Perspectives of conversion: Covid-19 and global bioethics

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Covid-19 and ethics

The Covid-19 pandemic perfectly illustrates what are the typical dimensions of bioethical concerns and debates today: width and breadth. The first refers to the experience that the viral threat is a planetary phenomenon; even when it is emerging locally, it presents a menace globally. Bioethics therefore should have a worldwide scope. The second dimension refers to the understanding that Covid-19 is not just a medical or epidemiological event but a social, psychological, economical, and political crisis, necessitating a bioethical approach that is broad and encompassing, focusing not merely on medical perspectives but also on social and environmental ones. The dominant conception of bioethics has provided a powerful mindset of four principles to enlighten individual conscience and practical decision-making in contemporary healthcare. However, the pandemic experience is generating mutations in this conception.

Covid-19 has caused a flood of ethics publications (2,521 in 2020, and 1,691 in 2021 until July). Many of these studies proceed from the dominant bioethics framework and analyze specific concerns such as disease management, individual treatment, and protocols for triage and vaccine prioritization. At the same time, it becomes clear that relevant issues such as vulnerability, human dignity, inequity, cooperation and solidarity are insufficiently addressed and that another way of thinking and working is necessary to clarify the ethical dimensions of present-day life in emergency conditions. These conditions have the tendency to structure and format ethical considerations in a specific and narrow way relegating relevant issues to a lower level of urgency and interest.

Covid-19 clarifies how a wider and broader bioethical approach is inevitable since it highlights the basic relationality of human beings. This is not just the anthropological experience that human beings are connected to other beings and the environing world but also the philosophical realization that being human means being-together. From the perspective of global bioethics, at least three lessons can be learned from the pandemic experience: protect the vulnerable, remediate inequalities, and practice solidarity.

The pandemic experience

One reason why the phenomenon of the pandemic reactivates the notion of global bioethics is related to the characteristics of the pandemic experience. For many people, especially in high-income countries, globalization has been a rather abstract and external process resulting in useful and less expensive products such as smart phones, computers, and clothes, ordered online through Amazon, Google and Apple as well as the ability to travel and have holidays everywhere on the globe. The threat of Covid-19 has lifted global phenomena out of beneficial abstractness. Globalization now has become an internal experience, impacting human life itself, regardless where you live. It becomes a source of tension between countries and regions, and an impediment to public health measures, manifesting dependencies and inequalities. The pandemic experience thus highlights *connectedness* as a basic feature of globalization. One dimension of global bioethics is its worldwide or planetary scope, illustrated by the image of Earth on the cover of Potter's first book on bioethics [1]. The planet is visualized as a lonely globe in outer space, articulating the experience that it is the fragile common home of human beings within the universe. This image, powerful as it is, posits the Earth as an external object. It does not provoke the sense that it is in fact the habitat of human beings so that our relationship to 'environing' conditions is internal rather to external; we cannot disengage ourselves from our habitat; our lifeworld cannot be disconnected from the planet. The image of 'globe' risks therefore to separate humans from the context within which they dwell. A more appropriate metaphor to express the characteristic of connectedness is 'sphere' [2]. Using this metaphor evokes interconnectedness, relatedness, and interdependency. This is also expressed in notions such as 'atmosphere,' 'biosphere,' 'ecosphere,' and 'virosphere.' The planet is not just the dwelling location but the world within which humans live, in which they feel at home. For human beings, as embedded in spheres, the environment is not an external setting but part of their lifeworld. The notion of sphere presents the world as lived experience, perceived and understood from within. The human world begins in the local rather than the global because the spherical view accentuates embeddedness,

and thus locality. Globalization therefore is not an external process that impacts our common globe; it concerns the human world, the *mundus*, expanding the life world through global interaction and cultural diffusion. This is why *mundalization* is proposed as a better term for global processes [3].

