HEC Forum (2021) 33:1–6
https://doi.org/10.1007/s10730-021-09448-6

A Journal of the COVID-19 (Plague) Year

Brian H. Childs[1] · **Laura Vearrier**[2]

Accepted: 19 February 2021 / Published online: 23 March 2021

Abstract
The essays in this special issue of *HEC Forum* provide reflections that make explicit the implicit anthropology that our current pandemic has brought but which in the medical ethics literature around COVID-19 has to a great extent ignored. Three of the essays are clearly "journalistic" as a literary genre: one by a hospital chaplain, one by a medical student in her pre-clinical years, and one by a fourth-year medical student who reports her experience as she completed her undergraduate clerkships and applied for positions in graduate medical education. Other essays explore the pandemic from historical, sociological, and economic perspectives, particularly how triage policies have been found to be largely blind to structural healthcare disparities, while simultaneously unable to appropriately address those disparities. Central issues that need to be addressed in triage are not just whether a utilitarian response is the most just response, but what exactly is the greatest good for the greatest number? Together, the essays in this special issue of *HEC Forum* create a call for a more anthropological approach to understanding health and healthcare. The narrow approach of viewing health as resulting primarily from healthcare will continue to hinder advances and perpetuate disparities. Health outcomes result from a complex interaction of various social, economic, cultural, historical, and political factors. Advancing healthcare requires contextualizing the health of populations amongst these factors. The COVID-19 pandemic has made us keenly aware of how interdependent our health as a society can be.

In the March 28, 2020 Book Section of the *Guardian* an interview with Catherine Camus, the daughter of Albert Camus, indicated that orders for his

✉ Brian H. Childs
childs_bh@mercer.edu

Laura Vearrier
lvearrier@umc.edu

[1] Professor of Bioethics and Professionalism, Mercer University School of Medicine, Savannah, GA, USA

[2] Associate Professor of Emergency Medicine, University of Mississippi Medical Center, Jackson, USA

allegorical novel *The Plague* was outpacing its publisher's ability to print them. Catherine Camus attributed the increase in demand to the relevance of that novel in the midst of our current COVID-19 pandemic. The younger Camus explained that the novel brings to the fore the question of human responsibility in the face of crises whether they be political or natural. While Camus' novel certainly is relevant to our current politics and pandemic it might be that Daniel Defoe's historical novel *A Journal of the Plague Year* is equally if not more relevant in the face of the COVID-19 pandemic. While Defoe's work is fictional (Defoe was only four years old when the plague struck London in 1665), he did structure his work as a journalist would by incorporating statistical mortality data that was widely available as well as his own personal reflections and the reflections of citizens who were enduring the pandemic that killed in the millions. The data and anecdotes illustrate how persons behave under stress as well as an implicit anthropology that human survival in the face of mass affliction depends on the need for community and that the good life is one lived collectively.

The COVID-19 pandemic is a stress test of our human condition and values on a global basis. It forces us to focus questions that need be asked about human nature, freedom, our duties and obligations to one another, as well as distributive justice not only in healthcare but in political, economic, and educational spheres as well. As soon as it was clear that there was a dangerous pandemic spreading across the globe, medical ethicists began the process of considering how best to respond to the pandemic. With just a few exceptions, it seemed that medical ethicists concentrated their energies in dusting off and recalibrating triage structures, algorithms that were developed during previous pandemic threats, particularly the SARS threat in 2002 and the H1N1 threat of 2009. As hospitals across the country reached capacity and the healthcare system became overburdened, hospitals became buildings of triage—with doctors and nurses making decisions about which patient to see next, who should be placed in which physical location or get which medication, and where to focus their mental and emotional energies, and how to protect themselves in a faltering workforce, the triage process was at the forefront of ethicists' deliberation. While there is and will continue to be a need to develop methods to maximize benefit, allocate scarce resources, and preserve essential workforces, something seems to be largely missing in this focus on triage. As Sheri Fink (2020) has noted, triage plans have an implicit anthropology. They tell us as much about human values implicit in their plans as they do about the emergency practice of medicine.

