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COVID-19 Makes Clear That Bioethics Must Confront Health Disparities

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With some reluctance, I've come to the sad realization the COVID-19 pandemic has been a stress test for bioethics, a field of study that intersects medicine, law, the humanities and the social sciences. As both a physician and medical ethicist, I arrived at this conclusion after spending months at what was once the epicenter of the pandemic: New York City. I was overseeing a 24/7 bioethics consultation service.

I work in a nationally ranked academic medical center in Manhattan. As it did with all hospitals in New York City, COVID-19 put us under tremendous pressure to respond to the surge of patients who came to us for care. In the early days, we struggled with inadequate provisions. Yet we persevered. We increased our ICU capacity by more than 200%, redeployed our clinical workforce in creative ways, and provided a "crisis standard of care." Simply put, we did the best we could under extreme conditions. In all my years in medicine, I have seen nothing like it. I imagine the only analogy would be practicing medicine on a battlefield.

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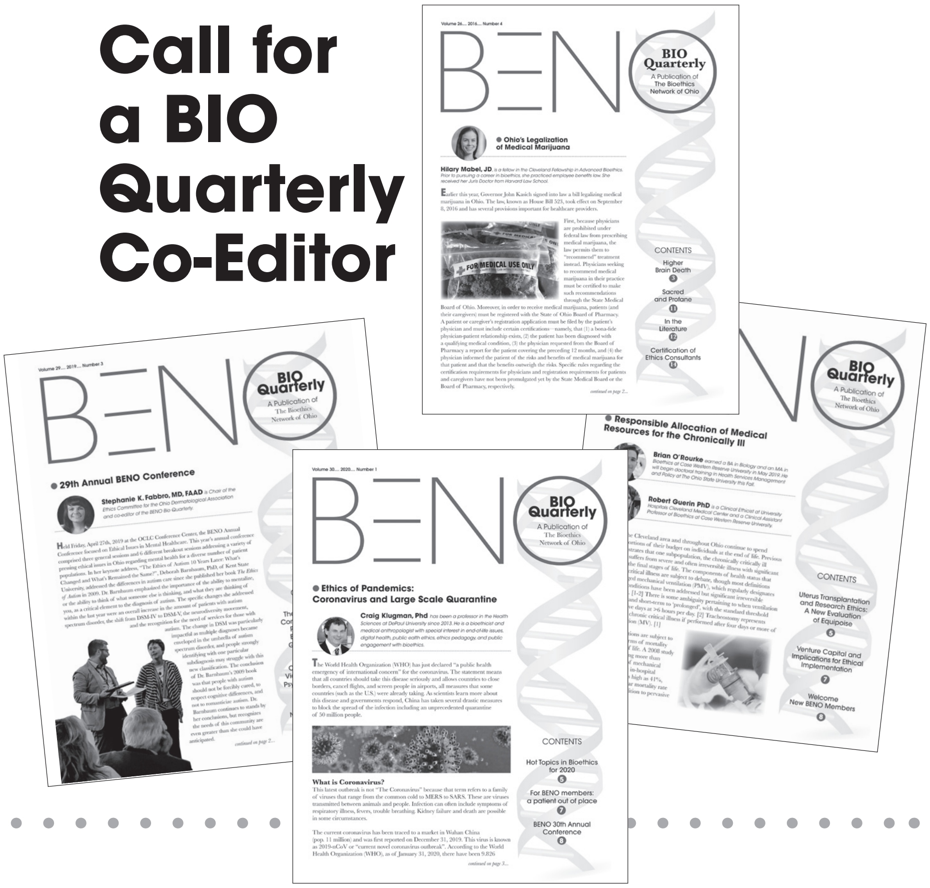

The Bio-Quarterly is in search of a new co-editor. This volunteer position involves generating new topic ideas relevant to contemporary ethical dilemmas, soliciting articles from interested parties, and editing the submissions for inclusion in each quarterly issue. If you are interested or would like to learn more about the position, please email stephaniefabbro@gmail.com and alan.murphy@ohiohealth.org.

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We love hearing from you...