The second characteristic of the pandemic experience is *differential vulnerability*. In principle, all humans can be infected but SARS-CoV-2 is not affecting everybody in the same manner and with the same severity. Older citizens, people with underlying health conditions, and racial and ethnic minority groups have increased risk of getting sick, being hospitalized and dying from Covid-19 [4]. People in poor neighborhoods are more vulnerable to the disease, while recurrent Covid outbreaks are described in nursing homes, slaughterhouses, and prisons [5]. Disadvantaged populations often have more health problems as the result of lack of access to healthcare, poor and unsafe living conditions, lack of employment, and environmental degradation. People with disabilities, chronic illnesses, and older people all have conditions that reduce long-term life expectancy. These populations and people risk to be doubly affected, not only by the virus but also by utilitarian triage criteria that aim to maximize the number of life-years saved so that priority in treatment is denied because of their poor long-term prognosis [6] One of the most harmed areas of numerous societies are elderly and nursing homes while policy-making for a rather long time is focused on acute hospital care with little protection available for the older, frail and vulnerable residents of these homes. Public health measures furthermore have unequal effects. These measures such as lockdowns and widescale testing are implemented in wealthier parts of the world and advocated for other countries, while the different context of less-resourced countries is not taken into account. A substantial number of people are not able to comply because they live together with many others in crowded housing, or lack adequate housing, with limited sanitary facilities, reduced access to healthcare and to internet, do not have formal jobs, and have to go out for making a living, when government efforts to provide economic relief, secure income and health insurance are absent. Low-income countries are supposed to implement the same public health measures as more affluent countries, but they are not able to acquire sufficient protective equipment, and are not prioritized in the distribution of global resources such as test kits, medicines and vaccines. But even in well-resourced countries people in low paid service jobs (such as retail, food services, childcare, and hospitality) must continue to work. The same is true for people with lower socio-economic status who have to work in crowded conditions (e.g. in slaughterhouses), have to use public transportation, and often live in multigenerational households. Lockdowns, distancing, and self-isolation are measures that can be best carried out by wealthier citizens and those with better accommodation. The evidence that Covid-19 is worsening the existing inequalities in health and society points to the need to pay special attention to notions of vulnerability, solidarity and equality to address disparities from a more encompassing ethical framework [7] The pandemic has also made some people vulnerable due to xenophobia, stigmatization, and discrimination. That experiences are not the same everywhere and that Covid-19 reinforces existing inequities is evident in the global vaccine gap.

The third characteristic of the pandemic experience is *unexpectedness and unpreparedness*. It is not the first time that humanity is confronted with pandemic diseases. Human life has always been marked by infections, since humans, animals and microbes cohabitate in the same world. But the advances of medical science have promoted the belief that these diseases can be managed and controlled, and sometimes eradicated through vaccinations and medications (especially early in life). Infectious diseases as lethal threats have become less frightening for many people. However, this is a cultural prejudice since populations in less developed countries are continuously threatened by infectious diseases. In 2019, just before the Covid-19 outbreak, 409,000 people have died from malaria, and 1.4 million from tuberculosis [8] Previous lethal pandemics such as the Black Death in the 14th century, cholera in the 19th century, and Spanish flu in the 20th century have had a major impact on society and culture, but they are mostly regarded as history. Diseases such as Avian flu, Ebola, and Zika have been an early warning for the current pandemic but the lessons have not been taken seriously in most countries. For most countries and authorities the

viral threat of Covid-19 came as a surprise. An example is the list of ten threats to global health requiring attention for the next decade, published by the World Health Organization in early 2019 [9]. Air pollution and climate change are on the top of the list. The 2019 list differed from the one published one year earlier. The number one on this 2018 list was pandemic influenza. In fact, the majority of threats on this list were infectious diseases, including cholera, diphtheria, malaria, meningitis, and yellow fever. Just before the outbreak of Covid-19 there obviously is no expectation of an imminent pandemic threat, although since 1992 experts have warned against the dangers of emerging infectious diseases.

Framing ethical concerns

How ethical concerns are formulated and conceived is the result of a specific manner of framing. For instance, caring for infectious patients is interpreted as professional duty leaving aside considerations of personal risk or risk to family members and relatives but also the responsibilities of healthcare facilities to provide a safe environment. Another example are policy measures such as physical distancing and masking that often move from appeals to voluntary responsibility to mandatory requirements with the argument that the collective interest overrides the interests of individuals, emphasizing compliance with the measures rather than adherence to them on the basis of persuasion and motivation. A third example is the argument that in emergency circumstances priority should be given to treatment of Covid patients since that will save most lives while treatment of patients with other conditions is scaled down or cancelled. The framing of ethical concerns is performed with three fundamental notions: exceptionality, controllability, and binarity.

