PODCAST TRANSCRIPT

Podcast title: WORLD: we got this | In conversation | Episode 2 | Ethics and pandemics

Date: 19/05/2020

Intro: WORLD: we got this.

The podcast talking big global challenges with the experts taking them on.

Brought to you by the School of Global Affairs at King's College London.

Throughout this series we will be discussing some of the major global challenges we face, deforestation to global pandemics.

In our first season of WORLD: we got this, we'll be speaking with experts about the factors at play during a global pandemic, the differing global perspectives and ultimately the way in which we can meet this challenge.

Julia: Hello and welcome to the podcast.

I'm Julia Stepowska from the School of Global Affairs at King's College London.

In today's WORLD: we got this in conversation episode we explore the ethics behind the coronavirus pandemic from a more personal perspective.

We look at the trade-offs from a medical standpoint as well as the subsequent lockdown- and the ethical questions people having to ask themselves every day.

We include our personal experiences of living and working in the UK, Italy and South Africa.

Before I get started, I should also say that all our episodes are now available on iTunes as well as Spotify and Soundcloud.

Please do rate and review us.

It helps us to share these conversations with more people.

Now for today's episode I have with me Dr Silvia Camporesi, senior lecturer in bioethics and society, and Caitlin Gardner, an A&E doctor in London and a master's student with us here at King's.

OK, so let us kick off with a question that we start with in every episode: how are you and how is your lockdown going?

Silvia, do you want to go first?

Silvia: Yes, thank you for inviting us Julia.

I'm doing well.

I'm based in northern Italy near Bologna and I've been stuck here since the beginning of the lockdown in northern Italy, which was on February 23rd and this is actually the first week that we're able to go out so it feels like a relief and yeah.

The reason I'm here is that I had a baby in January, and I decided to be closer to my extended family and then we just got stuck here.

Caitlin: Hi, yes so hi, also thank you for having us today.

The lockdown's...

yeah it's going OK for me.

I'm staying in north west London at the moment.

I've been here in London for the whole lockdown and it kind of feels for the last couple of weeks or so there's nothing much that's terribly different with my life.

I'm going to work, I'm studying part-time.

The real only difference for me is I can't study in coffee shops like I'd like to do, but yeah, otherwise it's going well.

Julia: What about at work?

Have you noticed any changes at work?

Caitlin: I have yes, so yeah, the biggest changes at work have been... everything is COVID focused now.

At least from the A&E where I'm working, and there are COVID areas and non-COVID in areas.

But everyone is treated as a suspected COVID case and you take all the precautions.

Initially this started in...

I think everyone, everywhere globally, was a bit disorientated and so we started with very high PPE and then it was downgraded and there was confusion and then the different areas of the hospital changed to the COVID and non-COVID areas, which caused more disorientation.

And I think quite soon though the hospitals were doing quite well in coordinating what to do about COVID, so that was my experience in the hospitals.

And yeah, I've been quite impressed with the speed with which they've responded and the protocols that have been drawn up within the hospitals for that.

Julia: What do you think of that Silvia?

I think that that's great to hear and definitely, the NHS seems to be coping, at least from what we can read.

It seems to be coping with COVID- there might be different factors that can explain that.

One that comes to mind is that the UK had a few more weeks to get ready and Italy was really the first to bear the brunt of the outbreak in Europe and also I think that is a culture- this is something that I wrote about...

There is a culture of...

Caitlin, feel free to correct me because you are the expert of discussing more openly with the public about issues of triage.

So if you don't have...

which might not have been the case because the healthcare capacity has ramped up quite quickly but, you know at the peak of their pandemic the problem in Italy was just that we don't have enough ICU, although northern Italy is well known for healthcare services and Italy just does not have that culture of talking about triage.

So what happened was that the Italian college for anaesthetists and intensive care and the Ethics Committee released guidelines saying we're gonna prioritise patients on basis of comorbidity.

And functional status, so looking over at the functional status of patients and when it might be necessary is to set a threshold on the basis of age for access to ICU.

Although not...

it wasn't specified the cut off in terms of age because the guidelines said well this cut off would need to be contextual to a given hospital, not depending on a hospital in Milan or in Turin or in Bologna, but it might be necessary and this provoked total outrage from Italian media.

Because we are just not used to the decision so about you know privatisation and the response of the Italian media has been, we have our Italian constitution so we have the right to health and the right to healthcare, and we should just not have this kind of decision on the one hand.

