Marie Bashir Institute
"tackling infections, locally and globally"

THE UNIVERSITY OF SYDNEY

COVID-19 ethics and social issues
Webinar 1st April 2.30pm-4pm
Q&A

Answered questions:

Q to Diego. In relation to isolation/social distancing a subset of the population clearly are not applying the principles espoused by government (mainly young people who don't presumably see themselves at risk and may not be considering the risk infection could pose to the vulnerable eg they parents/grandparents; how are they best engaged into the public good argument.

A: According to the Guardian 20 % of COVID-19 cases are in ages 20-29 and 10% are on cruise ships. The question on how to enforce the message to individuals in teens or 20s, I will leave to the behavioural scientists but wagging the finger is probably not the way to go. It is important that we all take what is going on, seriously and that those in their 20's take their responsibilities seriously, but we must acknowledge that they may not have thought about epidemiology and spread. They may not have beliefs about government that are shared with other generations or other people. It is important to understand why these messages are not getting across to these groups of people, is it because they are rebellious? Not sure. It is best to understand why these individuals or groups are not adhering to the instructions we are giving them and try to use evidence and what we know about behavioural phycology to get the messages across.

Q. What should we do in situations in hospital where there is a shortage in PPE? It is a given that healthcare workers want to do the best for their patients but there is potential that they may be in situations where they are putting themselves at risk through operating particular procedures that increase those risks?

A: Lyn- There is a global shortage of PPE, in particular masks. The important thing to start with, is that there are appropriate guidelines based on evidence about what is the states use of PPE. What will protect healthcare workers in particular situations? The national infection control group have established these guidelines, based on evidence to guide the use of PPE. Some members of the public and healthcare workers have been using PPE, in particular masks in a way that is unnecessary and wasteful. A lot of masks been used unnecessarily during the outbreak, it is decreasing but still happening to some extent. In addition, the use of masks during the fires have depleted stocks. There are still enough masks to go around for healthcare workers to wear in the appropriate circumstances. Until recently it has been easy to identify who are the high-risk circumstances, the people likely to be at risk and this coincides with those that have been recommended to be tested, return travellers, people with signs and symptoms or contacts. Now that there is more community

transmission it is getting harder and healthcare workers are understandably becoming more anxious, but the situation still remains that the routine infection control guidelines and procedures that are appropriate all the time in healthcare be applied. That we should be using precautions for patients with symptoms, patients with clinical risk and that we should be doing risk assessments where we decide based on symptoms and clinical history what are the risk of a patient having an infection, COVID-19 specifically and use PPE appropriately. This can be a big ask for big hospitals who are busy with little time for individual risk assessment, but infection control needs to be ingrained in people's way of working in hospitals. Unfortunately, we haven't done enough of this in the past and we are trying hard to get up to speed with this, so healthcare workers do understand the risk and how infectious diseases like COVID-19 are transmitted and so they can understand how they are at risk but also others, their patients. PPE supplies are limited, and it is a difficult situation, but the government have made enormous efforts to attain PPE and they are on the way. PPE is in demand by everyone in the world, so we need to use what we have cautiously. There is enough and no one that needs one should miss out.

Q To Diego and Jane- What are the different ethical frameworks that underpin different nation states & governments, and why might this be important to reflect on during infectious disease pandemics in terms of acceptability of interventions, social norms etc?

A: Jane -When we were looking at the pandemic flu, we looked at different countries pandemic planning documents and diff countries prioritise different values. The US had a big focus on security and use of the army, whereas NZ had a strong communitarian focus and a fantastic ethics section including Maori perspective. Both are different but underpinning most countries ethical framework thinking is a utilitarian, greatest good for greatest number type of thinking but expressed differently in different places. Diego – Defer to Jane for what frameworks exits. In terms of the values, it makes a difference on how public health is taken up and effects how emergencies are dealt with. If that is what countries do, then what ought to be done? To what extent can we cherry pick from one jurisdiction to another? News is global but that doesn't mean we need to apply what happens in different countries everywhere. It often points to the need that we need to make better efforts to communicate what we need to do, and the reasons why we need to do them based on the evidence and how that gets translated through the values for each country, will differ. Angus- There is a need to address the metaphor of frameworks, it is being used in different ways in this discussion. Jane is using frameworks in endemic plans and they have striking differences in their nation plans prioritise. US security focus versus NZ community focus. People can also use framework in ethics based on literature, so to set down or articulate a list of different values or principles and that can be useful as a summary of the literature based on a topic but personally I think they need to go a little further than that and try and offer assistance to people that have to make difficult decisions. Often these are ethical decisions made by people that don't have any training in ethics, so we have a translational obligation, as academics in ethics, to engage with people that need to make these decisions. We should be producing documents and be on committees so we can engage, encourage and shape the discussions around these ethical issues.

