

Triaging ethical issues in the coronavirus pandemic: how to prioritize bioethics research during public health emergencies

David Shaw^{1,2} 

¹Department of Health, Ethics and Society, Care and Public Health Research Institute, Maastricht University, Maastricht, The Netherlands

²Institute for Biomedical Ethics, University of Basel, Basel, Switzerland

Correspondence

David Shaw, Department of Health, Ethics and Society, Maastricht University, Postbus 616, 6200 MD Maastricht, The Netherlands
Email: d.shaw@maastrichtuniversity.nl

Abstract

Much of the ethical discourse concerning the coronavirus pandemic has focused on the allocation of scarce resources, be it potentially beneficial new treatments, ventilators, intensive care beds, or oxygen. Somewhat ironically, the more important ethical issues may lie elsewhere, just as the more important medical issues do not concern intensive care or treatment for COVID-19 patients, but rather the diversion towards these modes of care at the expense of non-Covid patients and treatment. In this article I explore how ethicists can and should prioritize which ethical issues to deal with, and develop a method of triage for identification and prioritization of ethical issues both in the next public health emergency and in bioethics more widely.

KEYWORDS

conflicts of interest, coronavirus, prioritization, research ethics, triage

1 | INTRODUCTION

Many ethicists wrote articles about Ebola when the virus became a hot topic several years ago. The emergence of a deadly disease with no effective treatment in a resource constrained setting raised many ethical issues, but the one that garnered most attention was the conflict between conducting randomized controlled trials (RCTs) to generate reliable evidence about potential treatments, and the need to help patients who were in dire need of aid. There was a series of articles¹ and letters on this topic in *The Lancet*,² the WHO organized a

special conference on the ethics of RCTs in this context,³ and a related debate arose around who should be prioritized for any promising effective treatments among patients, local healthcare workers, foreign healthcare workers and carers.⁴

While RCT ethics and rationing scarce resources (and the interaction between these two issues) seemed like the most important ethical issues at the time, ethicists were criticized for neglecting other, potentially more important issues. In an editorial in the *British Medical Journal*, Christian Gericke excoriated ethicists for their failure:

The current epidemic of Ebola virus disease has attracted medical ethics commentators like bees to a honey pot. No previous infectious disease epidemic

¹Rid, A., & Emanuel, E. (2014). Ethical considerations of experimental interventions in the Ebola outbreak. *The Lancet*, 384(9957), 1896–1899. [https://doi.org/10.1016/S0140-6736\(14\)61315-5](https://doi.org/10.1016/S0140-6736(14)61315-5)

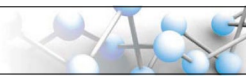
²Shaw, D. (2014). Randomisation is essential in Ebola drug trials. *The Lancet*, 384(9955), 1667. [https://doi.org/10.1016/S0140-6736\(14\)61735-9](https://doi.org/10.1016/S0140-6736(14)61735-9); Adebamowo, C., Bah-Sow, O., Binka, F., Bruzzone, R., Caplan, A., Delfraissy, J.-F., Heymann, D., Horby, P., Kaleebu, P., Muyembe Tamfum, J.-J., Olliaro, P., Piot, P., Tejan-Cole, A., Tomori, O., Toure, A., Torreele, E., & Whitehead, J. (2014). Randomised controlled trials for Ebola: Practical and ethical issues. *The Lancet*, 384(9952), 1423–1424. [https://doi.org/10.1016/S0140-6736\(14\)61734-7](https://doi.org/10.1016/S0140-6736(14)61734-7)

³World Health Organisation. (n.d.). Ebola R&D summit to develop R&D plan of action for next global health emergency. https://www.who.int/medicines/ebola-treatment/ebola_r_d_summit/en/

⁴Satalkar, P., Elger, B., & Shaw, D. (2015). Prioritising healthcare workers for Ebola treatment: Treating those at greatest risk to confer greatest benefit. *Developing World Bioethics*, 15, 59–67.

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has elicited such a flurry of articles on the ethical challenges associated with infection control and treatment in such a short time.... commentators argued about whether randomised trials were required in the heat of the epidemic, the level of personal risk that might be acceptable for recipients, who should receive these drugs, how to ensure informed consent, and whether health professionals should get preferential treatment, among other things. The inappropriate focus on experimental treatments for individuals diverted attention away from infection control and other measures that would benefit everyone.⁵

Though this is accurate in its description of the focus of discourse, it is also a little unfair to ethicists. In many cases they were approached by doctors and epidemiologists and asked about these issues; in others, ethicists simply joined in because they found the issues interesting. It is true, though, that some ethicists simply reacted to the agenda as set by doctors, and did neglect the more important capacity building and infrastructure issues.⁶ However, (some) ethicists do suffer from a conflict of interest to some extent; it is easier to get published (and get publicity) if you are writing about the issues that are (rightly or wrongly) perceived to be important by policymakers and healthcare professionals. Partially because of this conflict, many ethicists go where the issues that are perceived as important are, rather than writing about neglected issues or directing people towards considering these issues instead. Unfortunately, history appears to be repeating itself in many ethicists' approach to COVID-19 despite such warnings. There has been an overwhelming focus on one predominant ethical issue, specifically the constraints imposed upon intensive care resources given the anticipated number of infected patients.

