those involving workers in precarious economic positions, or those facing various social pressures, legal requirements, enormous practical hurdles, and so on ought to be viewed as non-voluntary, or at least of limited voluntariness; but this will depend heavily on the particulars of both the case and the more precise account of voluntariness one endorses.

These conditions obtain most obviously in many ordinary settings: at stores, bars, and restaurants; in one’s living space with a partner, roommate, or family member; at one’s workplace; and in a variety of other shared spaces, both public and private. Call these the ordinary cases. I assume the default view for these cases is as follows. In the absence of special justification, killing is wrongful. These ordinary cases do not possess any special justification. Therefore, they, too, are wrongful. (Of course, acts can be more or less wrongful; my concern here is only with whether or not they are wrongful, not how wrongful they are when compared with other wrongful acts.)

Is the default view correct? Many will surely find it implausibly strong. In particular, one might emphasize that in these ordinary cases, individuals voluntarily accept the risks inherent in being in close proximity with other potentially infected people. And when one voluntarily accepts such risks in this way, one thereby waives one’s rights against those harms, should they manifest, and is not wronged if they do. Of course, it is rare that one acquires an explicit waiver of rights – although this may occur in certain cases involving intimates, families, or others who openly discuss the terms of their interactions, as well as in some particular venues where explicit waiver is made conditional upon entry. Most cases, however – particularly cases involving strangers – rely on a tacit or implied rights waiver. (We will return to the point about explicit waivers later.)

But how, exactly, would an implied rights waiver come about? One possibility is simply that knowingly and voluntarily entering spaces in which there are known risks of harm or death constitutes an implied rights waiver against the harm risked. In other words, your having accepted the risks that I might unintentionally transmit a deadly virus to you means that, if indeed I do unintentionally transmit the virus to you and you later die from it, I do not thereby wrong you. You knew the risks and you accepted them.
But while it is true that we often knowingly accept such risks, it does not follow that we waive our rights against such harms. As Jeff McMahan puts it: ‘A person who voluntarily walks through a dangerous neighbourhood late at night assumes or accepts a risk of being mugged; but he does not consent to be mugged in the sense of waiving his right not to be mugged, or giving people permission to mug him’. More generally, we accept all sorts of risks from others throughout our lives; doing so is an inescapable part of living in a society with others. But surely this does not entail we waive our rights against the harms that might eventuate. To accept this would be to hold that a mugger does not wrong his victim – indeed, that few if any wrongdoers ever wrong their victims, since most victims accept the risks of the harms they experience. But this is clearly an implausible result.

McMahan’s mugger example is helpful for demonstrating that rights waiver does not follow from risk acceptance, but its utility as an analogy for COVID-19 transmission is limited. For one thing, the mugger’s harmful acts are intentional, while the cases of COVID-19 transmission we are interested in are unintentional. This difference should not affect the underlying judgement, though. Even if we imagine that the victim accepts the risk not of being mugged, but of, say, being shot accidentally during a nearby altercation, he still does not waive his right not to be killed. But there is another important structural difference in the two examples. In the mugger case, the risks imposed are fundamentally non-reciprocal: one person imposes the risk of harm, while the other accepts it. But this is not true of most cases of COVID-19 transmission. When I venture out in public, I do not only accept certain risks from others; I also generally impose the same sort of risks on them.

Here, an alternative proposal suggests itself: it is not mere risk acceptance, but rather reciprocal-risk imposition that generates the relevant waiver of rights. In their piece discussing the justification for lockdown policies during the pandemic, Christian Barry and Seth Lazar countenance this possibility (although they do not ultimately seem to endorse it):

\[O\]ne could argue that it is possible for any given individual to protect themselves from risk, by strictly limiting the contacts they have with others. Could one not say, then, that everyone who goes out into the world voluntarily assumes the resulting risk, and that in cases where the risk-imposition is mutual, it is permissible?\]

In other words, each party imposes on the other what would otherwise be unjust harms; but since the imposition is reciprocal – by which I mean a mutual and roughly equal risk – each implicitly waives their rights against the harms that might befall them in exchange for the other’s waiver of rights against them.