Q. More people are wearing masks in Sydney and the advice from public health is that wearing a mask won't protect you as an individual. So, are these people that have COVID-19 or are they protecting others? What is the latest evidence in relation to the wearing of masks? If each of us prioritises what we believe to be the kind of way that we deal with our own anxiety, are we then feeding into a culture where more people are essentially conceptualising these issues as protecting themselves, rather than thinking, what is the evidence and living in a society where we are social distancing but that doesn't necessarily mean that we have to literally wear a mask that presents that fact to everyone else?

A: Lyn- In the first part where you mentioned if people have COVID-19 they should be wearing a mask, I hope this is not the case. If someone has COVID-19 they should be self-isolating they can't be out and about with COVID-19. There are now increasing penalties for being out and about at all let alone being COVID-19 positive! The reason why people recommend that people don't wear a mask around the streets is because it doesn't really make a difference. There is a lot more to infection control than just wearing a mask. COVID-19 doesn't spread long distances in the air, it is spread by direct contact with close contact from people or contact with the droplets of contaminated surfaces or it is transmitted by contact – touching contaminated persons. In crowded places it could be direct contact with someone but more likely to be touching a surface that has been contaminated. Casual contact out in community is rarely the way people catch COVID-19, most people that have developed COVID-19 in family situations or very closed circumstances such as Cruise ship backpackers and nursing homes. These are of concern and high risk because they are like household environment with lots of people. Evidence for use of masks is two-fold. They were first introduced to protect surgical patients, their wounds, from microorganisms in the throat and mouth of surgeons and secondly to protect healthcare workers from infectious diseases that are spread by aerosol and in close contact. It is an effective way to prevent infections and the main indications for using masks. Asking a person to wear a mask if they are infectious can protect healthcare workers to some extent. Jane- I am interested in evidence values of masks. In South-East Asian countries people wear masks if you have a cold or not feeling well to prevent others from being infected and is considered being a good member of society, also a visual symbol of being safe. Not advocating the wearing of masks but in some countries like Singapore they wear masks to prevent others from getting sick and keep other people safe pre COVID-19. Lyn- If someone has a respiratory illness it prevents the spread and protects other people, in addition wearing a mask will prevent them touching their face and then touching others. So that motivation to try and protect other people is not somethings I would argue with. Not sure how much it would overall reduce the transmission in the community, but in crowded situations it probably does but there no evidence for this. This however is not recommendation for COVID-19 because if there are any symptoms or suspicion of having COVID-19 then they should get tested and then if they have COVID-19 then they should self-isolate. Angus: I am really interested in the presentation of the self-aspect and something for anthropologist to explore. In the South-Asian context, masks are commonly seen as benefits to individuals, being a good citizen by protecting others from me, if I am infected, whereas in an Australia the cultural significance of wearing a mask is a different one. Is it protecting me from you rather than you from me? Or are both of those going on in general? In Australia, people I see wearing masks are overwhelmingly from South Asian heritage and is this because it is a cultural legacy within an Australian society that generally have different attitudes or whether it is an expression of

alienation from Australian culture? Interesting project for why people are wearing masks. Potential infection risks that may be attached to masks so wearing the same masks can accumulate other diseases if not used properly.

Q The exclusion of cruise ships from ports and denial of disembarkation is ethically and medically troubling. What does the panel think should happen? What should we do as a public health community? What should we be doing about cruise ships?

