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The Penn Bioethics Journal (PBJ) is the premier peer-reviewed undergraduate bioethics journal. Established in 2004, the Journal provides a venue for undergraduates to make contributions to the field of bioethics.

Embracing the interdisciplinarity of bioethics, PBJ reviews and publishes original work addressing debates in medicine, technology, philosophy, public policy, law, theology, and ethics, among other disciplines. The biannual issue also features news briefs summarizing current issues and interviews with eminent figures in the field.

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Letter from the Editors

Dear Readers,

It is our pleasure to present Volume XVI, Issue ii of the Penn Bioethics Journal, titled "Beyond the Clinic: Physicians' Duties to Society."

Our first article, "A Permissive Duty to Warn," considers the ethics of balancing doctor-patient confidentiality with the responsibility of the physician. The article justifies its support of a permissive reporting system over either absolute confidentiality or mandatory reporting on both deontological and consequentialist grounds. The article also makes use of the law, including legal and political precedents and a New York gun control law, for an applied view of the bioethical considerations at stake.

Our second article, "Unequal Access: The Bioethics of Racism during the Time of COVID-19," argues that bioethical principles that have historically guided physicians in clinical decision-making have done little or even have exacerbated racial disparities in health outcomes in the United States, whether by permitting racial discrimination or failure to allocate resources to disadvantaged communities according to their need. Under the lens of structural racism, the article considers the utility of beneficence, nonmaleficence, and distributive justice in achieving racial equality in healthcare outcomes.

Our Bioethics-in-Brief section presents three news briefs that touch on current events in bioethics. The first brief examines physicians' responsibilities with respect to public health communication and medical information during the COVID-19 pandemic. The second brief takes up the ethics of facial recognition technology in medicine, including data privacy and racial bias. The third brief explores the unique issues faced by the elderly during the COVID-19 pandemic, such as age discrimination and the proliferation of telehealth, which raises concerns of accessibility.

We wish to manifest our most sincere gratitude to all the contributors to this issue, including the authors of the articles and the entire PBJ team. Leading the Penn Bioethics Journal team over the course of 2020 was a memorable and enriching experience, despite, or perhaps because of, the tumult of that year, which cast bioethics in a new light, given the COVID-19 pandemic, the public controversy thereover, and the renewed focus on racial matters in American society in the aftermath of the death of George Floyd.

It is our hope that this issue will be of use to you in deepening your understanding of bioethics as we continue to confront the public ethical controversies that have left their mark on the country's social and cultural landscape.

Shreya Parchure and Aditya Rao
Editors-in-Chief 2020

Bioethics-in-Brief

Controversial Physician Decision Results in License Suspension

Ayotzin Bravo

On December 3rd, Oregon Doctor Steven LaTulippe had his medical license suspended due to his comments regarding the pandemic—specifically regarding face mask use at a “Stop the Steal” rally that took place on November 7th in support of President Trump (Barreda 2020; Steinbuch 2020). A recording of the remarks was uploaded to a YouTube account run by Multnomah County Republicans. In said video, LaTulippe urges the public to take off their masks of shame, threatening freedom and our Constitution (Steinbuch 2020). He likens the threat of Covid-19 to that of the common flu, citing the flu season protocols his clinic has used to deal with the ongoing pandemic. He says that neither he, his staff, nor the patients wear masks usually in his clinic (Burke 2020). Although the Centers for Disease Control and Prevention (CDC) began recommending the use of face masks in early April, the current president and his administration have been less consistent in their advocacy for mask use which has contributed to the politicization of the issue (Japsen 2020).

In later interviews regarding the video, LaTulippe confirmed his previous statements and continued to argue against mask use, arguing that there is bad science behind it. He argues that the masks do more harm than good, creating a variety of problems for the wearer and that he is guiding himself by the tenant “first, do no harm” found in medicine. This decision to refuse to use face masks is directly in violation of Oregon Governor Kate Brown’s mandate, which requires health care professionals to wear a face mask while in the health care office. In support of his stance, LaTulippe emphasizes that Governor Kate has much less knowledge regarding infectious diseases and epidemiology (Barreda 2020). Thus, by refusing to wear a mask, he believes he is challenging the system and the overreach in power on Governor Kate’s part, not placing his staff and patients in any danger.