The roots of this idea can be found in tort law theory. Charles Fried defends a Kantian-inspired view of reciprocal-risk imposition. He writes, ‘By granting the right of others to impose on him, he does, of course, increase his own risk of death. However, he grants this right and increases the risk of death as a way of purchasing, as it were, the right to pursue his ends and capacities, and in so doing to impose risks upon others’. George Fletcher defends a similar view, arguing that one is not liable for injuries stemming from reciprocal risks – namely, ‘those in which the victim and the defendant subject each other to roughly the same degree of risk’. Of course, both of these views are focused on legal liability, rather than moral rights. But the former provides an intuitively plausible picture of how we might understand the latter.
The idea that reciprocal-risk imposition might generate a mutual waiver of rights has clear application in other contexts as well. For example, in boxing or mixed martial-arts matches, both fighters accept the risks each imposes on the other and, provided the mutually accepted rules are followed, agree to waive their rights to any harms that might eventuate. While some such harms are, of course, intentional, many others – possible long-lasting damage, serious injuries, or even death – are usually unintentional. And yet, on this proposal, boxers do not wrong one another when such harms result.

Another example that is more closely related to the case of COVID-19 transmission is the risk of HIV transmission resulting from consensual sex. Partners mutually accept roughly equal risks of harm or death, since either party could be an unwitting carrier of the virus and could transmit it to the other, who could then later die as a result. (Again, set aside cases where one knows one carries the virus. The analysis of such cases is quite different.) This is a risk that, typically, both parties knowingly accept when consenting to sex (provided there is no deception, coercion, or invalid consent). On the current proposal, then, partners who engage in consensual sex when there is a risk of HIV transmission waive their rights against the harms – in particular, death – that might result, and thus, do not wrong their partner by unintentionally transmitting HIV to them.

Although they are imperfect analogues of COVID-19 transmission, these examples illustrate the independent plausibility of the claim that reciprocal-risk imposition generates a mutual waiver of rights. As applied to the COVID-19 case, the claim here is that, for all interactions during the pandemic that involve imposing reciprocal risks of harm, the individuals involved in such interactions thereby implicitly waive their rights against being harmed in cases where the interaction results in infection.

As I suggested, many will find this account plausible, at least insofar as it aligns with most attitudes and behaviours during the pandemic. Anecdotally, I have encountered many who justify their public outings throughout the pandemic by pointing to mutual risk exposure – usually some version of ‘They’re here too, so they can’t exactly complain’. More generally, there is something intuitively compelling about the idea that one’s claim to being wronged by someone else’s risky actions is diminished when one imposes the very same sort of risks on the alleged wrongdoer.

Whatever its apparent plausibility, this view suffers from at least two serious problems. First, it remains unclear how rights waiver is supposed to follow from the existence of reciprocal-risk imposition. By analogy, suppose Alice drives drunk and unintentionally seriously injures Bernice, who also happened to be driving drunk. That Bernice was also drunk does not render Alice’s act non-wrongful: the fact that Bernice also imposed similar risks does not yet constitute an implied waiver of her right not to be killed. It might be said that Bernice has little ground for complaint against Alice – how could she criticize Alice for the same behaviour she herself engaged in? But this concerns the issue of whether Bernice has standing to blame Alice, rather than the moral status of the action itself. (I return to this point in the next section.) Of course, the analogy with drunk driving is imperfect: in addition to each other, Alice and Bernice also threaten others on the roads; and their respective threats are likely riskier, in terms of both probability and severity, than the average case of interpersonal interaction in the pandemic. Nevertheless, the basic structure of the drunk-driving case is sufficiently similar to that of the pandemic case to illustrate the basic point.

Second, upon closer inspection, the proposed account applies to many fewer cases of COVID-19 transmission than it may have initially seemed. In most cases, the risks
individuals pose to one another are not, in an objective sense, even roughly equal. As we know, some people are at significantly greater risk of experiencing serious complications from the virus, whether due to pre-existing vulnerabilities, such as a compromised immune system, age, or other such factors. Furthermore, access to health care (let alone quality care), even within a given community, often differs wildly, which can have a significant impact on the harms one suffers. This is even more significant when availability of valuable resources fluctuates, as it has throughout the pandemic. Thus, many interactions among strangers often do not involve even roughly reciprocal-risk imposition: one party is among the more vulnerable group, while the other is not. Moreover, even many ordinary relationships involve imposing asymmetrical risks. It is not uncommon, for example, for one spouse or roommate to work outside the home, perhaps even in venues where risks are heightened, while the other person works in a safer environment (e.g. from home).