On the other hand, you have a pandemic and it was the case that the hospitals did not have the capacity hence the attempt to flatten the curve and some patients were moved from a hospital to another with helicopters in an attempt to try to offer care to everybody.

So I think this very interesting.

Afterwards, I've been reading guidelines from the British Medical Association and where the US, the guidelines have been quite similar to the ones that were released in Italy or even like more severe, setting stringent cut offs in terms of age.

But the reaction was quite different in Italy.

I would curious to hear more from Caitlin about the UK and also South Africa a bit more.

Caitlin: Yeah so, again one foot in South Africa, one foot in the UK.

It's very, very different.

Speaking first about the UK, I personally have had quite limited exposure personally to having to do that triage myself.

From A&E, we're very well supported in terms of seniors and specialties and you refer to ICU or medicine and they go ahead and make those decisions but what I know is that it is based to a degree on age maybe not age specifically but frailty of a person and the comorbidities and everything that goes into making a person frail and generally unable to cope in their daily lives.

So that has been a very big criteria in the UK as far as I know for limiting or considering withholding ICU if there is no capacity.

I have not encountered in my personal practice any big limitations on ICU capacity so far in the UK, but again I'm part-time.

You know, I'm not in the ICU.

I don't know what it's like on the ground in those areas.

But from South Africa the story's quite different.

So pre-COVID we are constantly having these dilemmas and these conversations.

We do not have enough ICU beds, we do not have enough ventilators, we are constantly triaging on the basis of who gets high care, who gets admission, who gets the treatment, who doesn't.

And decisions have been made before and a lot of it is again on frailty and age and comorbidity.

You know, this is not a new thing.

At home even for junior doctors or you know we often don't have senior support as we do here in the UK.

So doctors are to some extent making those decisions on the ground themselves.

With guidance from principals because it's been so longstanding.

Now with COVID...

... so I've been discussing this issue with a friend of mine who's working at a rural hospital in mpumalanga and they have a single ventilator to use in the A&E.

They have two ventilators in theatre.

So, they have three in total, but they actually can't use the two ventilators because the manpower it would take to man those is too great.

So effectively they have one ventilator but then you're having a multitude of people coming in and keeping coming in.

Now who to you decide who gets that ventilator.

And not only that the patients now on a ventilator- your hospital does not have the resources to support them.

They need to be referred to a higher level hospital but now there are other criteria to say you can or cannot refer that patient is now on the ventilator.

So there is constantly balancing acts that are happening.

Even before COVID, we have such a high extent of TB and HIV and Aids in South Africa that has made these realities just all ordinary morbidly ordinary and yeah just speaking to what Silvia was saying that these decisions that are being made aren't new.

And they are being made constantly in parts of the world that are not as well-resourced and are not as privileged and no one should have to go through that and it's terrible that Italy is having to make those choices and anyone's having to make those choices but they're not new and you know we need to find ways to decide who gets who gets what.

Julia: So let's look at bioethics here because that's you know the domain that you're both looking at. So what exactly is a bioethics and how does bioethics shape your understanding of these circumstances?

Silvia: I would say bioethics is the investigation of the ethical and social issues that arise from biomedicine, biotechnologies, but also life sciences more broadly.

So it really brings together bios, life and ethics.

And it is more than an academic discipline.

It's a field of inquiry enquiry people with different backgrounds and expertise meet to come up mostly with policy solutions, some kind of recommendation for how to you know do things in the world.

Some of us work in academia, like myself where I'm a senior lecturer.

I have a background in biotechnology and philosophy and applied ethics but then you can have people working in the field.

Meaning in different capacities, in policy making, in public engagement, in hospitals.

So these questions that Caitlin was talking about so eloquently about triaging are quintessentially bioethical issues and actually bioethics as a discipline as we know it today is...

The early years of bioethics in the sixty's in the US were years of great optimism in medicine and in science because we had access to wide programmes of immunisation, antibiotics, so we had access to organ transplant, successful organ transplants for the first time.

We had access to dialysis, so we had years of great optimism but then the problem was a similar problem to what we have today meaning we had these new technologies that were able to save lives, which I've mentioned, but we didn't have enough to save all lives.

So the early bioethicists were referred to as the God Committee because they had to come up with criteria which could be transparent and consistent so that in the case of having to allocate scarce resources, it could be done in a transparent way.

So there different criteria to do that.

Without entering into the detail, I think it's important to stress that yes these decisions are not new.

In the Global North we might be in this privileged position in which many doctors were not confronted with these decision and that's why in Italy and also elsewhere, we had doctors having been reported as weeping in the hallways of the hospital because they had to make this decision.