The essays in this special issue of *HEC Forum* will provide reflections and contributions that make explicit the implicit anthropology that our current pandemic has brought but which in the medical ethics literature around COVID-19 has to a great extent ignored. Three of the essays are clearly "journalistic" as a literary genre: one by a hospital chaplain, one by a medical student in her pre-clinical years, and one by a fourth-year medical student who reports her experience as she completed her undergraduate clerkships and applied for her position in graduate medical education. Other essays in this collection explore the pandemic from historical, sociological, and economic perspectives, particularly how triage policies have been found to be largely blind to structural healthcare disparities while simultaneously unable to appropriately address those disparities (Rhodes, 2020). We have to look somewhere

else to address structural disparities. Central issues that need to be addressed in triage are not just whether a utilitarian response is the most just response, but what exactly is the greatest good for the greatest number? If we agree with Defoe that the good life is one that is shared and lived collectively, then there are implications for how we interpret and define a modern utilitarian approach. Are there duties and obligations or communitarian imperatives that need to be on the forefront? Defoe's work seems to point to an anthropology that is resistant to a classic utilitarian calculus and the essays in this collection come to similar conclusions, although with modern technology and public practices clearly in mind and a redefining of utilitarianism from a principalism perspective.

The essays in this special issue point to domains of knowledge and activity that must contribute to our understanding of the core values of health and flourishing as well as medicine and public policy's response to illness and suffering. The concentration of energy with triage and resource allocation among medical ethicists comes with the neglect of wider and more preliminary concerns. Specifically, a focus on rescue medical ethics is blind-sided due to a neglect of public health medical ethics. While triage and resource allocation in a crisis is necessary, the medical ethicist needs to be more sensitive to at least four domains to which the essays in this issue point.

Ecologic and Environmental Considerations

SARS-CoV-2, it is hypothesized, began its spread in a wet market in Wuhan, China. It is argued that this virus may be an example of Zoonosis, which is defined as any infection that is transmissible from a vertebrate animal to humans (World Health Organization, 2020). While it is not entirely clear that our current pandemic is a result of zoonosis (Haider et al., 2020), it is well known that urbanization and deforestation has increased the threat of zoonotic disease transmission for which we may have no understanding or treatment. Rescue medical ethics does not concern itself with how the disease came to be and what can be done to prevent this kind of disease or the healthcare ethics that might address the health threats of industrialized farming and crowded urban environments. Not only rats, but coyotes with no natural environment have been seen on the streets of many cities during the pandemic. Furthermore, when at one time an outbreak might be considered local, our globalized transportation capabilities make the entire world local, emphasizing the importance of international partnerships and a global health ethic.

Healthcare Disparities

The COVID-19 pandemic has been shown to disproportionately affect populations who have been underserved by healthcare. This is particularly the case among African Americans as well as Hispanic populations (Garg et al., 2020). The social determinant of health that drive these disparities, such as the inability to socially distance, work from home, avoid public transportation, etc., highlight

the need for an understanding of health and healthcare outcomes within the greater social context. Decreasing healthcare disparities cannot be done by the healthcare system alone; a broader social and economic response is required to improve health equity.

According to some epidemiologists, healthcare outcomes are reliant 70% of the time on social and economic factors as well as the health behaviors social and economic factors influence, such as smoking, poor diet and lack of exercise (Kelly, 2020). The social and economic factors that result in structural disparities are broad and impactful, and they include more than just access to healthcare but also how children are educated. When schools shut down and school systems began using the internet for virtual classroom education, children in socially and economically disadvantaged communities did not have internet to attend virtual classes or had to sit in cars outside libraries that had Wi-Fi. These communities also comprised persons least likely to be able to work at home and had to use public transportation to go to work thereby exposing them to infection. Calls for taking into account these healthcare disparities within triage algorithms complicated and call into question serious justice concerns.