I want to thank Dr. Craig Klugman of DePaul University, whose article "Ethics of Pandemics: Coronavirus and Large Scale Quarantine" was featured in a recent edition of BioQuarterly (Volume 30, 2020, Number 1), for taking the time to conduct a Zoom meeting with my undergraduate Bioethics course at Ursuline College. He led a thorough and very engaging discussion of the ethical issues involved in the Covid-19 pandemic which we used as the foundation for our detailed discussions throughout the class. Again, a big thanks from my students and me.

— Daniel Evangelista, Ursuline College

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As challenging as our situation was, colleagues across New York City had it worse. I was especially struck by what hospitals experienced in the boroughs of Queens and the Bronx. Chronically under-resourced, they were also caring for patients who long suffered from the consequences of inadequate primary care. Those with untreated hypertension, diabetes, obesity, and other chronic conditions were especially prone to the ravages of coronavirus. The rows of refrigerator trucks outside a hospital in Elmhurst, Queens, parked there to temporarily hold the dead, was a horrifying symbol of the distress. As a scholar, I try to avoid becoming emotional, but seeing them reminded me, once again, of a battle: specifically, what my Dad had seen as a combat medic in World War II. But this was happening in New York City.

Such images have forced me to question the relevance of bioethics – and ask why my field hasn't done more to identify these disparities and do something about them. To be sure, my team and I provided ethics consultations in our hospital, and I participated in policy discussions at the institutional and state level. But our focus for the most part was too narrow and ignored a tale of inequity unfolding around us.

One example: Our hospital in Manhattan evacuated patients from hospitals in Brooklyn and Queens to help with their case load. At the state level, there was talk to make things easier by coordinating such transfers. But mostly, the efforts were too little, too late. Inequity was baked into the system long before the pandemic. Nothing could be done to reverse that inequity, once waves of patients flooded the system.

Why hadn't bioethics done more to anticipate these challenges and mitigate them? The answer is complex, and the history goes back generations.

Bioethics 101

Bioethics, a phrase coined in 1973, was a response to the Nazi atrocities in medicine, the Tuskegee Syphilis Study, and the challenges posed by increasingly sophisticated medical practice (1). Bioethics called for including the patient's voice in care decisions, an affirmation of their rights, and a focus on four principles: autonomy, beneficence, non-maleficence and justice.

But along the way, one of those principles was prized to the exclusion of the others. A European bioethicist once told me, with irony, that American medicine followed four ethical principles: autonomy and three others he could not recall.

Still, bioethics in the U.S. became something of a rights movement, akin to other civil rights movements of the era. The goal was to minimize hierarchies and give voice to the voiceless. The sanctioning of patient enfranchisement in bioethics was a response to entrenched paternalism (doctor knows best). Notably, it led to the right-to-be-left-alone and the right-to-die movement typified by cases like Karen Quinlan, Nancy Cruzan and Terri Schiavo.

With the elevation of self-determination, the pursuit of the other three principles – the promotion of good, the avoidance of harm, and the passion for social justice – was diminished. These limitations were laid bare by the morbidity and mortality data from the COVID-19 pandemic in New York City. Neighborhoods of color, poverty and poorer educational attainment were hardest hit – those very neighborhoods that had hospitals with an insufficient number of beds and poor access to primary care. The death rate in the Bronx was double that of Manhattan (2). This was a consequence of poverty, population density and the structural racism in medicine and health policy.

> ***With the elevation of self-determination, the pursuit of the other three principles – the promotion of good, the avoidance of harm, and the passion for social justice – was diminished.***

Bioethics needs to move beyond narrow questions of patient choice, particularly when the disenfranchised are not in a position to exercise that choice.

In 2009, as we prepared for an avian flu pandemic that never arrived, I posed these questions in an essay for the Hastings Center Bioethics Forum (3). I was worried about how entrenched and endemic disparities might compound the malign effects of a pandemic.

At that time, the average number of ventilators was 39.2 per 100,000 people in Manhattan, compared to 14.1 per 100,000 people in Queens. Imagining a pandemic flu, I worried that "rationing ventilators would be especially harsh in Queens" and would lead to "disproportionate death." This is precisely what happened during the COVID-19 crisis a decade later.

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Disparities continued from page 3...

While physicians and health care officials focus on the acute consequences of COVID-19, we must also recognize the real pathology existed long before the pandemic struck. The pre-existing condition of health care disparities led to the disproportionate burden on vulnerable communities from COVID-19.