These statements by LaTulippe are the antithesis of those of his public health colleagues, such as Dr. Anthony Fauci. In an interview with an editor at The Journal of the American Medical Association (JAMA) in late October, Dr. Fauci adamantly advocated for all Americans wear masks in order to control the spread of COVID-19 (Japsen 2020). Recently, institutions like the Oregon Health & Science University (OHSU) have conducted evidence-based reviews to study the role of masks in limiting the spread of the virus—concluding that they were indeed beneficial (Barreda 2020). Moreover, according to the OHSU associate professor Dr. Gopal Allada, the few adverse effects found were infrequent and were far outweighed by the benefits.

Both LaTulippe’s words and actions highlight some important ethical issues regarding the liberties a physician may take in their practice. By establishing different protocols in his clinic that differ from the current standard of care during the pandemic, he exerts a direct form of paternalism by imposing his own belief of what the best form of receiving care looks like on the patients. Even though LaTulippe may be free to discuss his views regarding the overreach in power by Governor Kate Brown, as a physician, it is essential to keep the patient at the forefront while considering communications of concern to public health.

As government administration continues to confront the recent challenges posed by COVID-19, politicians often portray public health matters in a political light. During these times, physicians and healthcare professionals must be careful to remain unbiased and prioritize the provision of ethical care for patients.

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Facial Recognition Technology Raises Ethical Concerns

Nari Natalie Kim and Anusha Keshireddy

The principle of justice often arises when discussing the way algorithms are made, specifically the underlying bias within algorithms. Within the last year, there have been numerous studies that have published results on the building of training algorithms to use facial recognition in order to distinguish members of Chinese minority groups. In particular, in September 2019, a group of researchers asked for a 2018 study to be retracted that focused on the use of algorithms to distinguish a predominantly Muslim minority ethnic group in China from those of other ethnicities, such as Korean and Tibetan (Noorden 2020). This brings up the question of unethical facial-recognition research and the collection of enormous data sets of images of people's faces without consent, many of which have helped hone commercial or military surveillance algorithms and raises ethical concerns within the healthcare industry.

In the discourse surrounding AI in medicine, algorithmic bias is a large part of the discussion. Facial Recognition Technology (FRT) encompasses the use of algorithms and software to scan a person's face to store as a template for later reference in a database (Martinez-Martin 2019). It holds several applications, particularly to the healthcare field, as FRT can be used for diagnosis of genetic or medical conditions as well as for patient monitoring. Amongst its benefits include advantages that can be seen with technological applications which have assisted clinicians with identifying and treating genetic disorders early on through an analysis of facial morphology. Additionally, FRT can be incorporated as a measure to assist patients with dementia as a way to monitor and ensure their medications are being taken on time.

With FRT, one can see the significant implications it poses to society and technological advancement. However, along with these benefits include accompanying serious ethical concerns that should be addressed. This brings up the question of the collection of patients' images into a wide database and concerns regarding invasions of privacy and liberty violations that accompany the monitoring and surveillance of patients (Vilimek 2019). As patients are being constantly monitored by the FRT to ensure their adherence to the treatment and medication plan they are prescribed, it raises concerns that include the harmful impact surveillance can enact on the trust underlying the patient-physician relationship. Whilst trust is the foundation and basis for a strong relationship between a physician and his/her patient, constant surveillance by the physician on the patient has the potential to cause a strain. This also includes the patients' potential feeling of encroachment by their physician on their daily life as they can receive the feeling that their privacy is being breached with the constant surveillance.

