NEWS

THE TEST OF A MORAL SOCIETY

BW talks with CU-Anschutz bioethicist Matthew Wynia

BY ANGELA K. EVANS

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 have 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 during a disaster which will alienate some group [so much] that community cohesion is destroyed because of these difficult decisions that had to be made.

So, for example, you might put resources into palliative care and hospice 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 Kisner in the* Atlantic *that around the country governors are reluctant to issue crisis of care because it "would mean admitting 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 how accountability and responsibility comes into this discussion in terms of who's making the decisions?*

MW: There are definitely states that have crisis standards of care guidelines that have been in circumstances where they were completely swamped and overwhelmed, and the governor was never willing to sign off to say, OK, we're swamped and overwhelmed, we need to implement these.

These are very painful, very difficult decisions and so they run downhill and end up in the lap of the last person who can't not make a decision. And that may end up being the doctor at the bedside who has to make a final call. My sense, and I think broadly the sense of people who've thought a lot about this, is that that's not optimal, that you should not have that doctor making those decisions. You should have a team that tries to make those decisions that can have better situational awareness, and that does not have the legal and ethical responsibility to be an individual patient advocate.

BW: *You've also done a lot of work on vaccine rollout, helping Gov. Polis decide who to prioritize with your work on the medical advisory group. And some of these priorities have changed due to public discourse, especially when it comes to those held in prisons and jails, as well as teachers. You recently told the* Washington Post *that viewing the priorities in terms of who deserves to be inoculated "might end up prolonging the pandemic and killing more people." How should we be thinking about vaccine prioritization?*

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 likely to transmit this to a whole bunch of other people.

If you're trying to save as many people as possible and prevent transmission 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 people come in and out of prisons and jails: more than 90% of people in prison 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 vaccines 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 community? 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 vaccines 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 community. 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 power 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 ourselves 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 criteria that we have in our state crisis standards 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 cohesion 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 fundamentally based on a lie. And so you can imagine a community that has excellent 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 bioethics 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 dealing with now are things that were very predictable. No one that had given 20 minutes of thought to this was surprised when we started to see tremendous health disparities in the pandemic'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 pandemic, 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.