



COVID-19 current controversies

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This July 2020 issue of JME introduces a new section, “COVID-19 Current Controversies,” which will be a recurring section in each issue for the foreseeable future. This issue reflects on some of the most pressing ethical issues that have arisen roughly 6 months into the pandemic.

Kathleen Liddell and colleagues examine important legal considerations at play in ventilator allocation decisions raised by the pandemic.¹ They point out that ethics-based triage protocols that argue from the principle of “saving the most lives” by withholding or withdrawing ventilators from certain patients could violate the law (U.K. and elsewhere). Patients’ legal rights are not suspended during this crisis, they remind us. The mere action of ventilator removal (extubation and proning) may constitute battery without consent, for example. Moreover, there may be problems with “evidentiary weakness” in some of the prognostic models used to inform such decisions. And, decisions that are inconsistent, subjective, and/or discriminatory may be deemed illegal. Those developing policies need to consider and consult various areas of law including criminal law (eg, murder, battery, negligence, manslaughter), human rights law, civil law (eg, battery, negligence, duty of care, consent), public and administrative law (eg, discrimination, case law), law on decision-making for incapacitated adults, professional regulations, and derogations from current law (eg, immunities and indemnities). Liddell *et al* offer 10 concrete, legally informed recommendations for those developing triage-policies to consider.

Michael Parker and colleagues take on the issue of contact tracing using mobile apps and point out that such apps can enable people to emerge more safely from lockdowns, which provides a strong autonomy-based argument in favour of them even if they were to constitute a privacy infringement.² They argue that the use of such apps should be voluntary rather than compulsory and note that, combined with other measures, these apps can still make an important impact even if uptake is below 50%. They point out, however, that there are good reasons to think uptake would be higher given the promise for potential personal benefits. Finally, they advise that oversight bodies

ought to be established and that data ought to be deleted post-pandemic.

Udo Schuklenk also reflects on what healthcare professionals owe “us” during the pandemic and explains why their duty to treat is contingent on proper personal protective equipment (which many governments have deliberately failed to provide).³ Schuklenk draws an analogy to widely accepted “duty to treat” arguments during the early days of HIV and points out that they were predicated on assumptions of proper protective equipment and universal precautions training.

Michael Dunn and colleagues examine duty to provide care as well in their piece on the ethics of allocating staff to high-risk clinical roles.⁴ Dunn *et al* emphasise process-based considerations (eg, size of workforce, specificity and acuity of patient needs) to inform this question as well as examine various theoretical models including a voluntary one, lottery, and equal assignment of risk (eg, rotation of high-risk work). Dunn *et al* argue that whatever model is adopted, high-risk workers are owed acknowledgement (eg, professional, financial), sufficient preparation and training, and possibly priority for resources if they become sick.

Amy Solnica and colleagues offer a Jewish ethical perspective on the issue of the risks to healthcare workers. Solnica and colleagues conclude that Jewish law and professional responsibilities obligate physicians to care for all patients, including those with COVID, but that society owes workers care and risk-minimization efforts.⁵

Solnica and colleagues argue that various strains of Jewish thinking are consistent with a utilitarian approach to triage (maximising potential life-saving), but there is disagreement about how to handle cases where it is impossible to triage based solely on utilitarian considerations.⁶ Some would say that humans must remove themselves (eg, allow matter to chance with a lottery) and others would say humans can have a voice and a role in these decisions. However, all agree that once treatment with life-saving equipment has been initiated, it should not be removed to treat another patient.

Jordan Parsons and Harleen Kaur Johal ask whether COVID might cloud decision making for the cognitively impaired.⁷

They raise various concerns, including that capacity assessments and decision making regarding incapacitated patients’ “best interests” might be compromised due to stressed and rushed situations, short staffing and junior staff with less training, virtual interactions, and factors that make communication difficult such as the presence of personal protective equipment and ventilators. They also warn that decision makers for patients with a cognitive impairment ought to be especially conscious of any resource allocation influences during the pandemic.

Two articles in this issue ask what lessons countries can learn from each other. Vera Lucia Raposo examines China’s standard of care for COVID-19 (eg, mass and intense lockdown, high-tech tracking of movement) and whether it can or should be implemented in Europe.⁸ In short, the answer is “no” because of the legal and regulatory framework of the European Union (EU) as a whole. Additional reasons include technological limitations and differing views on human rights. Benjamin Herreros and colleagues consider triage policies during the COVID-19 epidemic in Spain and their “better and worse” ethical arguments.⁹ They point out that “controversial, non-clinical criteria have also been defended by Spanish scientific societies and public institutions, including setting an age cut-off value for unilaterally withholding ALS, using ‘social utility’ criteria, prioritising healthcare professionals or using ‘first come, first served’ policies.” They contrast this with accepted triage protocols in organ transplantation and argue that the above-mentioned considerations are “bad criteria”. This paper is a great review and resource as well as a window into the early days of the pandemic in Spain and how ethicists responded.

Finally, two articles take up issues in COVID paediatric ethics and COVID research ethics respectively. Emily Barsky and Sadath Sayeed raise the COVID and non-COVID issue of parental manual (temporary, hand-bagged) ventilation in resource-limited settings and develop an algorithmic approach to ethically permissible parental participation.¹⁰ Joshua Teperowski Monrad examines ethical considerations for pandemic vaccine trials.¹¹ Specifically, the ethics of

“secondary vaccine trials”—whether and how it is ethical to continue to test novel vaccines in the midst of a pandemic once one has been found to be safe and effective. There are good reasons to think it is not ethical, including that it involves withholding a beneficial intervention and that it might worsen control of the pandemic. That having been said, there *may* be situations where secondary vaccine trials during a pandemic are permissible. These include whether the initial vaccine only offers immunity to some populations but not others (though this depends on percentages—consider effective for 98% vs 75%), the length of immunity offered by the initial vaccine (eg, lifetime vs short), likelihood of reduced adverse immunological responses and symptoms by the secondary vaccine, and production/administration considerations (eg, not requiring cold storage) as well as economic ones. The issue of secondary vaccine research will be a pressing issue in the months to come (hopefully), and Monrad stresses that his is not a finalised account.

Outside of the COVID realm, this issue also contains an original research article

on the limits of trust in medical AI. Joshua James Hatherley argues that there is merit to concerns about the effects of AI technology on relationships of trust in clinical practice given that by their nature, AI systems are capable of reliability but not trustworthiness.¹²

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