A: Lyn- It's almost impossible to reliably contain a COVID-19 outbreak once it starts on a cruise ship. Part of this reason is because the people that go on these ships are often vulnerable elderly with other health conditions, so they are at high risk. Only need to know the statistics that this is a high-risk situation for them. No one wants boats to dock to put people in an increase risk and lots of efforts are going into moving people safely back to their country of origin. The aim is to safely bring all the people on cruise ships back to land, in safe circumstances in quarantine where they can receive medical care and taken care of appropriately and then repatriated to their country of origin as soon as possible. Thousands of people are still on cruise ships around the world today. Diego – Cruise ships raise the question of how do we think through the ethics of risk and imposition of risk? They do not allow people to get off the cruise ships because they pose a threat to public but there is a risk that is posed to those vulnerable group of people that are still on the ship. What risk are we asking people to place on themselves and is that acceptable? Are people responsible for taking on the additional risk when they agree to go on a cruise? How well prepared or informed are people about the risk of acquiring infectious diseases on the ship? Lyn- No one is wanting people to stay on the ships except for the first boat decided by Japan but they were then removed from the boat. There is enormous efforts to move people off the boats for their own safety but also in a way that is also safe for the community. People aren't being kept on ships they are moving people off the ships to go to a safe place away from the community but where they can receive the medical care they need, if needed. Diego – I agree but there is also a public sentiment following last weeks cruise ship that let people into Sydney and the means it was done was not the best. There seems to be public push back from the public to let them in, in the first place. What do people know about cruises when they take the risk to go on cruise? Lyn- Outbreaks are well known on cruises but do those that cruise know this, should cruise companies warn their travellers of the risk?

Q. Thinking about asylum seekers, stateless people, people in prisons. What kind of infection control measures or what kind of ethical issues are raised in relation to these type of communities?

Answer- Diego – We have an obligation to these individuals. If someone is seeking asylum, fleeing their country of origin, they are under grave danger. So in terms of the risk they are taking, the harms that they are fleeing, that can't be dismissed because there is a pandemic. We need to undertake the measures required to protect them and the population, but they are not criminals. Our duty is one of care, to protect these individuals who are fleeing dangerous situations. In respect to prisons, the removal of freedom of movement is the punishment when people go to jail. It is not that you go to jail and get additional punishments or that all your other rights disappear. We need to think through it and although it must be logistic nightmare to control COVID-19 in prisons, as a society and govt

we can't wash our hands of people in prison. They are a vulnerable population and need to take it seriously, removal of freedom is the punishment, the risk of acquiring COVID-19 is not. Lyn-To some extent this is about the heart of asylum seekers being kept in detention for years on or offshore. This is a high-risk situation for them if COVID-19 gets into these detention centres and the only way to prevent this from happening is essentially to confine them in their rooms and this is an imposition for people that aren't criminals and even so for prisoners. There are many people in asylum or prisons that are not regarded as being dangerous to the population and as far as the rest of the population is concerned, they could be released during this outbreak without any risk to the population. We are putting these people at extraordinary and different risk from the one they are actually incarcerated for and as many of these people also have other health issues, they could be at a significant risk of COVID-19 or even death. My personal opinion is that we have responsibility to care for them and not put them in any extra risk, including dying.

Q. A question about responsibility and capacity. If liberty in a community depends on mutual understanding of limits to liberty and potential harms to others, what do we think about differential responsibility here? For example, thinking about punitive measures against people who break quarantine or distancing measures assumes everyone is equally capable of understanding the reasons behind the measures. But that probably isn't true. How should we think through our response?

JW: does it assume everyone has an equal understanding? Or that people would value the outcomes the same way? Or have the same appetite for risk? I guess what's more pertinent for me is that we don't bear the burden in the same way – it is much easier for some people to follow the rules than others. If everyone is being asked to behave in the same way then where sacrifices are greater that should be acknowledged in some burden minimising way. Maybe this is a situation where intention is important (understanding that this leads us don a difficult path of difficulty judging whose reasons are valid and whose aren't).

DS: I agree that not all persons can be held responsible to the same degree regarding abiding by distancing measures. Some baseline exists though given how 'in the news' COVID-19 is, including the rules around social distancing. So breaking these rules should come with some kind of repercussion (however, I don't think ought they to be punitive since I'm not sure what public health goals that would fulfil). However, those in positions of power who are seen to flaunt the rules, like government ministers breaching rules, should take on greater negative consequences, as has been the case already (e.g., Don Harwin in NSW) since they should have greater knowledge and special responsibilities by virtue of their postions.

Q. Does anyone have any thoughts on the rise of domestic violence being reported across some countries including Australia - as a result of staying at home/self-isolating.