This was reported in the New England Journal of Medicine in early March and it is something that researchers call moral distress or different terms that indicate that you know these doctors...

it was the first time that they had to confront this decision but as Caitlin was saying, we have much to learn from the Global South where this balancing act is done on a daily basis and there are possibly ways to discuss with the family and the patients outside of an emergency context that there need to be criterion in place and I think I would say it's better to have clear and transparent criteria then just to leave you know doctors to have to make these decisions alone.

Doctors do not want to make these decision alone, Caitlin can say more.

Caitlin: Yeah, no exactly.

Just to speak to that.

It's very difficult for or I don't think it should be necessarily the duty of the doctor who has a patient in front of them to decide do I get to save this patient's life or not?

I read a wonderful article that stuck with me.

It was a while ago so I can't remember the source unfortunately but it was saying that the doctor is the patient's advocate and these criteria that say whether a patient should get ventilation or should get ICU, they need to be drawn up and made before it comes to the doctor having the patient in front of them.

And you know the doctor is the patient's advocate and is you know is trying to help the patient as much as possible but in light of guidelines that have already been drawn up.

So it's not then the sole responsibility of that single doctor who is choosing for this patient's life and then has to go on for the next 11 hours of their shift continuing to do that and feeling like the burden of that person's life which they may not have been able to save is solely on their shoulders.

No one can cope with that and be effective in their job I think and so this is why bioethics and having bioethical teams and hospital ethical teams is so important to make these decisions, to discuss the ethics round them beforehand, to draw up these guidelines and then help the doctors and give advice to the doctors who are facing the patient be able to make these.

Julia: That's really interesting because as a non-medical person I hadn't really been thinking so much about the doctors and the ethical place that they have to go to in order to treat people because you can't save everyone and how challenging that must be.

I want to also turn to the ethics of the lockdown itself and in treating everybody the same so you know this idea that we're all placed in the same, we're all inside and we all have to be doing the same thing, we're all not going to work and that our homes may be different for different people.

I consider myself quite privileged.

I've got a flat to myself and though I'm pregnant and it is a bit confusing to be pregnant during the lockdown, I'm not in a situation where I'm living with eight other people or I am in situation where I can work from home, where there are many people in London who cannot, or there are many people in London who are frontline workers and then expose their families potentially by coming back home and then I'm also not in the situation where I live with my grandparents which is also would bring about an ethical issue.

It's like do you leave if you if you've got vulnerable people at home?

So Silvia you recently wrote piece in AEON and you talked about you know this idea of treating everybody the same.

I wonder if you could talk more about that now?

Silvia: Yes, I think it is a fascinating time at some level to be an ethicist or a bioethicist.

Because there are so many ethical issues in the pandemic and so the first one we talked about is the ethics of triaging.

And how to make this decision and how to support doctors and I agree with Caitlin that you know they should be supported, etc.

The second issue I had identified was among many others was the ethical issues in lockdown, so a public health extension, so we have lockdown because you know our governments are trying to flatten of the curve of the epidemics so that hospitals do not reach capacity and this is buying us time and buying us time to develop treatment, to have trials, to develop a vaccine and also of course to avoid having to triage as many patient as possible but then in public health, you are restricting individual freedoms for the public good and as a key principle in public health ethics are principles of proportionality and least infringement.

Proportionality means that you know, any restrictions of individual freedom should be proportionate to the public good that we are trying to achieve and of course we're talking about saving lives.

This seems the most important aim and indeed it was many governments including our government decided that it was justified to restrict our freedom movements.

However, you know, as many commentators as pointed out, there is not just one response to the pandemic.

There have been differences in national governments and earlier on Caitlin was talking about is a big difference between South Africa and the UK and I would be curious to hear more about what measure side in place in the South Africa but if we speak about Italy and the UK, Italy has restricted individual freedoms more than the UK for almost...

It was eight weeks we were not able to go out for a leisure walk or run and public health guidelines would say that there should be the best evidence possible support of you know these restrictions.

So is it the case that if you go out for a for a walk or run, are you going to contribute to the spreading of there coronavirus and I think my argument was that it was not justified because we just don't have that evidence.

If we go out with a mask and adopt protections, we are going out for a walk by ourselves, etc.

We're not going to contribute to the spread of the coronavirus and on the other hand you can have harms as a direct or indirect link to the lockdown: mental health, I've been mentioning, and also you Julia were talking about the fact we are in a privileged position in our household.

