

# The ethical challenges of the SARS-CoV-2 pandemic in the global south and the global north – same and different

The global COVID-19 death toll<sup>1</sup> stands at the time of writing at 163,500. By the time you read this, that number will have increased significantly, and it is likely that we won't have seen the end of it by that time. Policy makers in both the global north as well as the global south rose to the challenge, with decidedly mixed responses as well as decidedly mixed results, as comparisons between reported case loads of, say the UK and Germany or between Brazil and the PR of China, show. Discipline specific responses translated into many global collaborative efforts aimed at developing treatments, modeling of the impact of varying policy options on the continuing pandemic, preventive vaccine trials, and so on and so forth.

Unsurprisingly, as bioethicists we contributed in our own discipline-specific ways. Firstly, we took aim at determining what we considered relevant ethical issues. We focused initially on producing frameworks or guidance documents in various areas, one of the most prominent of which was fairness in triage decision-making.

## 1 | Triage and Inequality

Why did triage come up in the first place? Mostly because we had seen in the PR of China, Italy, Spain, and in New York City that there likely would be a significant shortage of ventilators and ICU beds. Invariably these shortages would occur both in the global north (see Italy, the USA and UK), as well as in the global south (see PR of China). The difference here was one of several magnitudes of higher need. India, for instance, has 2.3 intensive care unit (ICU) beds available per 100,000 people, while Germany has 29.2.<sup>2</sup> In Germany access to ICU beds is provided not on an ability-to-pay basis, but based on clinical need. Brazil has ostensibly 10 ICU beds per 100,000 people. Why 'ostensibly', you ask? Because half of these ICU beds in Brazil exist in private sector hospitals, and they serve a mere 25% of the country's population.<sup>3</sup> Uganda has reportedly only 55 ICU beds

for its 43 million citizens.<sup>4</sup> So, while the ethical question remains the same, and the ethical frameworks available to drive that decision-making remain the same, what complicates matters in a health care system like Brazil's is that patients competing there for the same resource, say, a scarce ventilator, are not in the same boat, as it were, unlike in Germany. In Germany a homeless person admitted to hospital on the same day as a captain of industry would find themselves subjected to the same triage algorithm as the wealthy patient. Their wealth would not feature as a relevant consideration. What this example suggests is that in Brazil at least the impact of the pandemic will disproportionately hit the country's poorest, both because of their living conditions, but also because of how access to scarce ICU beds is limited by having access to private health care facilities with their own supply of ICU beds.

## 2 | Duty to Treat?

A similar picture emerges vis à vis a different question: Do health care professionals have a professional obligation to provide care to COVID-19 patients? This question arose largely because in the two countries with the highest patient case loads at the time, the PR of China and Italy (since then well overtaken by the USA), health care professionals often provided care while having no or sub-optimal personal protective equipment (PPE). As a result of their inability to practice universal precautions, many of these professionals acquired a SARS-CoV-2 infection, and indeed, many of them died of COVID-19. I have argued elsewhere that health care professionals who refused in various countries of the global north to take such risks were not ethically blameworthy.<sup>5</sup> After all, we were warned that this kind of pandemic would occur during our lifetime, and the lack of respirators, gloves and all, was a direct consequence of our refusal to pay taxes sufficiently high to enable our health care systems to protect our health care workers adequately. By electing and re-electing low-tax politicians we accepted that our health care system would not be able to protect its staff in an outbreak like SARS-CoV-2. Arguably then those professionals serving in the global north's health care

<sup>1</sup>FT Visual & Data Journalism Team. Coronavirus tracked: the latest figures as the pandemic spreads. *Financial Times* April 22, 2020. <https://www.ft.com/coronavirus-latest>

<sup>2</sup>McCarthy N. The Countries with the Most Critical Care Beds Per Capita. *Forbes* March 12, 2020. <https://www.forbes.com/sites/niallmccarthy/2020/03/12/the-count-ries-with-the-most-critical-care-beds-per-capita-infographic/#5d0ae11e7f86> [Retrieved April 2, 2020]