JW: Clearly it's terrible and an unintended/negative (but predictable) consequence of moving life into the private sphere and reducing social contact. Since this could have been anticipated (maybe was?) there is an obligation on the part of the government to make it very easy for victims to seek help and for them and their children to be able to leave into a safe living arrangement that is longer than usual. Government decisions created the

conditions that are exacerbating family violence and so need to mitigate the harms caused by those conditions.
An example of how seeking help has been made easier in NZ, in theory, is on the website of the biggest retailer – a very unobtrusive link to women's refuge on the landing page via a shielded site that does not appear in browser history. With that said, seeking help is only useful if people can act on it in ways that accord with goals and values.

Q. To All Panelists - does anyone have an opinion on "systemic ethical frameworks". For example, there does not seem to be a "line of sight" to the general public from what occurs in medical practice for infection control i.e. hospitals, and how this interrelates with the recommendations made to the community. This directly impacts the effectiveness of the messaging to the community (how do they know what to trust and who to trust). How would each of you approach this problem?

JW: I am not sure it's a shortage of ethical frameworks as much as a lack of commitment to clear communications. There are a lot of inconsistencies that do not make sense across states and between federal and state assurances, and within rules. Examples include the federal government's insistence that there's no reason for schools to close, but that playgrounds must close. Lack of policy coherence reduces trust and creates anxiety and disharmony. It is also an invitation to break rules – e.g. "x wouldn't be open if I wasn't meant to go there". I'd call all of this a failure of leadership rather than a failure of ethics.

Q. To Angus and Diego, can you talk about the ethical principles involved in access to scarce resources such as ICD beds and ventilators? What principles are important, how are these balanced with attention to what Diego has described as social justice, and the health of marginalised populations?

DS: Balancing the need to maximize the benefit we gain by using resources during times of scarcity with the social justice considerations seems paramount to me. It is not enough to simply say that these are special circumstances and that efficiency ought to be the value that guides decision-making. However, alternatives, e.g., lotteries, may be unpalatable to the broader society. The take-home message is there are no clear or easy answers.

To Angus and Diego, we saw some staff in aged-care facility refuse to work because of concerns of infections. Do health care practitioners have a moral obligation to work in conditions where they believe they (and their families) are put at risk? And if they do, what is the basis for it?

DS: No, I do not think there is an obligation if the healthcare worker is put in undue risk of harm. The issue is gauging the threshold that cannot be crossed on the part of organizations, and whether the perception of the healthcare worker alone is sufficient to do away with this obligation to care. During times of emergencies and scarcities, it would seem too stringent to say that only the best PPE must be provided lest healthcare workers' obligations cease. But where you draw that line, exactly, would be context dependent.

Q. Diego - what are your thoughts about domestic violence/those at high risk? If we see a rise in DV -related deaths/injuries, where does the responsibility lie? This seems to be an interesting ethical dilemma.

DS: The responsibility for a rise in DV, I think, would rest with two groups. First and foremost are the perpetrators of the violence. Second, I think that governments must be seen to do their due diligence on the matter. In other words, it is not enough for governments to implement social distancing measures and not be responsible for the unintended outcomes, especially if they are foreseeable or have been alerted to them.

Q. Was wondering what the panellists (but Diego most specifically) thought about the policing methods in Australia to maintain the lockdown. Are fines/police in the streets a justifiable way to maintain public health or does this amount to overreach?

DS: Police measures as a last resort when there is good reason to believe that harm will occur may be defensible. For example, I would certainly be in favour of police enforcement of isolation as a last resort, i.e., those who we know are shedding the SARS-CoV2 virus. But using the police to enforce social distancing rules as a first resort seems, to me, too strong. The power of the police cannot be underestimated, nor their ability to impose themselves with little pushback by individuals. Again, there may be instances when police powers are necessary, but I would like to see greater public health efforts at education, messaging, and the like first.

Q. Diego, in relation to isolation/social distancing a subset of the population clearly are not applying the principles espoused by government (mainly young people who don't presumably see themselves at risk and may not be considering the risk infection could pose to the vulnerable eg they parents/grandparents continued; how are they best engaged into the public good argument

Thanks Diego - it is my impression that people don't follow social distancing constraints (or other constraints) until there is some sense of personal impact, or some sense of personal involvement. Could you comment on that, particularly related to the ethics of feeling responsible for others, for community and how a country might shift away from a highly individualist focus.

DS: NOTE TO GROUP – the first version of this question was answered above; I don't think I get this second version.