One might respond here that risk imposition need not be roughly equal in a fact-relative sense, but only in an evidence-relative sense. Roughly, the idea here is that, provided one’s evidence does not indicate any significant asymmetries in the risk imposition, then it is not wrongful. We must distinguish here between the evidence we possess and the evidence available. Surely, given the significance of the right in question, the more morally defensible of these two options is the latter. Merely proceeding with the evidence we happen to possess – which, among strangers, is almost nothing – is not sufficient grounds for a waiver of such a substantial right. Given the stakes, even on the evidence-relative view, an implicit mutual rights waiver requires at least an investigation of the known and possible risks each imposes on the other. As far as I can tell, such an investigation is not common practice among most customers at, say, the grocery store. (Notice that the same conclusion applies even if we limit it to only the available evidence that we could be reasonably expected to possess: it is still true that, given the high stakes, much more would have to be done than many currently do to inquire about the risks.)

Further, were one to do a thorough investigation of all persons on whom one might impose such risks, I suspect one would discover one of two things: (1) the asymmetries remain quite pervasive – and thus, many such interactions are not covered by the proposed view; or (2) certain relevant facts, such as how one’s immune system will respond to the virus, are indeterminate, which surely calls for a more cautious approach, and cannot therefore ground an implied rights waiver. The upshot is that the weaker version of this view is too weak, and the more thorough version of this view does not lend justification to the vast majority of the interactions it sought to capture.

These points suggest that perhaps it is not a requirement that the risks be roughly equal, but rather only that they be generally reciprocal. It would suffice, then, that both parties might impose some risks on one another, even if one might in the end impose considerably more risk than the other. Though this view would capture many cases of unintentional transmission, and avoids the concerns about evidence gathering and grossly unequal risks, it recalls the more basic problem of explaining how mere reciprocal-risk imposition alone could constitute an implied rights waiver. Why, in other words, should one be understood as having waived their rights against being killed in this case? We cannot simply insist anew that they have accepted these risks, and thus they have waived their rights; as we saw above with McMahan’s mugger case, this is a non-starter. Further, even if the mugging victim was armed – and thus imposed some risk – the mugger’s attack is still wrongful. And as we saw in the case of Alice and Bernice (the drunk drivers), the mere fact that each imposes risks on the other does not make the ensuing harm non-wrongful. More
generally, there are countless examples in all areas of life wherein individuals impose (foreseeable) risks on each other. To assume that mere reciprocity of risk imposition amounts to a rights waiver is deeply implausible.

This brings us to a more general concern about all rights waivers – implicit or explicit – against lethal harms. Even if we grant that one can, in some cases, explicitly waive one’s right not to be killed, the requirements for valid waiver of such a central right are much more stringent than any of the foregoing views suggest. Moreover, even if one does waive one’s right not to be killed, it does not follow from this that killing them is justified. In the context of unintentional HIV transmission, Rebecca Bennett, Heather Draper, and Lucy Frith write: ‘it is difficult to imagine a circumstance which absolves one of one’s obligation not to kill other people by infecting them with a fatal condition like HIV, and it is not clear that gaining their consent to this harm makes a significant moral difference’.29 In other words, in addition to a valid rights waiver – for which the bar is already high – there must also be sufficiently good reason to subject one to the relevant risks, over and above the fact that they have waived their rights against the harm. This could possibly be met in certain cases – for example, cohabitating partners or families who openly discuss their expectations governing risk exposure, for whom any lower-risk alternative (such as separate housing) is unacceptable or risks seriously harming the relationship; or when the risk mitigation practices are sufficiently robust to render the risks so low that the potential for harm is outweighed by the likely good of the interaction. Some might claim that most instances of explicit waiver throughout the pandemic involve sufficiently good reason – namely, the value of being able to engage in a range of valuable activities. However, certain token actions (e.g. superfluous gatherings) will fail to meet the relevant bar for value needed to justify the risk exposure, even with explicit waiver. The point here, in other words, is that explicit-rights waiver is not sufficient for justification. The reasons for the activity matter, and in many cases these reasons are insufficient to justify the risk exposure.