2 | PRIORITIZATION OF RESPONSE, PATIENTS AND ETHICAL ISSUES DURING THE PANDEMIC

The COVID-19 pandemic has generated vast amounts of ethical commentary and research. The main difference between the Ebola epidemic and the COVID-19 pandemic is evident from the terms used alongside the disease names; while Ebola was confined to some regions in a few countries in Africa, COVID-19 has spread around the globe and poses a threat to almost everyone. Perhaps unsurprisingly, given its global reach and effect on everyone's lives around the world, COVID-19 has also received much more media and ethics attention than Ebola ever did.

And just as ethicists focused on one issue during the Ebola epidemic, we see evidence of that again with COVID-19. The ethics has followed the medicine, and the medicine has been focused—rightly, to some extent—on making sure there is enough ICU capacity to handle the predicted upsurge in patients who need it because of the virus. This focus is understandable inasmuch as it was widely predicted that many countries would not have sufficient intensive care capacity to treat the anticipated number of patients with complications of COVID-19, and thus that the mortality rate would be extremely high; in the UK it was estimated that as many as half a million people could die without lockdown if intensive care capacity was not increased.

However, ensuring that there is sufficient ICU capacity is not in itself an interesting ethical issue (questions can be asked about why ICU capacity in a given country was so low to begin with, or why it took so long to ramp it up) so ethicists have instead focused in on those rare (and in many cases hypothetical) circumstances where there is not enough capacity and resources are scarce, or (as with Ebola) the ethics of developing new treatments. To take just one example, in the month preceding June 19, 2020, the *Journal of Medical Ethics* published 19 papers on COVID-19, nine of which concerned either triage or the ethics of vaccine development.

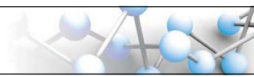
This focus on two narrow topics diverts ethical attention from other important issues, and is also unfortunate because the questions being asked in most of the ethics papers about COVID-19—concerning who should get priority for treatment—could have, and to some extent had, been answered long before the outbreak began. Thus we have dozens of ethicists writing articles (for example) and hundreds of countries developing ethics frameworks in parallel to answer questions that may not need to be answered during this outbreak. Furthermore, by spending time and putting their name to a topic, ethicists endorse the importance of it relative to other ethical topics, increasing the likelihood of focus upon it.

Ethicists will claim that they did not invent these issues; they were approached by doctors for help and they are simply responding to need. That is a reasonable response to some extent, and it is one that I myself made in response to critiques of ethicists' responses to the Ebola epidemic (see above). But if they are asked to make a contribution to the response to a public health emergency, ethicists also have a duty to take a wider view, and question not only whether the medical response is the right one, but also whether their contribution might also be focused on the wrong target. Ethicists have great expertise in identifying ethical issues that may go unperceived by others, and failure to use this expertise is regrettable. Just as doctors and public health experts may have overfocused on the potential costs of COVID-19 at the expense of non-Covid patients, ethicists have instead followed that rush towards what was perceived as the most pressing ethical issue, even though other more important ethical issues exist—perhaps because those issues are more morally distant.

Why should ethicists trust healthcare and public health professionals' prioritisation of the most pressing ethical issues? It is ethicists' job to identify and write about the most important ethical

⁵Gericke, C. (2015). Ebola and ethics: Autopsy of a failure. *British Medical Journal*, 350, h2105.

⁶Dawson, A. J. (2015). Ebola: What it tells us about medical ethics. *Journal of Medical Ethics*, 41, 107–110.



issues. The paucity of papers on other important topics may be partially related to ethicists' attention being on the predominant issues of resource allocation and vaccine development. Many ethicists would deny that ethics is a 'service industry', but if ethicists are responding to expressions of need from those working in medicine or science, and providing their services in response, it seems reasonable to argue that they ought to ensure that their services are actually doing some good by addressing important ethical issues rather than interesting yet practically irrelevant cases. (Equally, of course, most ethicists did not rush out papers on COVID-19, and may never write papers on that topic; others may have written on the topic but did so at the usual pace. This paper's topic concerns those who did rush out work that did not contribute much practical value to the debate.)

