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Meeting the Scourge: COVID-19 Responsibility, Ethics, and Morality

BY RANDOLPH FILLMORE • 1 SEPTEMBER 2020

"BUBONIC PLAGUE is the inescapable reference point in any discussion of infectious diseases and their impact on society," writes Yale University History Professor Frank M. Snowden in his 2019 book, *Epidemics and Society from the Black Death to the Present*. Of course, he wrote those words before the coronavirus pandemic.

And yet, we look back to fourteenth-century Europe because social distancing was the only hope for curtailing the spread of the Black Death, a disease that killed many, many millions. Nearly seven hundred years later, in an age of science, a medieval method appears to still be our best practice for containing COVID-19.

How did social distancing work then and what were the ethical and moral implications for those people suffering symptoms and death during the plague, as well as those living through the social disruption and forced quarantines?

Quarantines of Yore

Back in 1988, at the height of the HIV/AIDS epidemic, Paul Slack, British historian and Oxford University professor, published a paper in *Social Research* on responses to Black Death and their implications for public health. According to Slack, some of the social distancing strategies fourteenth-century Europeans used to curtail the spread of plague were brutal.

Early reactions by civic governments to plague outbreaks was to deny their existence for as long as possible, as outbreaks were a threat to commerce. Restrictions were placed on movements and strict quarantine regulations faced travelers and shipping. Games and festivals were banned. Children were prevented from playing in the streets. The infected were forcibly isolated in their houses and their social contacts traced and incarcerated.

In Slack's estimation, the people who suffered the most from the plague were most often those who opposed authoritarian efforts to gain control and resisted quarantines. Because there were no scientific explanations, the Christian view of the plague included supernatural origins. There was also scapegoating, as many believed the plague was caused by Jews poisoning water supplies.

Predictably Unprepared

Poet John Donne's famous quote about death—"don't ask for whom the bell tolls, it tolls for thee"—is set within the recurring Black Death that periodically swept Europe for centuries. It's not a far leap to the twenty-first century when the World Health Organization (WHO) tolled a warning bell about an imminent and deadly viral respiratory pandemic. But few listened.

A study completed in September 2019 by the Johns Hopkins Bloomberg School of Public Health's Center for Health Security, titled "Preparedness for a High-Impact Respiratory Pathogen," warned of the risks we would face in the event of a viral respiratory disease pandemic. Commissioned by the WHO Global Preparedness Monitoring Board and the World Bank, it suggested a pandemic was knocking on our door and predictively outlined how we should respond if something like today's SARS-Cov-2/COVID-19 disease came about. Their dire predictions about the consequences of being unprepared came true as 2020 progressed.

While the September 2019 report offers a window into proper and expedient readiness, today it's a mirror for inept and unethical governmental behaviors and lack of preparation on the part of industry and medical and political institutions. It anticipated the greed, stupidity, prejudice, xenophobia, and failed leadership we've experienced on almost every front and in every category—most seriously in the United States, the world's continuing leader in COVID-19 cases and deaths.

Specifically, the report defined, predicted and, most importantly, warned about shortages of medical equipment, the reckless promotion of unproven drugs, economic disaster, and irresponsibly placing blame on victims. It even looked in detail into the possibilities for how something like the COVID-19 pandemic could be perpetrated as a weapon.

Ethical Considerations: The WHO's 2007 Report

Twelve years before the Johns Hopkins study, WHO issued a report titled "Ethical considerations in developing a public health response to pandemic influenza." That the report focused on a potential influenza pandemic rather than a coronavirus pandemic is not what's important. A viral pandemic is a viral pandemic.

The purpose of the report was to "assist social and political leaders at all levels who influence policy decisions about the incorporation of *ethical considerations* [emphasis mine] into national influenza pandemic preparedness plans." The document focused on priority setting; equitable access to resources; and restriction of individuals' movements as non-pharmaceutical interventions, including isolation of cases, quarantine of contacts, and limiting of social gatherings. It highlighted the obligations and responsibilities of healthcare workers, their employers, and governments during a pandemic, stating:

> *[I]mplementation of public health measures aimed at limiting social interaction (such as restrictions on gatherings and population movements) are likely to have a major impact on trade and tourism. In view of these possible consequences, countries and the international community must prepare to cope with a pandemic and mitigate its impact.*

British writer Daniel Defoe—author of *Robinson Crusoe*, whose title character was no stranger to social distancing—wrote in his *Journal of the Plague Year* (1665) that he "sympathized with both sides," meaning he sympathized with those who resisted quarantine and social distancing and with the authorities imposing it. "There was no remedy," he said.

Over four hundred years later, Slack concluded that "reactions to threats to public health are never purely scientific…they always involve restrictions on civil liberties of a more or less severe kind."