Not only does there lie a concern regarding data and privacy issues regarding patients' private lives and a breach of trust within the physician-patient relationship, but bias can occur from the differentiation and categorization that arises through the use of an algorithm. Since algorithms learn from the data provided to them, poorly representative training data sets will introduce bias into algorithms (Vayena, Blasimme, and Cohen 2018). For example, most algorithms learn from information about Caucasian populations, because there is lack of data from non-white populations. Thus, AI usage in medicine can exacerbate the already existing racial biases within medicine, and negatively affect minority populations by providing incorrect diagnoses (Char, Shah, and Magnus 2018). This bias was exhibited when data from the Framington Heart Study was used by an algorithm to predict risk of a cardiovascular event (Char, Shah, and Magnus 2018). Due to less data collected about non-white populations during the study, the algorithm displayed racial bias and over/underestimated risk for non-white patients (Char, Shah, and Magnus 2018). In this case, the principle of justice was violated because the incorrect diagnoses and predictions will affect the overall population unequally, targeting the most vulnerable groups.

As a limited population sample that is not racially diverse can have the potential to cause racially biased results that may not be accurate to some racial or ethnic groups, it is imperative to ensure a large racially diverse population sample. Unfortunately, it is not easy to do so and it should be noted that the results can always hold the possibility of being more inclined towards one group that was more represented within the sample.

In addition to societal bias, algorithms may also carry medical bias due to assumptions that may be present in data training sets. For example, black patients have been historically over diagnosed with schizophrenia, which can wrongly teach algorithms that schizophrenia is common amongst black patients (Vayena, Blasimme, and Cohen 2018). Thus, algorithms can also over diagnose black patients with schizophrenia, and when new data is fed to algorithms to train them, it will reinforce the medical bias in an endless cycle. When a group of people is not appropriately diagnosed, it poses negative repercussions for the population.

With growing interest by both researchers, scientists, and health physicians in the promising future of FRT, it is crucial to understand and bear in mind both the advantages and concerns of FRT. This can be seen with the aforementioned ethical concerns raised by FRT along with recent current events that have caused a greater controversy over the ethics of facial recognition technology and research.

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Disparities in Care for the Elderly during COVID-19 and the Shortfalls of Telehealth

Samantha Costello and Michael Proano

One of the foremost deficiencies the COVID-19 pandemic has exposed in the healthcare system is the care and protection of the elderly. As the elderly face challenges like discrimination, isolation, and abandonment, healthcare workers and policymakers are left with the question: how should ethical healthcare be provided to the elderly population during a time of emergency?

In the early months of COVID-19, the elderly population was often neglected despite being the most high-risk age group. With hospitals reaching capacity, authorities frequently overlooked admitting patients from nursing homes and essentially "abandoned the residents to die" (Stevis-Gridneff, Apuzzo, & Pronczuk 2020). In an interview with the New York Times, nursing home owner Shirley Doyen recounts that even when hospitals had room, "they wouldn't accept old people…They had space, and they didn't want them" (Stevis-Gridneff, Apuzzo, & Pronczuk 2020). Doyen's nursing home is located in Belgium, a country with one of the highest COVID-19 death rates worldwide where two of every three COVID-related deaths is a long-term care resident. However, the discrimination of elderly people by the healthcare system was not only localized within Belgium's borders but occurred worldwide—in Spain, some nursing homes were found completely abandoned by care workers with some residents even left "dead, in their beds" (Minder & Peltier 2020).

In the occasion that elderly people received hospital treatment, they continued to deal with inadequate care, often despite the best efforts of health care workers. During the peak of the pandemic, resource-scarcity was a pronounced issue. Ventilators were particularly important, due to being a critical, life-saving intervention in the COVID ICU. As health care workers grappled to decide who the machines should be given to, the conversation ultimately centered on ethics—specifically, the elements of maximizing net utility and promoting instrumental value (Emanuel et al. 2020). These factors almost always favor younger individuals who have "more to lose from death" than the elderly, who have a lower life-expectancy and poorer prognoses (Miller 2020). Thus, older individuals who were at an inherent disadvantage in rationing systems may have felt as if their lives were less valued.

Moreover, even as elderly patients lie in critical condition, COVID-19 regulations separate them from their families. Family members often feel helpless as their loved ones are dying alone in hospitals or long-term care facilities. The implementation of telehealth services, or health services via the internet, provides hope by allowing for long distance patient care. However, transition to online methods of health delivery did not fully eliminate gaps in elderly care—even proving in some cases to accentuate them.