<sup>3</sup>Ionova, A. Brazil's health system isn't ready for the coronavirus. *Foreign Policy* April 20, 2020. <https://foreignpolicy.com/2020/04/20/brazil-bolsonaro-icu-beds-health-system-isnt-ready-for-coronavirus/> [Retrieved April 22, 2020]

<sup>4</sup>Goldin, I. (2020). Coronavirus is the biggest disaster for developing nations in our lifetime. *The Guardian* April 21. <https://www.theguardian.com/commentisfree/2020/apr/21/coronavirus-disaster-developing-nations-global-marshall-plan> [Retrieved April 22, 2020]

<sup>5</sup>Schuklenk, U. What health care professionals owe us: why their duty to treat is contingent on protective equipment. *Journal of medical ethics* 2020; 46: [in press]

systems do not owe us care, given society's neglect of their needs in terms of protective equipment. A province in Canada, for instance, proposed in all seriousness that health care professionals could only refuse to provide care if there was certainty that serious harm would be incurred by them otherwise.<sup>6</sup> Of course, there is pretty much no certainty ever in medicine, so this standard was probably quite deliberately designed to maximise the number of health care professionals available even if they were lacking PPE. Given that the purchase of sufficient respirators, gloves, face shields and gowns would not have brought the economies of countries like Italy, Canada or the USA to their knees, such demands on health care professionals are unjustifiable. The British Medical Association, as one of many such doctors' groups, was right to promise to defend any of its members who might get censured, if they refuse to provide care to COVID-19 patients when PPE is inadequate.

While the same question arises in the global south, the ethical analysis is not as easy, unfortunately. In Zimbabwe, for instance, reportedly a hospital shut down because its staff refused to work without protective equipment.<sup>7</sup> The reality is that, globally, many health care workers lost their lives after acquiring SARS-CoV-2 from their patients, so the anxiety expressed by the striking health care workers in Zimbabwe is understandable. However, Zimbabwe is also a country whose economy is broke and has been broken for many years. The purchase of large quantities of PPE may have genuinely been beyond its reach. Now even non-COVID-19 patients may die due to health care workers refusing to provide the professional health care services they promised during their graduation ceremonies to provide. I am less certain about the obligations of health care professionals operating under such conditions. Would what occurred in Zimbabwe be a case of indefensible patient abandonment, especially if the professionals in question did not suffer from health conditions that put them at high risk for death in case of an acquired SARS-CoV-2 infection?

### 3 | Flatten the curve vs economic survival?

Let me give you a third example where the ethical challenges faced in the global north and the global south are the same, yet different answers may be justifiable due to different economic circumstances. At issue is the question of how a country should respond to the challenge of flattening the epidemic curve, as it were, in order to ensure that the health care delivery system is not overwhelmed by patients needing care suddenly, and in very large numbers. While there has been some debate about this in the global north, eventually most countries shut down most non-essential business activity, and asked citizens to stay

home. The predictable harmful consequences of this public health response: a dramatic rise in unemployment, rises in domestic violence cases and deaths resulting from that, increases in depression and anxiety and so on and so forth. The choice here was essentially to balance those harms against the harms incurred in terms of COVID-19 deaths if there had been business as usual. Significantly, by using as the unit of comparison lives preserved and not quality adjusted life years preserved, the justification of the economic shutdown appeared uncontroversial. By virtue of being comparably well-resourced each of those countries spent very significant amounts of money to tie people over, and support businesses as good as they were able to, to ensure there would be businesses to return to after the forced shutdown would come to an end. So, despite significant hardship most people in those countries had a roof over their heads, and food on their table.