Now is the time for bioethics to broaden its gaze and appreciate that rights without opportunity ring hollow. The Nobel Laureate Amartya Sen rightly observed the limited utility of negative rights if they did not yield just results (4). Bioethics needs to learn from the COVID-19 experience lest its obsession with midcentury catechisms make it an historical artifact of an earlier era.

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● Moral Reasoning in a Pandemic

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Policy discussions during the pandemic have raised concerns for me, as a moral philosopher, about how policy analysts and policy makers are thinking about deaths from COVID-19 and the right way to combat them. The policy discussions I have in mind have ranged from broad issues about how and when to open the economy to more focused concerns about how Intensive Care Units in hospitals should allocate scarce medical equipment (including ventilators). I will here consider three areas of concern about how people are reasoning about what is morally right in the pandemic.

Interpersonal Aggregation

How should we weigh the economic costs of keeping the economy shut down versus the lives lost to COVID-19 from opening it up? Speaking on the PBS evening News Hour June 18, economist Nick Bloom calculated that the experience of being shut in and suffering economic trauma could result in the loss of a year of life for a person. I do not want to second guess his estimate, but to ask about the use it might be put to in reasoning about what to do.

Bloom added up all the years of life that would be lost given 40 million jobs lost in the last three months of economic distress and came up with 40 million life years lost. The aim was to translate economic losses into the language of life. The question is how that translation helps us compare a closed economy to deaths caused by opening up the economy.

Bloom did not go so far as to compare this total number of life years lost with the deaths of other people from the virus. Indeed,

he argued that people who are especially vulnerable to the virus should stay at home for their own safety while many others who are not so vulnerable could avoid the cost to them in terms of a life year lost by opening up the economy.

But some might be tempted to go further and conclude that the large total of life years lost (40 million) outweighs the deaths of individual people. But in translating economic loss into life years lost, we must not lose sight of the fact that if 40 million people each lose one year of life no one of those people will suffer a loss as great as someone who, for example, dies at the age of forty, thereby losing thirty years of life. It is a mistake in what is called "moral mathematics" to aggregate in an additive fashion small losses to many people, each of whom, for example, may die at age seventy rather than seventy one, and think of that summation of losses as greater than the loss of life to someone at age forty if he could otherwise have lived thirty more years. There is no one person who suffers the loss of 40 million years of life and there may be no one in the large group who dies at 40 rather than 70. This kind of "interpersonal aggregation" is morally misguided.

The moral idea is to give priority to the worse off.

Instead, it might be better morally speaking to use "pairwise comparison": see if there is anyone among the 40 million who would suffer as much (or nearly as much) as a person who would die of COVID-19 when he would otherwise have lived much longer. If not, give priority to helping the person who would be worse off in dying rather than each of the many who would suffer a significantly lesser loss and be better off even with that loss than the person who dies. The moral idea is to ***give priority to the worse off***.

Consider an even more extreme version of interpersonal aggregation. Suppose someone calculated that each one of 1.2 million people would lose a month of life due to the closing the economy. That would mean a total of 100,000 years of life lost. But no person will suffer more than a month of lost life. Even more grotesquely, someone might use this kind of interpersonal aggregation to calculate how many months there are in an average lifetime and then figure out how many "lifetimes" would be lost even though no single person of the 1.2 million people would lose a lifetime—indeed, none would lose more than a month of life. (I have been told that this method was once used to argue that lower speed limits that made many people waste more minutes in traffic "cost lives," once the minutes were added up to form units of minutes in an average life, and those lives lost could be weighed against lives saved from more traffic accidents occurring at higher speeds.)

Life Years

If pairwise comparison is a better way to think morally, how should we do it? Consider the death of a single person and the expected number of years that person would lose if they died or have if they were saved. Some people think that we can determine how bad a death would be on the basis of expected years of (adequate) life that would be lost if that person were not saved. A death is worse if more years of life are lost, and in pairwise comparisons, we should allocate resources to avoid the worse outcome.

Suppose, for example, we must ration a resource—e.g., a drug or ventilator. Some people (e.g., the philosopher Peter Singer) think that medical personnel should save the person who (assuming equal chances and costs of achieving survival) would live the longest after treatment. Typically, this will mean saving the younger person: the idea is that it is worse for that person to die now because they have more years of life left. A March 2020 report in *The New England Journal of Medicine* on

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Moral Reasoning continued from page 5...

the pandemic in Italy described doctors there considering rationing so as to save younger rather than older people because more life years could be expected from a younger person.