In 2007 the WHO addressed the cultural ethics and morality of imposing and/or opposing social distancing and cited a telephone survey carried out by the Harvard School of Public Health and the US Centers for Disease Control and Prevention (CDC). The survey was conducted in four locations: China, a province of Taiwan, Singapore, and the US. The report found that Americans were least likely to support quarantines.

Laurie Garret, author of the 1995 book *The Coming Plague: Newly Emerging Diseases in a World Out of Balance*, said in a March 18, 2020, radio interview: "My goodness. If people *still* don't understand that they need to have social distancing, then I don't think we have any hope at all. I think we're all going to drop dead."

The Politics and Pathology of Anti-Maskers

Christos Lynteris, a medical anthropologist at Scotland's Saint Andrews University, focuses much of his research on epidemics and their risk to humanity. In 2018 he published a study in the journal *Medical Anthropology* titled "Plague Masks: The Visual Emergence of Anti-Epidemic Personal Protective Equipment."

In it he examines human mask wearing historically and in many cultural settings, including those worn during the European Black Death era. He also looks at early twentieth-century epidemics in Asia and the 1918 Spanish Flu. About the anti-epidemic mask, designed to be worn in professional medical settings, he says that with mask acceptance "there is a transformation from mere cloth" to being the "reasoned subjects" of hygienic modernity.

Given the mask/no mask controversy raging in the US, his perspectives are suddenly more important than in the earlier SARS 2003 epidemic that led to the increasingly common sight of people in East Asian countries wearing masks. In his 2018 study, Lynteris said that in the fifteen years since the SARS outbreak "the use and efficacy of PPE [personal protective equipment] in epidemic control has become the subject of intense scientific debate." Today scientific consensus seems to have been reached—masks work in decreasing release of airborne virus. That debate seems to have left the realm of science and invaded city streets and even the halls of Congress.

Lynteris does talk about the "mistrust" between classes and professions during a 1911 Asian epidemic, offering historical photographs of "white-masked unity" in Manchuria and referring to "masks of reason."

Political tribalism also helps explain the unmasked face. The term "tribalism" in this situation refers to membership in a political and/or belief system. The unmasked person is tribal in the sense that they disidentify with science and may strongly identify with a different belief system, one that considers *not* wearing a mask as a symbol of identity and allegiance.

Supply-Line Morality and the Government Response

Garret (*The Coming Plague*) also commented in the recent interview that governments, especially in the US, have a moral obligation to get involved in a nationwide public health emergency. I think the key phrase here is "nationwide."

> *There's a role for the states. There's a role for local. We have this strange hodgepodge system of public health in America that is unlike any other country. And, as a result, the real burden at the federal level is a combination of setting guidance, providing wise strategic policy analysis, corralling resources in a timely fashion, and pushing connections between the public and private sector. All should be coming together, with science-based leadership from the top. And we don't have that on any single factor.*

Medical staff shortages

Nightly news programs have for some time emphasized the over-worked state of healthcare workers on COVID-19 front lines. By the end of July, the states most at risk for healthcare work force shortages were not the big three—California, Texas and Florida—but Idaho, Nevada, Oklahoma, South Carolina, Utah, and Washington. The data to make these predictions was not anecdotal. Estimates came from a tool called the "State Hospital Workforce Deficit Estimator" developed by George Washington University's Milken Institute School of Public Health. The purpose of the tool is to help the states and the federal government gauge the need for healthcare workers, especially those working in Intensive Care Units (ICUs). The big question here is: Who is using the tool and who is paying attention to its recommendations?

According to GW's Patricia Pittman, director of the Fitzhugh Mullan Institute for Health Workforce Equity, Arizona and Texas are already struggling with a shortage of doctors trained to treat COVID-19 patients in ICUs. "Our estimator suggests that a rapid increase in severely ill COVID-19 patients could overwhelm understaffed ICUs in many states," she adds.

Imagine a world of sickness without healthcare workers.

Given the unemployment rate during the pandemic, should future consideration be given to recruit more people for emergency healthcare? Can we quickly train and pay people to assist with the most basic healthcare tasks? Could better use have been made of the military earlier on to help fill in the worker gaps?

ICU bed shortages

In mid-July, the CDC posted state-by-state information regarding the percentage of occupied ICU beds in the US. Several states, including Georgia, Florida, Nevada, Arizona, Texas, Washington, and South Carolina all had 70 to 75 percent of their ICU beds occupied. Many other states had at least 50 percent of their ICU beds filled. Makeshift efforts to provide more ICU beds were reported and preceded by warnings issued by health authorities that one day this would happen.

Ventilator allocation

Early in the pandemic, the nationwide shortage of ventilators—the "breathing machines" that force oxygen into the lungs and help keep people with failing lungs alive—became apparent. Some estimates were that we would need millions of ventilators when only about 100,000 existed. What's a doctor to do?