Exceptionality

Ethical concerns during the pandemic are frequently pre-structured and formatted with the discourse of exceptionality. It can take two forms. *Intrinsic exceptionality* refers to the claim to be outside the general pattern, and thus especially privileged. Before Covid-19 some countries thought to be exceptional because they assumed to be well prepared for a global epidemic. After the outbreak of Covid-19, specific countries presume that they are less vulnerable and more resilient than others. During the pandemic, countries try to profile themselves as exceptional in their policy approaches, scientific contributions, or vaccination strategies. From an ethical perspective, arguments in favor of intrinsic exceptionality may be true or false but what they do is to assign such value to a country or profession that it becomes difficult to criticize policy-makers, scientists or healthcare workers because they are special. The second form is *extrinsic exceptionality*, i.e. the argument that an emergency situation creates special conditions in which the usual standards and practices no longer apply. In this form, the ethical perspective itself is affected. It is argued that special circumstances justify actions that normally would not be acceptable, for example confining citizens to their homes, testing mandates, crisis standards of care, expediting of scientific research, or deprioritizing older patients for ventilatory interventions. Allegedly, as these examples illustrate, the ethical considerations that apply in normal circumstances can no longer be used but should be either bypassed or reversed into a utilitarian framework so that the individual interest of patients will be subordinated to the common interest of all.

In mainstream bioethics, the basic principles of ethical discourse are respect for autonomy, beneficence, nonmaleficence, and justice. The principle of respect for autonomy is usually dominant, focusing on concrete individuals and interpreting vulnerability in an individualistic way. In the pandemic, the balance between principles changed. Public health and utilitarian ethics give priority to benefit and harm, focusing on abstract individuals as specimens of a collective, and ignoring issues of vulnerability. The ethical debate then shifts from individual to public interests but in both frameworks minor attention if given to the principle of justice and to respect for human dignity. The notion of exceptionality defines the fundamental challenge as a conflict between individual and common good. Rather than bypassing, reversing or shifting moral principles, the ethical framework guiding public health, clinical medicine and research should be broadened, so that more principles are taken into account.

Controllability

One of the striking features of the pandemic is the predominance of the war metaphor. Since the virus is an omnipresent threat to everyone, a massive common effort is needed to fight it. There are only two options: victory or defeat. The entire society must be mobilized. All hopes are established on a technical solution to the Covid crisis, overcoming the vagaries of human behavior by simply injecting a vaccine. In the meantime, the emphasis should be on hospital care and the best possible treatment. In this context, there are only heroes, victims and villains, and dissent cannot be tolerated. After this world war is over, strenuous efforts should be undertaken to prevent future outbreaks. The arms race between viruses and humans demands the building of a critical defense system at the global level. Like powerful countries have established extensive military systems to prevent nuclear war and have concluded international treaties to limit proliferation of nuclear weapons and to prohibit chemical and biological weapons, taking the war against viruses seriously implies a similar global system with surveillance and public health capabilities as well as international regulations than can be verified to ensure global security, concluded in a pandemic treaty [10].

The driving force of these efforts to fight the virus is the belief in controllability. Nowadays, viruses can be quickly identified, their genomes sequenced, diagnostic tests produced and vaccines developed. The viral spread can be controlled with rigorous public health measures, first of all physical distancing. Controllability, according to German philosopher Hartmut Rosa is a characteristic of modernity. Modern social existence is characterized by an "incessant desire to make the world engineerable, predictable, available, accessible, disposable (i.e. *verfügbar*) in all its aspects" [11] But the drive to control separates humans from the world in which they are situated, and regards the world as a resource to be exploited, a collection of objects to master, a treasury of facts and data to discover and to make useful, and an assemblage of obstacles to overcome in order to advance human flourishing. Everything is seen as a challenge. Against this backdrop, we encounter the world, in the words of Rosa, as a "point of aggression" [12]. This is exactly the perspective of the military metaphor in the pandemic. The virus is an outside enemy that needs to be controlled, and ultimately destroyed. The four dimensions of controllability are reflected in the approach of the viral threat. First it is made visible, using science to identify the virus and mathematics to quantify the impact; second it is made accessible through the development of a diagnostic test so that it can be followed how the virus spreads; third it is made manageable with the help of public health measures but most of all through vaccines; finally the threatened world is made controllable by making it useful and more efficient through digital surveillance, remote work and education, and economic restructuring.