Only a few ethicists pointed out the potential costs of overprioritization on COVID-19 early on in the pandemic.⁷ Much of the early discussion of how to deal with the pandemic neglected several important contextual features; these included the excess deaths from other causes than COVID-19 because of suspension of some medical services such as screening, and increased mortality and morbidity from the effects of lockdown. The cumulative mortality from these 'missed' patients and potential patients may well outweigh the already massive cost of COVID-19 in terms of years of life lost. Lots of people died every day before coronavirus, and that number will increase because of the pandemic. The impact of emptying ICU in anticipation of a surge of COVID-19 patients that never materialized will take years to quantify fully—and that is without even considering patients who will die sooner because of suspended cancer screening, and in some cases treatment programmes. Another neglected issue was the sheer number not just of lives lost, but of *years* of life lost by each coronavirus fatality and the earlier deaths of non-Covid patients.⁸

Doctors have a duty to treat the patient most in need, not the most interesting patient. Similarly, ethicists who want to make a contribution during a public health emergency have a duty to treat the most important ethical issues, not the most theoretically interesting ethical issues. This is not to say that ethicists should focus on potentially ethically uninteresting topics such as health system preparedness (which was very important to both Ebola and COVID-19, but may not be so rich in terms of ethical content)—but to highlight complex yet neglected ethical issues such as the implications for non-Covid patients. Indeed, ethicists have a duty to focus not on what the media or medical narrative says are the most important ethical issues, but on what *they* think the most important issues are. If ethicists simply follow the herd and write yet another paper on triaging intensive care patients, they increase the likelihood that important ethical issues connected to Covid will be neglected by adding yet more momentum to an already oversaturated topic. Thus, as well as

having a (weak) obligation to try to identify the most important issues, ethicists also have an obligation to avoid potentially wasting their time and diverting yet more attention from more pressing issues. (It is possible to write about neglected ethical issues while also critiquing the focus on one or two diversionary issues; for example, intensive care colleagues and I wrote a paper about the apparent belief that ICUs switch from normal operations directly to emergency care during a pandemic, rather than progressing through different levels; not only is this an important practical point, it also illustrates how jumping straight to considering the ethics of worst-case resource constraint situations can actually worsen things both clinically and ethically.⁹)

3 | TRIAGING ETHICAL ISSUES: A ROUGH GUIDE

If ethicists are to triage ethical issues, how are we to decide which issues are most important? In the context of contributions during a pandemic, priority should be given to the potential benefit of ethics research on a given topic; this benefit will be a function of issues that are neglected and/or urgent and/or complex. These criteria are closely interrelated. Let us look at each of these in turn, in the context of a new pandemic or potentially a different type of public health emergency. (Note that I am not claiming that ethicists *always* have a duty to choose their research priorities in this way; only that they have a weak duty to do so if trying to make a time-sensitive contribution to a public health emergency response.)

Even if the ethics of utilitarian dilemmas in resource allocation might seem more interesting, the added value of a 20th (or indeed 50th) paper on the same topic is marginal compared to the first paper on, for example, the increased mortality among those waiting for an organ due to transplantation coming almost entirely to a halt. The former issue has been covered almost to the point of saturation, while the latter has not been addressed at all. In this sense, the potential benefit of ethics research is a function of its novelty, and novelty in turn depends on being the first to respond to an urgent need. The perceived novelty of the ethical issues raised by the potential ventilator shortage, combined with the perceived need for guidance among healthcare professionals, resulted in the deluge of papers on this topic. But the actual ethical issues involved in allocation of scarce resources were not new;¹⁰ they had been analysed for years in hundreds of papers, and the lessons learned were just reapplied to the new pandemic situation. There was a novel perceived need for ethics input, but the novel ethical issues actually lay elsewhere.

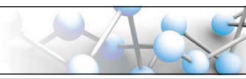
Instead of going where the dominant medical narrative leads, ethicists should consider which areas of medicine are being

⁷Shaw, D. (2020, April 2). The vital context of coronavirus. *Journal of Medical Ethics Blog*. <https://blogs.bmj.com/medical-ethics/2020/04/02/the-vital-contexts-of-coronavirus/>

⁸Shaw, D. (2020, May 28). Coronavirus and lost life: Three million years. *Journal of Medical Ethics Blog*. <https://blogs.bmj.com/medical-ethics/2020/05/28/coronavirus-s-and-lost-life-three-million-years/>