Healthcare Delivery and Medical Education

Healthcare delivery in the United States is not a system or at least a coordinated system. The pandemic has underscored some of its weaknesses. One glaring example was the nearly immediate shortage of personal protective equipment (PPE) and even ventilators. Just in time purchasing of equipment by hospital systems meant there was no ready surplus or stockpile and with a general global shutdown the ability to manufacture and ship needed supplies became problematic (King, 2020). In addition, a hospital, be it for profit or not for profit must deliver well-reimbursed elective services with predictable lengths of stay. When hospitals were forced to cancel and delay elective services, they faced considerable economic shortfalls forcing many to furlough employees, many of whom were economically disadvantaged. Rural hospitals which serve the disadvantaged were the most vulnerable to drastic reduction of services if not closure (Levins, 2020). Medical education and the medical profession has been challenged. The celebration of the healthcare worker as hero is accompanied by burnout and resentment of platitudes and praise without substantive protections and compensations (Sobowale, 2020). Essays in this special issue of *HEC Forum* suggest real challenges the pandemic has raised for medical education (Anderson and Southworth and Gleason). Two others (Hopkins and another by Forbes) illustrate the effect of pandemics on professional identity and the medical profession's image with the public. Furthermore, the pandemic has brought to light how nursing homes and extended care facilities, which are lightly regulated and have high employee turnover and less skilled labor, have 5% of all U.S. cases but 38% of all deaths (Kim, 2020). In addition, the impact on dental health by the pandemic has been underappreciated.

Resource Allocation

Medical ethicists have been essential in developing ethically sensitive resource allocation policies. The pandemic has put public health ethics in the forefront. As Vearrier and Henderson point out in this special issue, principalism need not be jettisoned in utilitarian policies. The Utilitarian Principalism framework that they define involves a modernization of the notion of utilitarianism in which the greatest good for the greatest number involves that good being based on societal values. In classic utilitarianism, justice is not a concern, but in Utilitarian Principalism, justice is one of the four central pillars that must be considered in resource allocation.

The absence of national guidance is problematic and is at least in part the result of politicization of science and public health policy. Even on the state level there is very little coordinated effort for a state-wide policy. The essay in this issue by Elson, et al., discusses their attempt to provide a uniform policy for Maryland but to date there has been a lack of positive response from the Maryland political leadership. Such policies should be sensitive to healthcare disparities, and medical ethicists must be familiar with and advocate for public health ethics.

As with the Bubonic Plague in Defoe's time our time with the current COVID-19 pandemic has stressed our global community. While the pandemic has put in bold relief some of the shortcomings due to the lack of public health preparedness both within the United States as well as globally. There is an adage among medical ethicists that many requests for ethics consultations (and referrals to hospice care) come days if not weeks too late. The same is true in many ways with our response to our corona virus pandemic. Now that there are vaccines it is hoped that this current virus can be controlled, though at the same time we know that this virus mutates and there are other pathogens that can sicken and kill that can enter our ecosystems. It is hoped that the essays in this collection can spur further discussion among a variety of scientists, public health researchers and administrators, public policy planners, politicians, physicians, and others so that we can be proactive rather than mainly reactive to future threats. There will be more pandemic threats to come as history so clearly reminds us. Medical ethicists do not have the expertise to address all that needs to be addressed however as these essays attest medical ethicists do have a role to play. Values and obligations and how best to live in a community of others belongs in any further discussion. Medical ethics can play a role in making sure those voices are heard.

The essays in this special issue of *HEC Forum* create a call for a more anthropological approach to understanding health and healthcare. The narrow approach of viewing health as resulting primarily from healthcare will continue to hinder advances and perpetuate disparities. Health outcomes result from a complex interaction of various social, economic, cultural, historical, and political factors. Advancing healthcare requires contextualizing the health of populations amongst these factors. And if we agree that the good life is one that is lived collectively, then we need a greater intersection of clinical and public health ethics. The COVID-19 pandemic has made us keenly aware of how interdependent our health as a society can be.

References

Anderson, V. C. (2021). Academic during a pandemic: Reflections from a medical student on learning during SARS-CoVid-2. *HEC Forum*. https://doi.org/10.1007/s10730-021-09439-7

Bunch, L. (2021). A tale of two crises: Addressing Covid-19 vaccine hesitancy as promoting racial justice. *HEC Forum*. https://doi.org/10.1007/s10730-021-09440-0

Defoe, D. (1722/1986) *A journal of the plague year.* Penguin Classics.

Elson, N., Gwon, H., Hoffmann, D.E., Khan, A., Kelmenson, A., Kraus, J.F., Onyegwara, C., Povar, G., Sheikh, F. & Tarzian, A.J. 2021. Getting real: The Maryland Healthcare Ethics Committee Network's working group debriefs lessons learned. *HEC Forum 33*(1).

Elster, N., & Kayhan, P. (2021). Oral health matters: The ethics of providing oral health during COVID-19. *HEC Forum*. https://doi.org/10.1007/s10730-020-09435-3

Fink, S. (2020). Ethical dilemmas in covid-19 medical care: Is a problematic triage protocol better or worse than no protocol at all? *The American Journal of Bioethics, 20*(7), 1–5.