Things could have not been more different when countries in the global south copied their own policy response from those playbooks. When India's Prime Minister Narendra Modi and South Africa's President Cyril Ramaphosa introduced similarly draconian shutdown measures the consequences of their policies were much more costly. The stakes are high. The lack of strong health care infrastructure meant that it was important to flatten the epidemic curve quickly and efficiently. However, unlike in the global north, hundreds of millions of people in countries of the global south are day laborers, they work in the informal sectors of the economy, in order to avoid starvation they must work. I recommend to your attention a video produced by *Picturing Health*, people there explain vividly why their real-life choice consists between starving to death during the lockdown, or taking their chances with acquiring SARS-CoV-2.<sup>8</sup> To them it's not even a choice, a coronavirus infection is preferable to starvation. Academics like Johannesburg-based philosopher Alex Broadbent have picked up on this and ask the question whether Western public health responses are appropriate for 'Africa', taking into account these predictable costs.<sup>9</sup> He drew a sharp response from another South African philosopher, Lucy Allais, and her co-author, HIV specialist Francois Venter. They defend the current South African lockdown, while acknowledging that it cannot go on for much longer, precisely due to the cost that Broadbent is noting in his piece.<sup>10</sup> They question whether Broadbent has sufficient evidence to support the empirical assumptions motivating his normative analysis. As I write this the United Nations warns that the world's poor face a devastating-in-scale famine, due to the global economic collapse, where a quarter of a billion people face starvation. The world body's World Food Programme in its report warns that the coronavirus pandemic has doubled the number of people facing acute food

<sup>6</sup>British Columbia Ministry of Health Provincial COVID-19 Task Force. *COVID-19 Ethics Analysis: What is the Ethical Duty of Health Care Workers to Provide Care During COVID-19 Pandemic?* March 28, 2020 [https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/duty\\_to\\_care\\_during\\_covid\\_march\\_28\\_2020.pdf](https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/duty_to_care_during_covid_march_28_2020.pdf) [Retrieved April 3, 2020]

<sup>7</sup>Munhede L. Zimbabwe: COVID-19 – Harare Hospital Closed, Patients Discharged as Doctors, Nurses Down Tools in Demand of Protective Clothing. *AllAfrica* March 27, 2020. <https://allafrica.com/stories/202003270832.html> [Retrieved April 2, 2020]

<sup>8</sup>Picturing Health. (2020). *COVID on the Breadline*. <https://www.picturinghealth.org/covid-on-the-breadline/> [Retrieved April 22, 2020]

<sup>9</sup>Broadbent, A. (2020). Lockdown is wrong for Africa. *Mail&Guardian* April 08. <https://mg.co.za/article/2020-04-08-is-lockdown-wrong-for-africa/> [Retrieved April 22, 2020]

<sup>10</sup>Allais, L, Venter, F. 2020. Lockdown or no lockdown: we face hard choices for complex times. *Mail&Guardian* April 13. <https://mg.co.za/article/2020-04-13-lockdown-or-no-lockdown-we-face-hard-choices-for-complex-times/> [Retrieved April 22, 2020]

insecurity and starvation from 130 million to 265 million.<sup>11</sup> Public health experts will rightly reply that because their policies were so successful, we only see a relatively small number of COVID-19 deaths globally, and yes, they may well be dwarfed by the number of deaths caused by the economic meltdown their policies triggered. However, we also could not know what the death count would have looked like had we not intervened. Quite likely we will never know. Perhaps a team of South African academics has found the holy grail with their proposal on how to end the economically catastrophic lockdown in the country.<sup>12</sup>

Ethics certainly provides us with the tools to think about such difficult policy choices.

Talking about ethics. You may have noticed that the writers reflecting prominently on these issues in academic journals overwhelmingly hail from the global north. They typically give no thought to the issues raised in this Editorial vis à vis the global south. It is disappointing that there are very few voices from the global south participating in this conversation currently.

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<sup>11</sup>Anthem, Paul. Risk of hunger pandemic as COVID-19 set to almost double acute hunger by end of 2020. *World Food Programme Insight* April 16. <https://insight.wfp.org/covid-19-will-almost-double-people-in-acute-hunger-by-end-of-2020-59df0c4a8072> [Retrieved April 22, 2020]

<sup>12</sup>Madi, S, van den Heever, A, Francis, D, Valodia, I, Veller, M, Sachs, M. (2020). South Africa need to end the lockdown: here's a blueprint for its replacement. *The Conversation* April 10. <https://theconversation.com/south-africa-needs-to-end-the-lockdown-heres-a-blueprint-for-its-replacement-136080> [Retrieved April 22, 2020]