Telehealth serves as a prime example of the broader implications an older demographic has for medical care during the pandemic. In the latter half of this year, the amount of telehealth providers increased dramatically due to the U.S. Health and Human Services' curtailing of regulations on the service. These relaxations included disregarding aspects of the HIPAA privacy agreements as well as Medicaid or Medicare eligibility requirements (Hyder 2020). The Centers for Medicare and Medicaid Services

(CMS) reports that 24.5 million out of 63 million Medicare beneficiaries have used telemedicine during the pandemic (King 2020). On December 1, CMS extended coverage of telehealth services for Medicare beneficiaries past the end of the COVID-19 Public Health Emergency, building upon President Trump's executive order, "Protecting and Improving Medicare for Our Nation's Seniors" (Shatzkes 2020).

Simply put, telehealth has unprecedentedly taken over the healthcare landscape this year. But has it been adequate enough to substitute in-person care for older populations? Investigations and evidence do not seem to suggest this is the case.

For the most part, the transition to telehealth has not been difficult for those well-versed in technology and video-conferencing. However, one-third of Americans over the age of 65 reported difficulty accessing their physician online, mostly as a result of inadequate technology ownership or a lack of skill using it (Bloomberg 2020). An interview with four primary care organizations serving mostly elderly patients found that for one provider, 40% of their patients did not have the devices, Wi-Fi, or data plans necessary to meet their physician online properly. Another organization, Landmark Health, which serves a greater proportion of patients of vulnerable ages and health conditions, reported that between 60-70% did not have appropriate technological access. These providers also reported some of their patients having conditions that significantly affected their experience with telehealth, such as hearing or vision loss. One doctor stated how the majority of their interactions with patients were "spent looking at the ceiling fan" (Ikram et al. 2020).

After examining around 40,000 virtual patient-provider meetings during the height of the pandemic, researchers found age as one of the three major areas of disparity in telehealth, with language and race being the others. The study, reported in the Journal of the American Medical Informatics Association, found that although usage of telehealth was 41% for patients aged 18 to 29 and almost 50% for 30 to 49, it was a mere 24% for those over the age of 65 (Heath 2020). Not only do the elderly have a substandard experience with telehealth, but find it harder to even receive care from it at all, evidenced by their access to technology as well as overall turnout on these platforms.

Although COVID-19 may not have created these health disparities between the elderly population and other age groups, it certainly has exacerbated them. This ultimately raises key societal concerns about whose healthcare—and whose lives—are worth more than others. Providers and policymakers will ultimately have to think critically about what this year's approach to elderly care implies for the future of healthcare delivery, long after the pandemic has subsided.

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A Permissive Duty to Warn

Joseph Mertens*

The limits of doctor patient confidentiality are put to the test when there is a risk to a third party. This paper analyzes those limits in the context of psychiatric care and seeks to establish a framework that is compatible with both consequentialist and deontological theories of ethics. I conclude that a system of permissive limited confidentiality is most consistent with the principles of consequentialism and deontology. Finally, I test the bounds of my proposed theory by applying it to a New York gun control law.

Introduction

Since the decision in Tarasoff v. Regents of University of California in 1976, all but four states in America have adopted some form of duty to warn or protect laws for psychiatrists.[1] These laws, in some cases, require and, in others, permit but do not require psychiatrists to breach confidentiality if there is a danger to a third party. In effect, these laws extend the conditions under which mental health care professionals may breach confidentiality from the more traditional rationales. These traditional rationales include when a patient is a danger to themselves or when a child, or elderly individual, is being abused.

The broadening of conditions under which confidentiality may be breached has raised numerous ethical questions. From a deontological perspective, there is concern about the conflict between the prima facie duties of fidelity and beneficence, since these laws sometimes require a psychiatrist to breach confidentiality to protect a third party. Both those in favor and those opposed to these laws frequently invoke consequentialist arguments. One notable example of this is the case of Tarasoff. For those in favor, it is the classic precept of "making a sacrifice to ensure the best consequences." For those opposed, there is a concern that allowing for breaches of confidentiality will discourage those with violent feelings from seeking help and, ultimately, will result in more harm than good.