The quest for control and the discourse of war are difficult to criticize since they seem the most rational and efficient way to bring the pandemic under control. Efforts to control, manage, predict and calculate the spread of SARS-CoV-2 perfectly reflect the rationalization, bureaucratization and intellectualization of modern societies and cultures but they simultaneously demonstrate the uncontrollability, uncertainty and unpredictability of the modern lifeworld. When the pandemic lasts longer than expected, and policy measures begin to oscillate and are less consistent, this uncontrollability becomes more apparent, and makes people aware what is lost when the focus is only on efforts to make the world controllable. This awareness calls for a broader and deeper ethical discourse.

Binarity

Covid-19 has highlighted and aggravated existing dichotomies and contradictions within and between societies. While SARS-CoV-2 is a threat to everyone, not all people are 'in the same boat' since some are more heavily affected than others. This is especially true for persons who are already vulnerable and disadvantaged before the pandemic emerged. Covid-19 exposes and exacerbates the existing health inequities and accentuates the significance of socio-economic determinants of health. Another disparity intensified in the pandemic is intergenerational tension, putting the old against the young. Older people are the most vulnerable to serious consequences of

infection. Younger persons are least affected but asked to stay at home, keep physical distance, while schools are closed. They experience the prevention paradox: they can disseminate the virus without being ill and at risk of serious effects but have to change behavior in order to protect more vulnerable citizens. Seniors may complain that the curve of the pandemic is not flattening due to irresponsible conduct of younger persons while they themselves have to self-isolate and experience increasing loneliness. On the other hand, younger generations grumble that their social life is curtailed because of concerns with persons who are in the final stages of their lives, and that they have to wait longer to go back to normal since those persons are prioritized for vaccination. These tensions are magnified through some policies, for example the use of age as a criterion of triage for ventilatory support. Other examples are the lack of attention to nursing and care homes where older residents with multiple comorbidities were often not transferred to hospitals in case of infection, as well as policies of herd immunity advocated in Sweden, and initially in the United Kingdom and the Netherlands. Sometimes public proposals are launched suggesting that that the lives of some people, especially older ones who already had their 'fair innings' are expendable for the greater good which is usually interpretated as the free flow of the market and economic productivity [13].

The dichotomies and disparities highlighted by the Covid-19 pandemic reveal the dark side of utilitarian approaches in public health. The utilitarian focus of triage systems for example proposes abstract categories of prioritization and is blind to structural healthcare disparities, not taking into account the social context and the variability of patient's needs and vulnerabilities. Guidelines usually do not include voices from marginalized groups [14]. The use of the fair innings argument further articulates trends that already were visible before the coronavirus emerged. It proceeds from the anthropological vision of human beings as *homo economicus*: they are first of all a rational self-interested individuals motivated by minimizing costs and maximizing gains for themselves. Human life is like a commodity, a resource that can be divided in parts and shares. The terminology of 'innings' assumes that life is a form of producing and collecting benefits. Human life is not considered as a whole, in which all stages have a particular value and meaning. The concept of fair innings is also attractive since it is quantitative. Rather than having an ambiguous and inconclusive debate about ethical principles, it suggest clear rules that can be consistently applied and evaluated because it quantifies benefits [15]. This approach regards 'the elderly' as a homogenous group, and an abstract category which is necessarily associated with vulnerability, frailty, dependency, and deterioration, rather than as individual people with distinct personal, clinical, and social characteristics, conveniently ignoring that the majority of people older than 60 are not weak, dependent or frail [16]. Finally, the reference to 'fair innings' during the pandemic accentuates a problem that existed before. Age discrimination that was often implicit, has now become explicit [17]. Covid-19 not only illustrates the divide between young and old but further articulates already prevailing ageism. The idea of fair innings therefore is arbitrary and unfair, and ignores that the utilitarian focus on efficiency should be tempered with concerns for equality, vulnerability and human dignity [18].