Forbes, A. W. 2021. Covid-19 in historical context: Creating a practical past. *HEC Forum 33*(1).

Garg, S., Kim, L., Whitaker, M., O'Halloran, A., Cummings, C., Holstein, R., Prill, M., Chai, S. J., Kirley, P. D., Alden, N. B., Kawasaki, B., Yousey-Hindes, K., Niccolai, L., Anderson, E. J., Openo, K. P., Weigel, A., Monroe, M. L., Ryan, P., Henderson, J., Kim, S., Como-Sabetti, K., Lynfield, R., Sosin, D., Torres, S., Muse, A., Bennett, N. M., Billing, L., Sutton, M., West, N., Schaffner, W., Talbot, H. K., Aquino, C., George, A., Budd, A., Brammer, L., Langley, G., Hall, A. J., & Fry, A. (2020). Hospitalization rates and characteristics of patients hospitalized with laboratory-confirmed coronavirus disease 2019 — covid-net, 14 states, march 1–30, 2020. *MMWR. Morbidity and Mortality Weekly Report, 69*(15), 458–464.

Greiner, R. M. B. (2021). The cost of safety during a pandemic. *HEC Forum*. https://doi.org/10.1007/s10730-020-09438-0.

Haider, N., Rothman-Ostrow, P., Osman, A., Arruda, L., Macfarlane-Berry, L., Elton, L., Thomason, M. J., Yeboah-Manu, D., Ansumana, R., Kapata, N., Mboera, L., Rushton, J., McHugh, T. D., Heymann, D. L., Zumla, A., & Kock, R. A. (2020). Covid-19—Zoonosis or emerging infectious disease? *Frontiers in Public Health*. https://doi.org/10.3389/fpubh.2020.596944

Hopkins, P. (2021). Viral heroism: What the rhetoric of heroes in the COVID-19 pandemic tells us about medicine and professional identity. *HEC Forum*. https://doi.org/10.1007/s10730-020-09434-4.

Kelley, A. (2020). *Public health evaluation and the social determinants of health*. Routledge.

Kim, E. T. (2020). This is why nursing homes failed so badly. *New York Times*. December 12. [Online] Available: https://www.nytimes.com/2020/12/31/opinion/sunday/covid-nursing-homes.html.

King, R. (2020, July 7). Mayo clinic CEO blasts 'just-in-time' ordering as pandemic changes supply chain. *Fierce Healthcare*. July 07. [Online] Available: https://www.fiercehealthcare.com/hospitals/mayo-clinic-ceo-blasts-just-time-ordering-as-pandemic-changes-supply-chain.

Levins, H. (2020). Already in fiscal crisis, rural hospitals face COVID-19. [Online] Available: https://ldi.upenn.edu/news/already-fiscal-crisis-rural-hospitals-face-covid-19.

Powell, K., & Meyers, C. (2021). Guidance for medical ethicists to enhance social cooperation to mitigate the pandemic. *HEC Forum*. https://doi.org/10.1007/s10730-021-09445-9

Rhodes, R. (2020). Justice and guidance for the covid-19 pandemic. *The American Journal of Bioethics, 20*(7), 163–166.

Sederstrom, N. O., & Wiggleton-Little, J. (2021). Acknowledging the burdens of 'blackness'. *HEC Forum*. https://doi.org/10.1007/s10730-021-09444-w.

Sobowale, K. (2020, April 21). Health care workers are scared, sad, exhausted--and angry. *Scientific American,* April 21. [Online] Available: https://blogs.scientificamerican.com/observations/health-care-workers-are-scared-sad-exhausted-mdash-and-angry/.

Southworth, E., & Gleason, S. H. (2021). COVID 19: A cause for pause in undergraduate medical education and catalyst for innovation. *HEC Forum*. https://doi.org/10.1007/s10730-020-09433-5

Vearrier, L., & Henderson, C. M. (2021). Utilitarian principlism as a framework for crisis healthcare ethics. *HEC Forum*. https://doi.org/10.1007/s10730-020-09431-7

World Health Organization. (2020). Health Topics: Zoonoses. [Online] Available: https://www.who.int/news-room/fact-sheets/detail/zoonoses.