Q. How do you balance the demand of social justice with the demands of urgent health care. In a developing country, for instance, there is limited resources and instinctively, gov't would allocate resource towards urgent healthcare needs (medical facilities, supplies). But if we are looking at this as a protracted scenario, the number of people affected economically will keep increasing, and in turn the cost of addressing social inequities also increases. At

what point do we consider whether saving lives in hospitals is more important than keeping people fed, and what are the bioethical principles that could guide this decision-making?

JW: this is a terrific and really hard question. Undeniably the current measures will make life in the long term much more difficult for many people, impacting health. They're also making life very difficult in the short term in ways that impact health. Family violence, suicides, people not seeking healthcare because of the (perception of) unavailability of normal services. It's common in public health ethics to use a basically utilitarian approach that balances benefits and harms when deciding if an intervention is justifiable. This can be really fraught because it's often a matter of trying to balance incommensurate benefits and harms (e.g cancer deaths v screening harms). In the case of covid v other health harms created by covid mitigating measures, the temporal nature of the harms makes it harder. Assuming you look at the relatively easy comparison of number of deaths, covid deaths are happening (counted) now but most deaths caused by covid conditions will happen in the longer term. This means they're discounted as immediate harms. There are options that could do both – minimise harms from covid infection and minimise social harms that will lead to ill health but it means radical social and economic change. Aspects of covid response, such as housing people experiencing homelessness, indicate that scarcity is not necessarily the given that we assume.

Q. Do you think more medical professionals will be allowed in Detention Centres to help when more people become unwell with Covid? How do we address this duplicated ethical dilemma?

DS: Will they? No. Should they, of course on the basis of several principles of biomedical ethics (e.g., benevolence) and public health ethics (e.g., solidarity). Not sure what the "duplicated ethical dilemma" refers to here.

Q. Occupationally acquired infections for health care workers: do they have to verify (through contract tracing?) that they have acquired COVID19 virus from their workplace? This is to be able to access Workcover payments?

Q. As a veterinarian, declared an essential service, the dilemma is that the PPE I use could be used to protect our medical professionals. Ventilators have already been requisitioned from vet practices. Yet at the same time, bottle shops are open and the staff are wearing PPE. It seems that in a pandemic, human health trumps everything, but what constitutes human need is very broad. How should we balance animal welfare needs against human health needs?

Q. What are the different ethical frameworks that underpin different nation states & governments, and why might this be important to reflect on during infectious disease

pandemics in terms of acceptability of interventions, social norms etc? I also heard that Singapore had in it's living memory other SARS and MERS

JW: I'm not sure what this last bit means but it is clear that Singapore's experience with SARS meant that they have been better prepared for covid. That has manifested in practical planning for pandemics that has been regularly reassessed over the years and a population already used to the idea of the requirements for different behaviour during pandemics. In my opinion it's impossible to separate culture and norms and values from ethical justifications for practice. I think part of what we are seeing in the US (aside from appalling leadership) is what happens when a nation founded on the primacy of individual freedoms is asked to do things that are not necessarily in their own interests.

Q. I'm wondering if anyone can touch on the ethics of prioritisation of patients in the event that ICU capacity is reached and the hospital system is overwhelmed?

DS: Same as question above.

Q. Yesterday on ABC The Drum there was discussion about ethical principles involving access to ICU beds in times of scarcity. Please can you talk about this - what ethical issues are important? How can these be balanced by attention to social justice, when marginalised groups suffer poorer health?

DS: Same as question above.

Q. There is already a shortage of PPE in several hospitals and general practices. Can you provide guidance on the issues around when it might become unsafe for medical staff especially where they have underlying health issues, and/or household members with Immunocompromise. There is a culture in medicine to not leave the "frontline" complicating this.

DS: answered this question above.

Q. There are many different reasons given as to WHY we should stay home, keep kids home from school, avoid visiting, etc.: (1) protecting oneself from infection; (2) protecting one's loved ones from an infection you might acquire, esp the elderly; (3) reducing the circulation of SARS-CoV-2 in the community generally. There seems to be a perception that 1&2 are self-interested goals, and that younger ppl might not care about 3 - hence the Bondi Beach situation - but isn't (3) the main aim of public health strategies, and isn't it a goal in which *everyone* should an interest?

JW: Yes, social distancing is intended to reduce spread of infection and yes, technically everyone should have an interest. There are lots of examples of where self-interest trumps public health interest though. We could compare this to drink driving, which has long been illegal but still happens despite the risk to the public and was incredibly normal before RBT started.

And let's not forget the people working on the cruise ship; take the focus off the passengers.