One might object that my approach to rights waiver ought not to focus on token cases of reciprocal-risk imposition, but rather on the broader practice of risk reciprocity. That is, on this view, mutual rights waiver is secured not in some particular instance in which we each impose a discrete risk of harm on each other, but rather via the features of the practice of exposing each other to risks of that general type. Whether such a practice can be said to constitute a rights waiver would be determined by such features as: the relative value of the class of activities in proportion to the risks; general access to these valuable activities; fair distribution of the risks; and the relatively low-risk nature of the activity, which can be partly achieved through requiring preventive practices – for example, masks, social distancing, etc. When these conditions are met, but the transmission is nevertheless fatal, the current proposal suggests it is non-wrongful: the practice itself of imposing these risks is permitted and justified, even though this sometimes results in death. In other words, if this view is true, then provided that individuals engage in broadly valuable activities while exercising due caution, the individuals’ rights are thereby waived, and the relevant harms that may result are therefore non-wrongful.

This view is certainly appealing, and several different versions of it have been defended.30 But there are good reasons to doubt it. First, it is unclear what justifies shifting to the practice of imposing some risk to defend particular instances of harming. After all, we generally appeal to specific facts about the particular action to determine its moral permissibility. For example, if I suspected (or knew) there was a substantially greater chance that I could transmit COVID today, it would surely be harder for me to justify going to the
grocery store (even with a mask). That the practice in general is justified plays no meaningful role in determining permissibility here; the specific features of my circumstances override it.\textsuperscript{31} Relatedly, it cannot simply be the fact that some activities are valuable in general; rather, one must cite the specific value of this particular instance of imposing that specific risk. If, during the pandemic, I went to the grocery store simply because I wanted to wander the aisles for fun, this is surely insufficiently valuable to justify the accompanying risk imposition. Here again, the value of the practice is irrelevant to justifying this specific instance of risk imposition. It therefore seems that appealing to the broader practice is unlikely to generate the relevant mutual rights waiver after all.

Before moving on, let me emphasize that this section has focused only on arguments concerning the prospects of mutual rights waivers in the pandemic context. I have not attempted to offer a full theory of justified risk imposition; doing so is far beyond the scope of the present article. But if the arguments above are correct, one of the more plausible avenues for attempting to justify many of the ordinary cases of viral transmission is unsuccessful.

4.

One might worry that the foregoing arguments could point us toward a view that is far too demanding. It would seem to require nearly complete isolation for the duration of the pandemic – which, we now know, would have been well over a year. Virtually no one but the most virtuous few, it might be argued, could abide such restrictions. Marcel Verweij makes this point in a more general context concerning duties to avoid infecting others with illnesses like HIV and influenza:

Are all proposed implications of a duty to avoid infection warranted? If we are morally responsible for all avoidable cases of infection, morality would, in Charles Fried’s terms, paralyse us or make us obsessed with all possible (even remote risks of) harm. This seems highly unreasonable. Without limits to our obligations to take precautions against harming others, morality would be over-demanding.\textsuperscript{32}

Call this the demandingness worry. For some, the fact that a proposed moral requirement is over-demanding is sufficient reason to reject it. This is, after all, the basis for the classic demandingness objection to utilitarianism, which holds that since utilitarianism would require that we devote our lives to constantly maximizing the good, even at tremendous cost to ourselves and our lives’ projects, utilitarianism is implausibly demanding, and therefore false. But there is an important difference between a moral theory that requires a lifelong commitment, and one that requires only a certain period in which it is especially demanding. Few would wish to claim that a theory’s being this demanding for any period of time (e.g. a few weeks) is reason to abandon it. Moreover, the demandingness of utilitarianism is not just in its duration but also in its scope: it allows for no latitude in pursuing anything less than that which has maximum utility. But an account that requires that one not come into close proximity with others is considerably less demanding. Of course, it does not follow from these two points that such a view is not demanding; something less demanding than utilitarianism can still be overly demanding. However, these points do suggest that this sort of view – one for which the demands are time-limited and much less
pervasively applicable — makes demands of a rather restricted sort, and certainly does not leave one ‘paralyzed’ by morality in any significant sense.