The framework of global bioethics

Having examined how ethical reflection has been modelled and framed during the public health emergency, the challenge is how to envision a bioethics after Covid-19 which is global, not merely in the sense that it worldwide but also that is encompassing, inclusive and broad, able to go beyond the disparities and dichotomies and the narrow ethical imagination which have been prevalent. A global perspective in my view proceeds from the significance of relationality for bioethical discourse.

Relationality

Global bioethics articulates that human persons are essentially characterized by relationality. As integrated wholes of body and soul they are embedded within communities and they exist in a web of relationships with other beings and the environing world. This is why the notion of 'sphere' is more appropriate than 'globe.' Relationality is a more fundamental characteristic than relatedness

and connectedness. A person is continuously engaging in relations but this is often conceived from the viewpoint of the individual. The notion of relationality expresses that individuals not merely connect and interact with each other but belong together and are mutually dependent, taking responsibility and shaping their lives together. The first experience of humans is that the world is shared with others. From this perspective, individual autonomy is redefined as 'relational autonomy.' A human person is constituted through encounters and dialogues with other beings. Authentic human being is being-together, in the words of Gabriel Marcel, being present and available to others [19]. Relationality and being situated in the world implies vulnerability since it exposes humans to other persons and the environing world. Relationality is not an option and we cannot make ourselves immune to the world.

It is evident that relationships and relatedness have become problematic in the pandemic. Other people are presented as a threat, and relations may have lethal outcomes since humans are the principal vector of the virus. The main objective of public health measures is to prevent connections and interactions. Distancing, masking, prohibition of visits, working remotely, and sheltering at home obstruct being too close together with other persons. Covid-19 therefore seems to affect the anthropological condition of human beings. They risks to have their presence and availability reduced, and thus to lose what is specific for humanity. All people face the same dilemma between being secluded or being open to the world since relationships are disrupted but fundamental relationality is not annulled. For many people public health measures create significant problems, physical ones because they have difficulties in providing for their basic needs, and mental ones because they are lonely and depressed. This renders the continuation of isolation policies increasingly problematic. It also explains why the term 'physical' distancing is considered inappropriate, 'bubbles' appeared in which closeness and intimacy with at least some others was allowed, and many other ways of interaction and communication emerged [20].

Individual versus common interests

The opposition between individual and common interests that often dominates in pandemic discourses ignores the fundamental relationality of human beings. Individuals are not isolated, abstract entities but social beings. This point of view is not accepted in the ideology of individualism, prevailing especially in the West, according to which human beings are independent and self-reliant, the masters of their own life, choosing their own values, and thus as unique individuals separated and demarcated from other beings. The normative implication of this view is that respect for individual autonomy means non-interference: individual decisions and actions should be respected as long as they do not harm other human beings. In this perspective, public health measures should first appeal to individual responsibility; any interference with personal liberty is problematic, and lockdowns and curfew are unacceptable. In the perspective of global bioethics, however, the opposition between individual and common interests is false because the first type of interests must be reinterpreted, while the last type should be taken seriously. One argument is that personal autonomy is a relational notion. Not only has it originated and been nurtured within a context of dependency but it is also exercised in interaction with other people, dependent on social and cultural conditions [21]. Another argument is that preferences, values, and beliefs are not merely individual but conditioned by the social context. Societies transmit values across generations because norms are internalized. The human capacity to internalize norms means that human preferences are socially 'programmable' and human behavior is guided by the moral values of social life. Because human agents are socially entangled and networked, their conduct cannot be explained by self-regarding rationality directed at maximizing self-interests but by social rationality, that is taking into account the well-being of other people and the needs of larger society [22]. A further argument, especially expressed in global bioethics documents is that autonomy is intrinsically connected to responsibility. Individual actions and decisions have social consequences, so individual autonomy and social responsibility cannot be opposed. Personal autonomy is not abstract and decontextualized but has impacts on concrete other people [23].

The Covid pandemic clearly illustrates that individual behavior affects the well-being of the community. Widespread use of face masks will protect not only the individual but also other people against possible infection. Testing will identify whether someone is infected, but it is a warning signal that others may be at risk. The aim of vaccination is not only to protect individuals but society as a whole. In a public health emergency, appeals to self-interest cannot be separated from concerns with the interests of others. Individual decisions whether or not to adhere to public health measures have an inherently social dimension. Appeals to individual responsibility will therefore not be sufficient without articulating social responsibility, and without creating the social, political and economic conditions for the exercise of responsible autonomy.