"It might be best to do what doctors tend to do—make individual determinations about a patient's changes and maximize the care to those with the best chances," suggests Alison Bateman-House, an assistant professor in the New York University's Department of Population Health. "Does the data show that this patient is not going to survive? Data enables us to come up with protocols."

Looking at the data to make these kinds of ethical decisions is what researchers at Johns Hopkins University and the University of Pittsburgh did back in 2013. Their study became solid guidelines that could be put in place when an ethical decision was necessary.

The 2013 report suggested that ventilator allocation should be based on saving as many lives as possible in two ways: the likelihood of short-term survival enabling the patient to leave the hospital and the likelihood for long-term survival of at least twelve months.

The framework says: When ventilators are a scarce commodity, prospective ventilator patients are scored for suitability on a 1- to 8-point system. Short-term survival is based on an adult patient's organ failure assessment score using laboratory values and organ function indicators. For long term survival, patients would need to score from 0 to 3 and would be considered "high priority." Those patients likely to die within one year would be scored a 4-5 and would be an intermediate priority. Scores of 6-8 would be the lowest priority. The scores would be computed by a qualified "triage team" and reassessment could be done in any of the three categories. The teams could also consider appeals from the patient's family. With borderline scores, age could also be a determining factor.

During the Strasbourg massacre of 1349, several hundred Jews were publicly burnt to death or expelled from the city as part of the Black Death persecutions.

"In a public health emergency when there are not enough critical care resources for all, the goal of maximizing the benefit for communities of patients would be jeopardized if patients who were determined to be unlikely to survive were allowed indefinite use of scarce critical care services," the report explains. "In addition, periodic reassessments lessen the chance that arbitrary considerations, such as when an individual develops critical illness, unduly affect patients' access to treatment."

"First come, first served is an allocation of its own," suggests Bateman-House. "But in this case, it might not be a random cross section of the population. Questions about who can afford the care, who can get transportation to the hospital, and who has a cell phone to call 9-1-1 are issues."

The Ethics of PPE

In its 2007 report, the WHO said healthcare workers have the "moral obligation to work" during a pandemic, but that obligation is not "unlimited." It also noted that healthcare facilities have an ethical obligation to provide personal protective equipment "in line with technical advice" and that healthcare workers are obligated to use PPE.

Over the course of the pandemic, there have been several cases of nurses who refused to work without proper PPE and were fired because of their refusal.

"I don't believe it is unethical for healthcare workers to say they are not going to work if they don't have personal protective equipment," says Bateman-House. "We can't demand people to self-sacrifice. It was unethical to penalize those workers."

President Trump ordered meat-packing plant workers around the country to go back work in late April, although the workers said they didn't have proper PPE. As schools reopen, many teachers, school staff, as well as some students and their parents, express fears over returning to classrooms and school buildings. One hopes those in fear can appeal to the Occupational Safety and Health Administration (OSHA). Born in 1970 with the Occupational Safety and Health Act, OSHA says that "workers have the right to a safe workplace."

One section on the OSHA website highlights OSHA standards and directives (instructions for compliance officers) and other related information that may apply to COVID-19 exposure. Among the most relevant aspects are the PPE standards, which require using gloves, eye and face protection, and respiratory protection when job hazards, such as a viral pandemic, warrant. There is also guidance for when respirators are necessary to protect workers, saying employers must implement a comprehensive respiratory protection program in accordance with the Respiratory Protection Standard.

Our Responsible, Ethical, and Moral Future

If COVID-19 drags on for years, or if a new pandemic takes over where this one leaves off, what should we *stop* doing and what should we *start* doing to create a more responsible, ethical, and moral response?

Perhaps we can depoliticize pandemic responses by taking pandemic responsibility out of political hands and putting it—by law—into the professional hands of the CDC, the Food and Drug Administration, the US Public Health Service, and other responsible actors. In other words, do whatever is necessary to take the politics out of a pandemic. In addition:

- Take decisions on national health, quarantines, and drug research away from the Executive Branch
- If quarantine is warranted, take economic responsibility for those stuck at home, especially those left unemployed and who cannot work at home
- Allow the WHO/World Bank Global Preparedness Monitoring Board to play a role in determining outbreak seriousness and advise steps to reduce outbreak effects
- Nationalize healthcare materials production and distribution, especially in health emergencies
- Develop a national health crisis unemployment fund; train, repurpose, and pay workers to carry out some pandemic-related tasks for which they can be trained during non-pandemic times
- Boost and accelerate federal funding of continuous vaccine research for both influenzas, corona viruses, Dengue fever, and others, and conduct continuous clinical trials

If we fail to learn from the mistakes of the coronavirus pandemic response, echoing Walt Kelly's old *Pogo* comic strip: we will have met the scourge and the scourge will be us.

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