At any rate, while the demandingness worry does not tell us much about the wrongness of unintentional infection in the ordinary cases, it does provide us with a basis for relaxing our views concerning individuals’ blameworthiness for certain of these wrongs. In general, the fact that it would be difficult for an individual to avoid doing some wrongful act is not a compelling reason to view that individual as less blameworthy. Quite simply, morality makes demands of us, some of which are difficult to satisfy. But a key insight of the demandingness objection to utilitarianism is that the concern about these demands grows as we expand our focus from particular acts in isolation, and instead we view these demands in aggregate, as part of a broader constraint on one’s behaviour over an extended period. This point clearly applies to the pandemic: if, say, the only distinctly demanding aspect were a single one-week quarantine period, then, all else being equal, those who lethally infect others are nearly as blameworthy as they would be in more ordinary contexts. Of course, the demands throughout the pandemic were considerably greater: to adhere perfectly to the view proposed above, most of us would have had to spend well over a year essentially in complete lockdown. Given the sheer stringency of this demand — to say nothing of its practical impossibility for many — those who violated this requirement on occasion should, in general, be viewed as somewhat (and proportionately) less blameworthy.

Moral demandingness is not the only factor relevant to blameworthiness. In general, we ought to view as less blameworthy those who were forced to act under significant epistemic deficits; faced tremendous psychological, economic, or social pressures; or were, through little fault of their own, unclear or uncertain about the relevant moral facts governing their circumstances. Each of these conditions has been pervasive throughout the pandemic: most of us were forced to carry on with our lives under significant epistemic (or even existential) uncertainty; endured tremendous psychological, economic, and social pressures, anxieties, and harms; and had to carry on amidst vague and ever-changing social norms. In conjunction with the previous point about demandingness, it is clear that while many cases of unintentional transmission are indeed wrong, the individuals responsible ought to be viewed, in general, as less blameworthy than in more ordinary contexts. It is also worth noting the position of the would-be blamer. Most of us lack standing to blame others precisely because we behaved in a quite similar way. G.A. Cohen puts the point this way: ‘When a person replies to a critic by saying: “Where do you get off criticizing me for that?”’, she is not denying (or, of course, affirming) the inherent soundness of the critic’s criticism. She is denying her critic’s right to make that criticism, in a posture of judgement’. In other words, the fact that we behaved the same way does not make the wrongdoer’s actions any less wrong, but it does make us poorly positioned to criticize them. (The enormous influence of moral luck governing the outcomes in these situations further strengthens this claim.) It turns out, then, that the fact that we impose similar risks on each other is morally relevant after all — but this fact alters only our ability to blame wrongdoers, not the wrongness of the action itself.

A related point concerns how we ought to assess cases in which individuals comply with all relevant guidance from experts — namely, to follow social distancing protocols, wear masks, etc. — and still unintentionally transmit the virus. We might find that in these cases, provided the norms are well-founded, the fact that individuals acted more or less as the norms required — and, presumably, more or less as we ourselves act — they are significantly...
less blameworthy than otherwise, and we are not especially well positioned to blame them ourselves. More generally, we tend to think in a variety of cases that those who behave as recommended, following ‘due care’ guidelines, are less blameworthy for the resulting wrongs. A driver who maintains his car according to the relevant standards and operates it strictly in accordance with the laws and regulations, but who nevertheless unintentionally kills a pedestrian in a freak event, has (I believe) wrongfully killed that pedestrian. However, we will surely find it harder to blame him. He did everything right – he proceeded as he was supposed to. The same, I suggest, is true in general of the unintentional transmission case as well.