Solidarity

In the context of public health, solidarity has since long been endorsed as a key ethical value. Because health systems are interdependent, and disease threats are global, collaboration between healthcare institutions is necessary at national, regional and global levels, requiring open communication, sharing of information, and coordination of policy responses. In the Covid-19 pandemic, international bodies have repeatedly emphasized solidarity as a core concept.

Although there are many examples of solidarity at interpersonal and institutional levels, the absence of solidarity at the global level during the pandemic is striking. This is not surprising since the conditions for solidarity have been eroded in the past few decades. Global policies and international cooperation have primarily focused on economic interests. For example, in the European Union, protection of human health has not received priority since the organization and delivery of health services and medical care is the primary responsibility of individual member states. Global institutions such as the World Health Organization have been systematically weakened by budget cuts and attempts to delegitimize its work [24]. In most countries, public health infrastructure has been reduced, and health is first of all regarded as an individual rather than collective responsibility. The main driving force for cooperation is the neoliberal ideology of the free market, emphasizing competition, free trade, and commercialization of all aspects of human life. In this ideology, government interference must be reduced as much as possible, and deregulation, privatization, reduction of taxes and public expenditures encouraged. In this philosophy of rational egoism, societies are mere collections of individuals, and solidarity is rejected or regarded as a superfluous value. The same processes have undermined solidarity within societies.

The dominance of individualism and the view of the human person as *homo economicus* have diminished the experience of human beings that they are embedded within communities, cultures and environments, and that their destiny is connected to distant others as citizens of the world. Since solidarity cannot be imposed unilaterally or top-down, it will not emerge in these conditions [25]. Mainstream bioethics, relying on the language of autonomy, interests, utility, efficiency, and negative rights presents a myopic view of relevant ethical concerns since it does not recognize the connectedness of human beings, and the global dimensions of the pandemic, and thus the need for global responses. After Covid-19, bioethics can no longer assume that autonomy is the dominant ethical principle; it must recognize that taking human relationality seriously implies enhancing and embracing social and structural conditions that make solidarity possible.

Conclusion

Covid-19 has revived the, mostly forgotten, collective memories of the past, especially of the global influenza pandemic of one century ago. Humans now realize that they live in a pandemic era that begun in 1918 and that the idea that infectious diseases can be controlled is false. More than other disasters, Covid-19 has affected all dimensions of everyday life for all people across the globe. The spread of SARS-CoV-2 makes visible and tangible to everyone that human beings are interdependent, illustrating that globalization is a phenomenon of health and disease, and not simply of trade, travel, and finance. Globalization no longer is an abstract set of processes but an experience of mutual and personal vulnerability. Everybody is confronted with the same threat, while scientific knowledge of the virus is the same for everyone and rapidly shared across the

globe. Nonetheless, responses to the pandemic are diverse and heterogenous. Some countries have managed the impact of the virus rapidly and efficiently, when in fact numerous others have bungled, delayed, and vacillated in applying public health measures. One reason why global strategies in the face of the pandemic differ has to do with values (for example, individual vs social responsibility; voluntary compliance and self-control vs state enforcement and external control; individual liberties vs solidarity). That Covid-19 has ethical relevancy is furthermore manifested in the social inequities that it has revealed and aggravated. It exposes socio-economic and racial disparities in health and healthcare, as well as the privileges of people who have homes to shelter, and work that can be done remotely. Trends towards discrimination of elderly and disabled people are magnified, and stigmatization and scapegoating are not past. The pandemic also discloses the lack of preparedness of most countries and the insufficiency of public health infrastructures. Furthermore it clarifies that the economic order promoted by the neoliberal policies of globalization over the last few decades have led to the moral impoverishment of the social life-world and to multiplication of experiences of injustice, especially of humiliation, disrespect, and inequality.

For these reasons, the pandemic is an opportunity to rethink globalization, global governance, public health, and healthcare with a new appreciation of the common good and the role of governments in protecting citizens, with more emphasis on resilience rather than efficiency. If bioethics as a social and global endeavor mobilizes the moral imagination in order to expand the scope of moral concern by applying the human capacity to empathize, it crucially contributes to enhancing social life and civilization.

Notes

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