In the aftermath of the 2004 Indian Ocean tsunami, Matthew Wynia aided relief efforts on an off-coast hospital ship, where it quickly became clear there weren't enough resources to help everyone who needed it. “There were hundreds of thousands of people who needed help of various forms,” he says. “And how do you decide who gets to come out to the ship?”

It’s a question that led Wynia into the field of bioethics, which considers the moral aspects of decision-making around human health and well-being. It can be applied broadly — considering environmental justice or going beyond human biology — or minutely — discussing molecular biology on the level of lab practices around human genetics. Since the 1990s, the most common expression has been hospital ethical committees, which guide institutions in the event of ethical dilemmas, such as who receives an organ transplant first, or how a doctor responds when a patient or their family disagrees with their recommendations. Bioethics also comes into play during disasters, events like the Haitian earthquake, which posed, “a bunch of really big ethical issues about who gets access to the limited resources available,” Wynia says.

It’s similar to what we’re seeing now, as the coronavirus pandemic marches on, overwhelming hospitals and health-care providers more than a year after the first case of COVID-19 was reported in the U.S. Since then, 400,000 Americans have succumbed to it. Bioethics has largely informed pandemic policy, everything from state guidelines for prioritizing care, to treatment and vaccine access, to public health measures like restricting individual liberty for the sake of the larger community.

As the director of the Center for Bioethics and Humanities at the University of Colorado, we recently spoke with Wynia about his work, how we should be thinking about pandemic response and where we go from here.

The interview has been edited for length and clarity.

Boulder Weekly: I remember at the beginning of the pandemic, back in March, being just shocked reading how Italian doctors were prioritizing treating younger patients over the elderly due to lack of resources. Then similar questions faced New York hospitals in the spring and now we’re seeing the same issues play out in California as people sit in ambulances outside of hospitals waiting for a bed. How do institutions decide how to prioritize care?

Matthew Wynia: This is an extension of something that happens all the time in hospitals and emergency departments. If a bunch of people show up at the emergency department, some of them are going to wait and it’s up to the emergency department staff to make decisions about who needs to be seen first. And the general criteria are who needs to be seen most urgently and who can wait a little while, but the aim there is that everyone eventually gets optimal levels of care. In a disaster circumstance, the numbers of people needing specific services might so overwhelm the availability of that resource that there might be people who never get access to it.

With crisis triage, you are acknowledging the fact that some people are going to die because they cannot get necessary services because we just don’t have enough. Although it’s a continuation of that same kind of decision, it feels quite different to say, you know what? We just don’t have enough ventilators. And we’re going to have to pick who gets to go onto the ventilator and those other people who don’t get to go on the ventilator. Of course we’ll do our best to keep them alive, but we anticipate that they will die.

BW: What are the factors that go into making that decision?