To be clear, I am not suggesting that everyone who unintentionally transmits the virus is less blameworthy. For one thing, not everyone is affected – at least not equally – by the various limiting factors we canvassed. More importantly, many of those who unintentionally transmit the virus are aware of the relevant social norms and their corresponding scientific basis – for example, the benefits of masks and social distancing – and ignore or deliberately avoid adhering to them anyway. In doing so, they behave negligently or recklessly, increase the risks they impose on others (and themselves), and extend the timeline of the pandemic. This gives rise to a relevant asymmetry between such wrongdoers and those who generally comply with the relevant norms, which provides the latter with the appropriate standing to criticize and blame the former.

In other words, there is a place in our current theory of blame for adherence to these various social norms and government mandates (e.g. required quarantines, social distancing, mask wearing, limited social gatherings, etc.). As with our previous point about mutual risk imposition, the idea here is not that adhering to these norms mitigates the wrongness of unintentional transmission, but it does have an effect on our moral standing to blame others for their actions.

Taken together, the foregoing points suggest the following view. Adhering perfectly to morality’s demands for the duration of the pandemic would be incredibly demanding. Indeed, very few of us have even come close to meeting this standard. Further, even imperfect compliance with this standard can take a sizeable toll on one’s wellbeing. Accordingly, in many cases, those who unintentionally transmit the virus should be viewed as less blameworthy for their wrongful action. Moreover, given that most of us behaved similarly, we are not especially well positioned to blame them anyhow. One overarching theoretical upshot here is that while there is no basis for a sui generis ‘pandemic ethics’ (in terms of rightness/wrongness), the myriad extreme features applicable in a pandemic do significantly alter our ordinary expectations for blameworthiness and in that way constitute a meaningful shift in our ethical standards.

5.

As I noted at the outset, my focus in this article has not been on criticizing, defending, or proposing any specific policies for governments, medical institutions, or health-care professionals. Rather, my goal has been to explore certain ethical questions surrounding the ordinary cases of unintentional transmission of COVID-19. However, the conclusions of our discussion are not entirely irrelevant to these policy questions. In particular, the fact that most of those who unintentionally transmit the virus still act morally wrongly, and yet are mostly not blameworthy, can both illuminate and bolster the ethical justifications
for certain governmental restrictions, such as lockdowns or quarantines, mask ordinances, and vaccination requirements. In short, the fact that one not only harms but wrongfully harms others – indeed, violates their rights – by unintentionally transmitting the virus to them bolsters other existing justifications for these policies, many of which are based in more instrumental or practical (as opposed to ethical) considerations. The mutual risk-imposition view sketched above would seem incapable of offering much support here, since in those cases, the individuals’ rights have been waived, and the harms that befall them are therefore not wrongful; it is comparatively much more difficult for the government to justify restricting encounters in which individuals have waived their rights against the relevant harms.

Our discussion of blameworthiness also has application in criminal-law contexts. It would of course be enormously difficult to prosecute all those responsible for cases of lethal virus transmission. For one thing, it would be difficult to prove causation in most cases, even with the most advanced forms of contact tracing. Moreover, given the sheer volume of cases this would create, it would be infeasible in nearly all jurisdictions. Furthermore, many jurisdictions would require proving the individual behaved negligently or recklessly, and not merely that one caused the death. And this, of course, would be prohibitively difficult in all but the most clear-cut cases. Apart from these practical considerations, though, the fact that these individuals are typically not blameworthy for the harms they cause might play a not insignificant role in justifying the decision not to pursue criminal charges against those who cause these deaths.

The arguments of this article also have relevance beyond the current pandemic. Of course, issues like these might arise in future pandemics. But the central questions surrounding unintentional harms, reciprocal-risk imposition, and standards of blame have wide application – for example, with respect to other viruses like influenza, sexually transmitted diseases like HIV, and many other contexts. Thus, while the focus of this article was somewhat narrow, I am hopeful that the central points raised here might shed light on a range of related issues in a variety of other areas.