Regardless of our ultimate position on the policy of saving younger rather than older people, we should understand that an argument for the morality of saving younger patients need not be based on pairwise comparisons of life years expected from point of treatment. An alternative argument focuses on the fact that the older person will have had more life years even if he dies than the younger person will have had if he dies. On this view, if the younger person is not helped, he would wind up being the worst off, and so it would be most reasonable to save him rather than the older person who, even if not saved, would still be better off than the not helped younger person. In other words, it is morally more valuable (all else equal) to provide a benefit to someone who will have had less of that thing. This way of thinking, which conflicts with the focus on years of life lost, captures our intuitive thought that often a younger death is worse because the person will have had less of the good of life.

This way of making pairwise comparisons has practical consequences. Notice that if doctors think in terms of helping people based on expected life years they would have to help a sixty year old whose life would be extended 20 years by treatment in preference to a thirty year old whose life would be extended 15 years by treatment. By contrast, concern for helping the person who will have had the fewer life years if he dies would favor helping the younger person because he will have had only thirty years of life if he dies whereas the older person will have had sixty even if he is not helped. The death of this younger person is worse not because they lose out on more years than the older person but because they will not have lived very long.

Love and Masks

In his final daily address about the pandemic to the people of New York, Governor Andrew Cuomo said that "love does win" and gave as an example "I wear a mask for you and you wear a mask for me." The point of Cuomo's example was that the sorts of mask it is now recommended that we wear on the streets do not primarily protect the wearer from getting COVID-19. Rather they reduce the chances of transmitting the virus to others.

As is well known, many people in the United States refuse to wear masks. This would probably not be so if they had been told that their wearing a mask directly protects them. As it is, if someone doesn't wear a mask, they can still be a free rider: they get the benefit of protection from others wearing masks, while not wearing a mask themselves.

Is it really true that wearing masks to protect each other is an act of love? One reason for thinking otherwise is that a person may wear a mask in an effort to encourage a practice that protects the person who wears the mask: If I wear a mask, I may thereby encourage others to do so, which in turn will protect me. In this case, I am wearing the mask out of concern for self, not for others, so wearing it need not be an act of love. But there is another important concern about treating wearing a mask as an act of love. As Cuomo emphasized in earlier addresses to the public, if I do not wear a mask, I increase risks to others. This, as Cuomo said, is simply ***disrespectful*** to others. I think this way of putting the matter is more accurate.

Acts of love typically seek to benefit others, making them better off than they would otherwise be. Wearing a mask does not make someone else better off than they would otherwise be. Instead, it avoids making them worse off by spreading a disease to them. If I wear a mask, I am not a benefactor to others as if I saved someone from drowning; rather, I avoid being a threat to them. Conservatives and libertarians typically emphasize not violating the negative right people have not to be harmed. Why then might so many of them object to wearing masks?

Those philosophical beliefs do not deny that there should be restrictions on freedom to prevent some from imposing harm on others even if the harm would be unintended. And sometimes you can only avoid harming someone by ***doing*** something, such as waiting until someone leaves a space before entering it or swerving one's car to avoid hitting someone. If the risk of someone's spreading disease were extremely low and this person were the only one who posed the risk, there might be an objection to requiring a mask. However, we know that if everyone who presents this small risk goes maskless some people will be infected; to avoid this occurring, all who present only a small risk may have to pay a small cost, doing their fair share to reduce the risk.

Finally, what should be done if many people actually refuse to wear masks that would primarily protect others, not themselves? An N95 mask would protect to a high degree the person who wears it. Nonmedical personnel are strongly discouraged from wearing them primarily because there is a shortage and priority should be given to medical personnel. But perhaps production of these masks for those in the general public should be ramped up. Those who refuse to act for the sake of others (and indirectly for their own sake) may wear a mask or other device that is intended to protect them directly and those who cannot rely on people wearing masks for the sake of others could engage in self-defense by wearing an N95 mask or similar protection. For those concerned that people staying at home or even maintaining distance sufficient alone to prevent spread of the virus will prevent an economic resurgence, the question is whether the economic cost of providing N95 masks or similar self protection more generally would be smaller than the economic costs of not opening up the economy to avoid serious illness or death.