MW: First, you want to direct resources to people who will survive if they get the resources and who are going to die otherwise. So, if you have someone who might be able to survive, even if they don’t get the resources, then that person can go lower on the list. And similarly, if you have...
someone that you anticipate is going to
die, no matter what you do, that
person also should go lower on the
list. So that’s what we call efficiency
argument: You’re trying to use your
resources to save the most lives.
And efficiency is very important
when you’re doing triage, but it’s not
the only thing that we take into
account. We also take into account
equity, making sure that there are
resources available for the communities
that are hardest hit by the virus. We
also take into account long-term social
cohesion and our ability to live with
each other in the wake of the disaster.
You don’t want to make decisions dur-
ing a disaster which will alienate some
group [so much] that community cohe-
sion is destroyed because of these diffi-
cult decisions that had to be made.
So, for example, you might put
resources into palliative care and hos-
pice care during a pandemic that you
could have put into saving individual
patient’s lives. If you were being a cold
utilitarian, you would say, why put
anything into hospice and palliative
care, those people are going to die
anyways. We don’t take that view, and
the reason for that is because we think
end-of-life care and being respectful of
people and trying to provide them
comfort in their dying moments is
really important to our society, to our
community.
Those are three big ones, but there
are other things that come into play.
BW: Colorado is one of about a dozen
states that has implemented crisis of care
guidelines, but most states haven’t. You told
Jordan Kimer in the Atlantic that around
the country governors are reluctant to issue
crisis of care because it “would mean admit-
ting that we are not able to provide top-
quality medical care in the United States of
America in 2020.” Can you talk a little bit
about accountability and responsibility
come into this discussion in terms of who’s
making the decisions?
MW: I will say I’m not entirely
opposed to some of the changes that
the governor has made. And I think
they’re being made in relatively good
faith. I think the problem comes when
you start talking about, well, who
deserves the vaccine separate from
who’s most likely to get sick, who’s
most likely to die, and who’s most like-
ly to transmit this to a whole bunch of
other people.
If you’re trying to save as many
people as possible and prevent trans-
mission and bring this pandemic to a
close as quickly as possible, if you then
say, yeah, but we don’t like people in
prison, they’re bad people, they don’t
deserve protection, well that’s going to
prolong our pandemic because the
majority of our big outbreaks in the
state have started in prisons. In the
city of Chicago, back in the summer,
they estimated that 15% of all the
cases in the entire city of Chicago
could be traced back to the Cook
County Jail.
So, if we think that we can further
punish people by not treating them
the same as we treat everyone else
because they’re in prison, that is going
to backfire on us because prisons are a
very high-risk environment. And peo-
ple come in and out of prisons and
jails: more than 90% of people in pris-
on and jail are going to be released.
Plus, the staff come in and out every
day, so they’re particularly high risk for
the rest of us.
BW: The Pfizer and Moderna vac-
cines were developed in the U.S., so some
ethicists have argued that we should take
care of our own first. But should we share
with those in the international commu-
nity? Places like Brazil, which is second
only to the U.S. in COVID deaths and is
running out of supplemental oxygen as
well?
MW: Honestly, I think we should.
And I say that in part because of the
long-term implications of not sharing
versus sharing. I just think that is very
short-sighted not to share.
And it’s short-sighted because
there will be other big players in the
world who will choose a different
strategy and will end up making a
whole bunch of friends as a result. So,
you are going to see China send vac-
cines to countries around Africa and
around South America, because they
value those long-term relationships.
And they want to be seen as a force
for good in the world. And I think it
would do us well to want to be seen as
a force for good in the world also. We
used to have that reputation, and I
think we should be working hard to
gather that reputation.
In addition to that, it’s the right
thing to do. And sometimes, you do
the right thing, even though it’s hard.
That’s the test of a moral society is that
we continue and are able to do the
right thing, even when it’s a little bit
hard. And it would be hard, it would
be politically hard, it’s hard to send
resources overseas that you could use
here. But we should do more of that.
BW: You were talking earlier about
one of the decision points is asking how do
these ethical decisions affect the greater com-
munity. I was just looking through your
Twitter and you posted about new research
that shows successful pandemic response is
more about how we relate to one another
and our government rather than economic
capacity or scientific capacity. I’m trying to see
if I actually have a question — it just
made me think about that point, that we
have to be considering more than just our-
sets in this.
MW: I hadn’t really put that
together myself until you just said it, but
I think it does come back to those crite-
ria that we have in our state crisis stan-
dards of care guidance, which is we
want to save as many lives as possible
with our limited resources and do so
in a way that will preserve social cohe-
sion and our ability to come together
as a community and heal in the wake
of this disaster. And I think that’s true
for Colorado. It’s also true for the
United States and it’s also true for the
world.
My final point on that is that
social cohesion is an important goal,
but again, it’s not the only goal either.
Because, not to be too exaggerated about
this, but the Nazis had very
good social cohesion. Everyone was on
board, but they had cohered around a
noxious ideology that was fundamen-
tally based on a lie. And so you can
imagine a community that has excel-
lent cohesion built around a lie and
built around values that are not ones
that you would want your children
to grow up under. So, I think we do want
social cohesion, but we also want
social cohesion around shared values
that are really worth sharing. So, it’s
not just about cohesion. It’s about
what does the world look like in the
wake of this pandemic and how do we
get there to that, to the world that we
want to have? How do we create the
world we want to live in, and the kind
of world you want to pass onto your
children?
BW: Do you think the field of bioeth-
cics was prepared for a global pandemic?
As with any good question, the
answer is yes and no. It would be wrong
to say that there have not been people
in bioethics thinking about the ethics of
pandemic response for a very long time.
In one sense, if you look in the literature
of bioethics, the things that we’re deal-
ning with now are things that were very
predictable. No one that had given 20
minutes of thought to this was sur-
prised when we started to see tremen-
dous health disparities in the pandem-
ic’s effects. That’s something we knew
about.
On the other hand, I don’t think
many people thought that we would
do so poorly as a society in coming
together around this pandemic and
around a coherent response. … Our
assumption, I think, was that the
national leadership would come
together around this, like in a war or
after 9/11. What you anticipate when
the whole country is essentially under
attack is that the country comes
together.
This is not just about the pandem-
ic, it goes outside of bioethics and into
social ethics, but this is something
we’re going to be grappling with as a
society for a long time.