The lockdown can affect the different people in different ways and obviously having access to an outdoor space can- and there is evidence to show that it can really increase the wellbeing but what if people cannot work from home.

And then there are other issues of you know the vulnerable and how are we going to protect them.

So one of the case studies that I discussed in the article and in the other article that I wrote as a follow up when I discuss the phase two of the pandemic as we start to slowly emerge from the lockdown are issues of trust and we know that different countries as been classified as having a high trust or low trust towards their governments and in this classification, Italy or other countries such as Spain or southern Europe are classified as having low trust in their governments and they needed very stringent lockdowns, while Sweden or the UK have higher trust and have been able to have more freedoms and I think there is a research out there that challenges this distinction and I talk about this research in other areas in which social sciences research has looked at compliance with public health advice in other contexts.

Vaccination is a big one or climate change or pharmacologic treatment compliance and it has shown that it's not like a simple binary relationship.

If you have high trust in your government or you have high trust in expert knowledge or the medical profession your compliant, you have low trust, you're not compliant.

It is much more complex, so I was trying to challenge that and also, I had other thoughts about vulnerability, but I will stop here.

Julia: Caitlin, what are your thoughts on this issue?

Caitlin: It's very complicated and I'm still forming my thoughts around it and especially with regards to you know South Africa.

I'm aware I'm speaking from a place of supreme privilege.

I have safe home and I have food and I have security and so my opinion does stem from that.

In South Africa the lockdown has been very strict.

A national state of disaster was announced and the lockdown has meant that there has been a military presence on the streets and no one is allowed to leave their homes.

Now it's relaxing but at least for the last several weeks no one could leave their homes except to do essential shopping or as an essential worker and even I think maybe the only if one of the only countries to ban cigarettes and alcohol as well so.

Removing that personal freedom on top of the freedom of movement.

So South Africa's going very far with removing personal freedoms.

I and at least my echo chamber of medical professionals in South Africa.

As far as I know we feel that this is been largely quite good and quite beneficial for South Africa.

We have a huge amount to loose and we have a hugely vulnerable population which in itself causes problems with restricting movement because much of the business for example in South Africa is informal and so removing the ability to move or trade means that people can't eat now so there's that that's hugely problematic as well as in South Africa we have a quadruple burden of disease.

One of the burdens is interpersonal violence and domestic violence and violence against women.

That is one of our hugest problems in South Africa and now people are stuck in their homes with their abusers.

And there's less mobility, so there is less ability to remove oneself from that situation.

So there is this huge tension between all of these factors.

However I think that the limitation of the freedoms that South Africa has imposed has been to prevent a disaster that would completely eclipse all of those things, which would be to decimate our health system.

And thus cripple the economy.

Because we wouldn't have a health system and thus all those people who were undergoing violence or any of quadruple burden of disease would not get any help.

So I think in that respect it's been good to see what happens and to see that there has been a much lower rate of mortality now probably because of the lockdown, hopefully because of the lockdown.

It's been interesting to hear about the limitation of the cigarettes and the alcohol.

Yeah I've looked a little bit into the reasoning for that and the smoking I think was banned because obviously it damages the lungs and it further predisposes you to getting coronavirus and people in South Africa share cigarettes and so passing from your mouth to their mouth is going to transmit the disease a lot faster.

And the alcohol is a really big catalyst for violence and domestic violence in South Africa and trauma in South Africa and the head of trauma at Groote Schuur hospital had a piece of news in News 24 I think a little while ago that was saying that their level of trauma cases have dropped by one to two thirds.

They're not seeing half as many stabbings or violence and that could be because of the limitation on alcohol, it could be because people aren't moving around so much.

We've still got to see what that is but tentatively, we're speculating that alcohol might have something definitely to do with that.

But then the question is can be so paternalistic towards our population and say this is not good for you therefore we're going to ban it.

And there is possibly justification for that now and or previously when we were going into this crisis because we needed to save our health system.

It was so vulnerable and so precious.

But now a question of going forward in easing those restrictions, we're going to we're going to see you know how these freedoms are still going to be limited or not limited and I think that's going to be very difficult balancing act for home and so.

Yeah, I mean that's the situation in South Africa, very different to the Swedish model which is all over the news of almost complete freedoms and putting trust in the hands of the people.

I don't think this would have worked in a society like home where food is obviously a bigger priority than getting the coronavirus and so stricter measures have to be put in place.