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NOTES

1 Truog, Robert D., Christine Mitchell, and George Q. Daley. 2020. “The Toughest Triage: Allocating Ventilators in a Pandemic.” New England Journal of Medicine 382: 1973–75.
2 Lazar, Seth, and Christian Barry. 2020. “Justifying Lockdown.” Ethics and International Affairs, May. https://www.ethicsandinternationalaffairs.org/2020/justifying-lockdown/. Accessed 5 May 2021; Campbell, Ruth. 2020. “Face-Off: The Ethics of Compulsory Mask Policies.” Nuffield Council on Bioethics, July 31. https://www.nuffieldbioethics.org/blog/face-off-the-ethics-of-compulsory-mask-policies. Accessed 5 May 2021.
3 Monrad, Joshua Teperowski. 2020. “Ethical Considerations for Epidemic Vaccine Trials.” Journal of Medical Ethics 46(7): 465–69; Jecker, Nancy S., Aaron G. Wightman, and Douglas S. Diekema. 2021. “Vaccine Ethics: An Ethical Framework for Global Distribution of COVID-19 Vaccines.” Journal of Medical Ethics 47: 308–17.
4 Johansson, Michael A., Talia M. Quandelacy, Sarah Kada, Pragati Venkata Prasad, Molly Steele, John T. Brooks, Rachel B. Slayton, Matthew Biggerstaff, and Jay C. Butler. 2021. “SARS-CoV-2 Transmission from People without COVID-19 Symptoms.” JAMA Network Open 4(1): e2035057. https://doi.org/10.1001/jamanetworkopen.2020.35057.
One might wonder whether, rather than lesser-evil justification, such cases are evidence-relatively justified (though fact-relatively unjustified). After all, an EMT driver may be justified (as a lesser-evil) in killing one pedestrian to save five victims; but they are not justified in killing one to save one. In cases where the killing of one pedestrian is the result of a risk imposition that eventuates, the EMT would at best be evidence-relatively justified. This point, however, suggests that the EMT is nevertheless fact-relatively unjustified, and I find this conclusion difficult to accept: the intuition that it is fact-relatively justified for one person to expose some to an unavoidable risk of death in the service of saving many more is quite powerful. Moreover, the numbers here matter: the fact that the risk exposure is dwarfed by the benefits is central to this intuition.

Note that this point applies only in a rather limited way – namely, to those acting within these particular roles who transmit the virus during the course of their necessary work or during those actions necessary for carrying out their work (e.g. commuting to work via public transit). These individuals may still transmit the virus in other ways outside of this work – indeed, given their higher exposure, they may be more likely than the average person to unintentionally infect others in other public spaces. This lesser-evil justification would not apply to these acts.

We can also exclude those who have immediately completed a full quarantine period, just received adequate and sufficient negative tests, or are otherwise immune, since they are not at risk of transmission. However, this group is likely to be unhelpfully small, since their status shifts as soon as they interact with anyone who may be an unintentional transmitter.

As one reviewer points out, we could imagine cases in which one does not meaningfully act at all, and yet transmission from them to another person, resulting in their death, could occur. Imagine a person who is kidnapped, infected with COVID, and forced into proximity with another person who is infected and dies. This strikes me as sufficiently similar to the case of the incarcerated person just discussed. But is this a killing?
I am inclined to say yes, although it is clearly non-wrongful; others may disagree. While this question raises interesting issues for the broader framework, I will set it aside here, since my focus will be on those cases that are most plausibly understood to be voluntary actions – cases which seem most appropriately classified as ‘killings’.

17 Admittedly, even this will be difficult to determine precisely. As an anonymous reviewer noted, many individuals need exercise, to be outside, etc. in order to maintain their mental health. Should transmission that occurs during these acts qualify as voluntary? I leave this issue to one side here, since my view does not require that we take a firm stand.

18 Let us set aside for now the question of risk-reduction measures, such as mask wearing and social distancing; this point will re-enter the discussion shortly.

19 McMahan, Jeff. 2009. *Killing in War*. Oxford: Oxford University Press, p. 52. For his complete discussion of rights waiver and consent in the context of war, see pp. 51–7.

20 There are further analogues of this in war cases. Civilians who accept the risks of living near warzones do not thereby waive their rights against being killed.

21 Lazar and Barry op. cit.

22 Fried, Charles. 1970. *An Anatomy of Values: Problems of Personal and Social Choice*. Cambridge, MA: Harvard University Press, p. 186.