⁹Harvey, D., Gardiner, D., McGee, A., DeBeer, T., & Shaw, D. (in press). CRITCON-Pandemic Levels: A stepwise ethical approach to clinician responsibility. *Journal of the Intensive Care Society*, in press. <https://doi.org/10.1177/1751143720950542>

¹⁰Mannelli, C. (2020). Whose life to save? Scarce resources allocation in the COVID-19 outbreak. *Journal of Medical Ethics*, 46, 364–366.



neglected, and which ethical issues this raises. For example, instead of focusing on hypothetical dilemmas that would never arise in practice on the ICU, the focus could instead be on the potential consequences of the rush to empty the ICU in order to ensure capacity for Covid patients, including missed opportunities for organ donation and the increased mortality and morbidity among non-Covid patients denied access to the ICU. (Indeed, the focus on extreme ICU situations by some ethicists and doctors may even have contributed to the drive to empty ICUs to avoid such scenarios. This mistake was not repeated during the second wave of the pandemic.) Other important neglected topics include the cost of lockdown¹¹ in terms of domestic violence and psychological harm, and issues affecting various neglected patient populations, particularly BAME patients and those from socioeconomically disadvantaged backgrounds, who were particularly affected by the pandemic.

Urgency is also important: the perceived need for rapid responses to the problem of ICU resource shortages was what gave momentum to all the ethical responses. Indeed, this urgency probably contributed to the lack of attention paid to issues such as the side effects for non-Covid patients of emptying ICUs. Even if someone had written an article drawing attention to the potential use of ICU for opportunistic transplantation, it would have to have been done very quickly in order for anyone to take advantage of it. But even if this urgent window was missed, it remains important to highlight such neglected issues for the next emergency situation so that mistakes are not repeated—and hopefully many ethicists are writing or have submitted many such papers.

Another issue affecting ethicists' ability to respond urgently was the lack of empirical evidence regarding the effects of repurposing the healthcare system to respond to COVID-19. These issues are extremely complex, and the more complex they are, the more evidence is needed. This presents a paradox in terms of trying to deal with an urgent need; the more urgent the need, the less evidence will be available to meet it. However, ethicists can also assess the ethical complexity of a topic; the more complex it is, the greater the benefit of analysing it is likely to be (and the more interesting the resulting papers will be, though that should not be the main focus).

Ultimately, the potential benefit of a paper is a function of the urgency of the issue, which in turn depends on how neglected the topic is, the potential impact of its ongoing neglect, and the complexity of the issue at hand, both in terms of the ethics and of the available empirical evidence. Triageing ethical issues involves considering all these issues, and may actually be a lot harder (in terms of complexity if not importance) than deciding who should and should not be admitted to intensive care. Nonetheless, ethicists have a duty to try to triage effectively.

Essentially, triaging in this context involves applying the logic of effective altruism to ethical issues rather than charitable causes. If

BOX 1 how to triage ethical issues

- Survey the ethical landscape and identify the different ethical issues.
- Consider which issues are most urgent, neglected and ethically complex (These factors are interrelated.)
- 'Treat' the issue that is in greatest need.

benefit is a function of neglect, complexity and urgency, we can picture a system something like this. Let's imagine that, near the start of the pandemic, an ethicist is trying to decide whether to write a paper about ethical criteria for getting a ventilator, or the public health effects of suspending cancer screening services. For neglect, ethics on the ICU is low-priority—lots of other ethicists have already published on it. This in turn means that there is less urgency, unless a particularly novel contribution could be made. In terms of complexity, it scores quite highly, but that complexity has already been largely addressed. Now let's look at the cancer topic. It's certainly neglected, with hardly any articles on that topic. It's highly complex, so well worth looking at. And it might not seem urgent given the public health emergency, but it might well be urgent, if thousands of patients are failing to have cancer diagnosed as a result. On balance, the ethicist who wants to make a relevant contribution during this emergency should focus on the cancer topic. This is just a simple example (and we could quibble about the relevant criteria), but it does illustrate that it's at least possible to think about triaging ethical issues systematically. Box 1 summarizes this approach to triaging ethical issues.

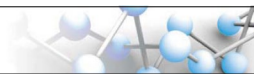
4 | OBJECTIONS

One objection might be that it is easy to triage retrospectively. The costs of focusing on Covid patients are now much more apparent than they were initially, and it is all too easy to second-guess ethicists' and doctors' actions after the fact. This is true, but a few ethicists were raising these points early in the pandemic, and their voices might have been more audible if not for the rush to focus on certain topics. In any case, looking back can identify lessons for the next pandemic.