Whatever the best policy turns out to be, the important point is that those on the political right and left should be able to agree that there is a duty not to harm others and wearing a mask to fulfill the duty may justifiably be required of most people, even if love or simply saving lives could not be similarly required.

Originally Published in Boston Review *on July 6, 2020.*

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Single-blinded Peer Review: Pitfalls with Potential Bias

Stephanie K. Fabbro, MD, FAAD *is Chair of the Ethics Committee for the Ohio Dermatological Association and co-editor of the BENO Bio Quarterly.*

Benjamin K. Stoff *is Assistant Professor of Dermatology at Emory University with special interest in Dermatoethics.*

Dear BENO:

I am a reviewer for an academic journal who has been assigned a research article by a highly-renowned physician from a neighboring institution. This article has significant methodological flaws and would not be fit for publication in my opinion. Though my identity is concealed from the author, I hesitate to reject the article given that this is someone I know and respect. I also have concerns that my identity may be apparent given my writing style and shared interest in this topic. What should I do?

-Young Academic

Discussion

Dear Young Academic:
Single-blinded peer review, in which authors are blinded to reviewers but reviewers are aware of the identity of authors, is the most common type of peer review for academic journals (1). Recently, bias associated with single-blinded peer review has been explored. Preliminary data suggest that reviewers may unwittingly favor submissions from particularly prolific authors or those from prestigious institutions, despite methodological flaws (2,3). Conversely, some data suggest that author demographics, such as gender or race/ethnicity, may be associated with unfavorable reviews (4).

Reviewers must hold themselves to an ethical standard of objectivity. This includes honest disclosure of expertise and conflicts of interest, avoidance of soliciting references of their own work for personal gain, and mitigation of implicit bias, positive or negative (5).

> *The use of single-blinded review may incentivize young academics to include more established authors on their submissions, even if those senior authors have not made a significant contribution, in order to increase odds of acceptance.*

Despite this, a reviewer may feel uncomfortable rejecting an article from a prestigious author, in turn questioning her own expertise of the subject. Evidence shows that grants are more likely to be awarded and manuscripts are more likely to be

accepted if the reviewer is personally familiar with or geographically close to the author (6). The use of single-blinded review may incentivize young academics to include more established authors on their submissions, even if those senior authors have not made a significant contribution, in order to increase odds of acceptance (7). Most medical journal reviewers receive no training, particularly related to implicit bias, during peer review. Simply bringing it to light may provide reviewers with insight into their behavior and motivation to change.

In this case, the author should uphold the ethical standard of objectivity and reject the article in question. While authors often can suggest reviewers they would prefer or prefer not to review articles due to expertise or possible conflicts of interest, reviewers should also consider declining to review articles when their objectivity is challenged. .

Double-blinded peer review, in which both the author and the reviewer are blinded to one another's identity, is an alternative that could mitigate bias and allow for greater fairness and objectivity in the peer review process. Some may argue that double-blinded review has its own limitations; namely, knowing the submitting author's body of work may allow the reviewer greater depth of understanding of the author's perspective and thereby bring greater context to the submission. There is no evidence showing that the double-blinded review process increases submissions from lesser-known authors or those from under-represented groups (6). It may also be technically difficult for the editorial office to eliminate all potential identifiers of the authors. Despite these concerns, the growing body of data characterizing the potential harms surrounding single-blinded review creates a compelling argument against its use in favor of a double-blinded model.

> ***Double-blinded peer review, in which both the author and the reviewer are blinded to one another's identity, is an alternative that could mitigate bias and allow for greater fairness and objectivity in the peer review process.***

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The artwork of Jean-Michel Basquiat was known for its poignant self-expression and political commentary. *Untitled, 1982* (pictured left) is a striking reminder of the anguish of those struggling with addiction and the artist himself shortly thereafter succumbed to an early demise related to heroin overdose. In this month's issue of the AMA Journal of Ethics, ethicists contend with the concept of foundations such as the Sackler family, owner of Perdue Pharmaceuticals, making donations to these arts museums and institutions while continuing to profit off opioid sales. Is it ethical to accept such donations as an artist, and if so is there any ethical obligation to financial accountability?