23 Fletcher, George. 1972. “Fairness and Utility in Tort Theory.” *Harvard Law Review* 85(3): 537–73, p. 542.

24 One might wonder about a natural omission here – namely, the case of driving. While it is true that by driving we accept risks from other drivers, and in some cases impose them on others, the cases in which harms do eventuate are generally too murky to provide a useful analogy here. To wit, many of them involve particular errors on the part of drivers, rather than merely the realization of some general risks.

25 For example, sex is a much more selective event, typically; interactions at the grocery store are not. There are opportunities for questions beforehand; not at the store. One might even think that one waives one’s rights against being harmed by having, say, unprotected sex at all – even if the person does know their status vis-à-vis HIV. Finally, relevant prophylactic use in sex is pretty close to symmetrical by nature: one’s use of a condom protects both parties almost evenly. By contrast, certain prophylactic measures for COVID-19 transmission, such as mask wearing, require two parties to comply separately to achieve the greatest minimization of risk, and asymmetrical masking creates differences in risk imposition among both parties.

26 An anonymous reviewer points out that the two cases are importantly disanalogous: whereas drunk driving is not carried out in pursuit of anything morally valuable, many acts of risk imposition during the pandemic were carried out in pursuit of those things that give our lives meaning – for example, leisure time, visiting with friends, etc. In certain cases, these morally valuable ends could help justify the action; see my discussion at the beginning of Section 3. In ordinary cases, however, the moral value of these acts will not justify the killing, although they may lower one’s blameworthiness.

27 Thank you to an anonymous reviewer for emphasizing these important differences.

28 Parfit, Derek. 2011. *On What Matters: Volume One*. Oxford: Oxford University Press, pp. 149–62.

29 Bennett, Rebecca, Heather Draper, and Lucy Frith. 2000. “Ignorance Is Bliss? HIV and Moral Duties and Legal Duties to Forewarn.” *Journal of Medical Ethics* 26: 9–15, p. 13. Note, however, that while HIV can ultimately be fatal, particularly in places where treatments are less readily available, the virus itself is very treatable. Indeed, the risk of transmission during even unprotected sex for those treated with HIV is exceptionally low. Bennett, Draper, and Frith’s discussion predates some of the newest advances in HIV treatments, although many of these have been around since at least the 1990s. (Thanks to Eric Mathison for pressing me to mention these facts.)

30 See, for example, Oberdiek, John. 2017. *Imposing Risk: A Normative Framework*. Oxford: Oxford University Press; Quong, Jonathan. 2020. *The Morality of Defensive Force*. New York: Oxford University Press.

31 For a related argument in the context of driving, see Helen Frowe’s reply to Jonathan Quong’s arguments in *The Morality of Defensive Force*. Frowe, Helen. 2021. “Risk Imposition and Liability to Defensive Harm.” *Criminal Law and Philosophy*. https://doi.org/10.1007/s11572-021-09588-3.

32 Verweij, Marcel. 2005. “Obligatory Precautions against Infection.” *Bioethics* 19(4): 323–35, p. 326.

33 Cohen, Gerald A. 2006. “Casting the First Stone: Who Can, and Who Can’t, Condemn the ‘Terrorists’?” *Royal Institute of Philosophy Supplement* 58: 118.

34 Consider the following point by McMahan in response to a related case: ‘Yet [the driver] is in no way culpable. The unjust threat he poses is not the result of wrongful intent, recklessness, or negligence; it is the result of sheer bad luck’. McMahan, Jeff. 2005. “The Basis of Moral Liability to Defensive Killing.” *Philosophical Issues* 15: 394. Although McMahan is primarily focused on liability to defensive killing (and the distribution of
harm(s), my sense is that his notion of culpability maps neatly onto my notion of blameworthiness here; and
given that he agrees the threat is unjust, he might also agree with my point that the infected person’s act of kill-
ing is wrongful.
35 Thank you to an anonymous reviewer for drawing my attention to this issue.
36 Thank you to Eric Mathison and the three anonymous reviewers of the *Journal of Applied Philosophy* for their
invaluable feedback.