Julia: This goes to show that you know one model in one country doesn't necessarily work in another country and maybe even from city to city it might be different and so this really needs a more personalised approach.

But looking to the future I mean do you see anything positive coming out of this?

I mean here in the UK, there's been discussions of inequality but there's also been this demonstration of solidarity with the people.

I mean everybody coming out every Thursday night and clapping for the NHS workers, the people volunteering online, people organising Zoom socials just to stay in touch with people.

I mean these are really nice things that are that are coming out of the pandemic. Do you see other positive things coming from this?

Caitlin: Yeah, I mean I do think that there is potential for many positive things to come from the us.

I think if we can move from a culture of individualism to a culture of collectivism.

And helping one another and solidarity, that would be amazing and there's a philosophy in South Africa, in Africa, called Ubuntu, which I think is really amazing.

And it is: I'm a person because of other people.

And I think if the world could embody that sense of community during this time, that sense of solidarity that would be amazing to move away from solitariness and individualism.

And another wonderful things at least that's been noted at home is the interactions and partnership between public and private sectors and there's a huge divide between those two places at home.

I mean at home there's the Global North and the Global South divide in South Africa.

And so, to see those two sectors coming together has been really really promising especially because we are wanting to develop an NHI, which is similar to the NHS.

So yeah that's really promising for the future so I just hope that we can move away from hoarding for ourselves, self-interest-ness and the spirit of wanting to help one another across the world- I hope we can sustain that.

Silvia: what both of you have said, I think solidarity is that word for going forward and a new concept for bioethics.

Speaking from the perspective of bioethics and having a look at the future.

It's not like.

It's a newish concept, some colleagues including colleagues in our department like Barbara Prainsack and Elena Borzner have talked about solidarity in bioethics as a new lens.

This was work from a few years ago but I think it's really relevant today as solidarity and responsibility instead of you know autonomy, which has been the pillar of bioethics at least in the Western world for the past 50 years.

Something else is that I think the pandemic is showing us is the solidarity between generations and something that I hope that can be continued post-COVID is you know I think the younger generation are making huge sacrifices.

I mean, this particular disease COVID-19 as a higher prevalence and severity in the older demographics but as we were talking about, the lockdown is affecting all the population in the same way and the younger generation are really having to make huge sacrifices in terms of not just of restrictions of freedoms but for

example education and not being able to have in person education but Teams or Zoom and this might go on for a few months.

There might be some kind of blended flexible form of learning in place.

And yeah what I want to say that I think that the older demographics should really be grateful- I think they are- to the younger ones for the sacrifices that they're making and some of the requests that the younger generation has been making over the past few years such as you know climate change or attention to the environment.

And in terms of requesting lifestyle changes, in travelling less by airplane especially unless when it's you know necessary.

Now I think some of those requests pale off in comparison to the requests we're making today, sudden life changes for weeks or months because I think you know the time frame out for months possibly you know one or two years until we have treatment or a vaccine, so solidarity going forward between generations and as the new cornerstone of bioethics or society, really.

Julia: There is definitely more that we can explore there Silvia.

Unfortunately, we don't have time but before we go I want to ask you Caitlin, you're studying a master's part-time and working. How is it studying at the moment considering the circumstances?

Caitlin: Yes I mean speaking to working and studying part-time.

It's been kind of wonderful actually.

I've been really enjoying it.

Bioethics is just so applicable to my work but actually just all areas of society, that to study it and then think about these issues on the ground while I'm working, while I'm thinking about my actual life, my practical life, has been so wonderful.

It doesn't feel like I'm in a sort of student bubble and then I'm going to go into the real world.

I'm incorporating those two things at the same time.

So I think because of technology it's not going to be as limited as I thought it was.

I have become very optimistic after just having had this training module last week.

It's not the same and I think we maybe just have to get used to something different.

Yeah...

Julia: Thank you for that Caitlin.

Unfortunately as I said this is all we have time for today but I wish you all the best with your master's course and Silvia, I wish you all the best with your teaching and your return to work from maternity leave.

It's been a great conversation and you're welcome back any time.

Outro: You've been listening to the podcast, WORLD: we got this brought to you by the School of Global Affairs the King's College London.

To find out more about the podcast and our work head to our website kcl.ac.uk/worldwegotthis.

Here you'll find a full list of further reading materials.

This podcast has been produced by James Baggaley and Julia Stepowska, with editing by Rachele Wall.

To help us reach more people please rate and review us in iTunes, acast or wherever you get your podcast.

Until next time remember WORLD: we got this.