A related, but separate objection is that measures had to be taken to stop COVID-19 or the death toll could have been much higher; it is obviously bad if non-Covid patients have suffered, but they might well have become Covid patients were it not for the focus on controlling the spread of the infection. This claim is true to some extent in terms of the public health and medical response, but it does not work as a defence for ethicists. It is (part of) our job to question the priorities of the healthcare system, and that job could be done better next time.

It also might be objected that guidelines are just that—guidelines. Ethicists can write about whatever they want without recourse to

¹¹Shaw, D. (2020, May 13). The many meanings of "stay safe" in a pandemic: Sympathy, duty, and threat. *Journal of Medical Ethics Blog*. <https://blogs.bmj.com/medical-ethics/2020/05/13/the-many-meanings-of-stay-safe-in-a-pandemic-sympathy-duty-and-threat/>



the triage criteria I have suggested, and have no duty to write about COVID-19 at all. This is of course true: the rules suggested here are intended only as suggestions, and good ethicists will know reflectively, if not intuitively, what they should write about; the triage system suggested here may help them to do so. But if ethicists do feel that they have something to contribute to a pandemic or other public emergency response, and do so, they generate at least a weak duty to ensure that their work will actually help—and it is more likely to help if triaging takes place first.

Finally, another objection is that ethicists simply can't set the agenda in this way—it might be nice for them to be able to dictate policy and response, but they can't. That may be true to a varying extent in different countries, but they nonetheless have a duty to try. As stated above, if encouraged to provide ethics expertise, ethicists have at least some influence on the agenda. Of course, it may not be necessary to write a peer-reviewed article in order to influence policy—many ethicists have written blogs during the pandemic that may have had some impact (and in any case there is increasing distrust of peer review during the pandemic¹²—again due to rushed research rather than careful scientific endeavour).

5 | CONCLUSION

C. S. Lewis provides a useful case study of triage ethics in *The Lion, the Witch and the Wardrobe*, where Lucy is trying to revive her wounded brother.

'There are other people wounded' said Aslan while she was still looking eagerly into Edmund's pale face and wondering if the cordial would have any result.

'Yes, I know,' said Lucy crossly. 'Wait a minute.'

'Daughter of Eve,' said Aslan in a graver voice, 'others also are at the point of death. Must more people die for Edmund?'

'I'm sorry, Aslan' said Lucy, getting up and going with him. And for the next half hour they were busy.¹³

Too many ethicists (and medics) have been like Lucy, focusing on the most interesting cases rather than those most in need—and also drawing the attention of others away from more pressing cases. The higher the perceived importance of an ethical issue, the more likely an ethicist (or doctor) will get a high profile publication or media coverage; this constitutes a major conflict of interest, just as Lucy's personal involvement with her first patient threatens to remove care

from others who are more in need. It is of course understandable that she should want to see whether her brother will recover, but Aslan gave her the cordial to do good in general, not just for her brother—Edmund didn't need Lucy to linger, and he certainly didn't need four people attending him when they could have been treating those more in need. (Edmund can also be seen as representing COVID-19 patients, while the others on the battlefield represent neglected non-Covid patients.)

This article has illustrated the importance of triaging ethical issues during a pandemic or other public health emergency. Like healthcare professionals, ethicists have a duty to go where need is greatest, and to avoid doing harm in their work. But ethicists should also consider applying these principles to their work more generally, as the conflict between 'sexy' ethics and what is actually most useful is one that we all had to wrestle with long before the latest zoonosis. Philosophers, too, might want to consider if their work is doing the greatest good that it could, and triage the issues that they want to analyse.

CONFLICT OF INTEREST

The author is an ethicist who always tries to triage and has blogged on this topic.

ORCID

David Shaw  <https://orcid.org/0000-0001-8180-6927>

AUTHOR BIOGRAPHY

DAVID SHAW is Assistant Professor of Health Ethics and Law at the Care and Public Health Research Institute at Maastricht University and Senior Research Fellow at the Institute for Biomedical Ethics at the University of Basel. He graduated with an MA in Philosophy and English Literature from the University of Glasgow in 1999, and an MSc in Philosophy from the University of Edinburgh in 2001. He obtained his PhD at the University of Lausanne in 2005 and went on to work in the philosophy department at the University of St Andrews and the medical school at the University of Glasgow. In 2011 he obtained a Masters in Medical Law. He is interested in all areas of bioethics, but particularly research ethics and shared decision making.

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¹²Rabin, R. C. (2020, June 14). The pandemic claims new victims: Prestigious medical journals. *The New York Times*. <https://www.nytimes.com/2020/06/14/health/virus-journals.html>

¹³Lewis, C. S. (2009). *The lion, the witch and the wardrobe*. HarperCollins, Chapter 17 (Originally published 1950).