In this paper, I will argue that permissive disclosure laws best balance the interests of all stakeholders in mental health care. First, I will briefly overview the sources from which medical confidentiality principles arise. Then, I will demonstrate that the system I propose is consistent with deontological principles. In the consequentialist section, I will contend that many arguments fail to consider all involved parties and, when resolved, make clear the best consequences occur in a system of limited confidentiality. Lastly, I will test the limits of permissible criteria to breach confidentiality with an examination of a New York gun law. This law utilizes many of the same arguments to allow information gathered in a confidential setting to be used in the process of confiscating guns. I will give consideration to counterarguments throughout.

Sources of Confidentiality Principles in Medicine

Before diving into the ethical discussion, let us examine the sources of medical confidentiality, as a basic understanding is necessary for later arguments. The first source is the Hippocratic Oath, which contains what amounts to a promise of absolute confidentiality even in modern versions (Loewy 2007). While there are much lengthier AMA and APA codes, the Hippocratic Oath is the code that doctors swear to uphold when graduating medical school. Thus, despite its possibly being outdated, it is important to consider. The second set of principles are those derived from professional codes. Since this paper will focus on mental health professionals generally, both the AMA code, which governs psychiatrists, and the APA code, which governs psychologists, are applicable. In the most recent versions of both these codes, there are a few exceptions. Most relevant for this paper is that both permit breaching confidentiality to protect a third party to whom the patient is likely to cause serious harm (AMA 2016) (APA 2017).

The Tarasoff decision, despite being a state and not federal case and having been decided in 1976, remains highly relevant in discussions of medical confidentiality for two reasons. First, the arguments presented in the case form the foundation of the contemporary discussion on both sides of the issue. Second, this decision sparked a conversation around the issue and influenced the creation of state laws regarding a mental health professional's duty to protect third parties. Related to this is the fourth source of confidentiality principles, state laws. At the time of this writing, four states do not have laws creating a duty to warn, seventeen have permissive duty to warn laws that allow, but do not require, breaches of confidentiality when there is an

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[1] In this landmark California Supreme Court case, the majority held that psychiatrists have a duty to protect third parties. This includes directly warning an individual if a patient discusses harming them. Specifically, in this case, a young man told his UC Berkeley psychiatrist that he was planning to murder a woman with whom he was previously in a relationship. A few weeks later he went through with the murder. Despite the threats made to the woman the therapist never warned her, and as a result was sued by the parents of the victim.

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* Joseph Mertens studied Political Science at George Washington University and graduated in 2022. He can be reached at joemmertens@gwmail.gwu.edu.

endangered third party, and the remainder have mandatory duty to warn laws (Adi and Mathbout 2018). Lastly, underlying all of these codes are various ethical considerations and justifications that I will now examine at length.

A Deontological Perspective

In examining this issue through a deontological lens, I will adopt a prima facie duty framework.[2] Although this allows for more flexibility than if one were to adopt a more Kantian framework, there nonetheless remains disagreement surrounding which is the more stringent duty. In this case, two of Ross's prima facie duties conflict. First is the prima facie duty of fidelity which, in this instance, relates to the promise of confidentiality that is essential to the doctor-patient relationship (Ross 2013). Although modern codes recognize instances in which confidentiality may be breached without consent, this should not be taken as a guarantee that such provisions are ethical. Rather, as in normative ethics, a theory must be first expounded, and then permissibility assessed. Thus, the duty of fidelity becomes relevant since such provisions sometimes demand doctors to breach a previously made promise of confidentiality.

The other prima facie duty invoked is beneficence, which is derived from the acknowledgment that moral agents can make the lives of others better through their actions (Ross 2013). When a patient expresses intentions of seriously harming a specific individual, it becomes possible for the mental health professional to help the at-risk third party. Hence, there is a prima facie duty of beneficence, which conflicts with the prima facie duty of fidelity.

Having established that there is a conflict of two prima facie duties, we must determine which is more stringent. For this, there are several options. First, is to continue with confidentiality warnings as they are currently done to address the prima facie duty of fidelity. If patients are warned that there are limits to confidentiality from the outset, in the manner laid out by both AMA and APA guidelines, they are being offered a qualified promise. In which case, if the mental health professional breaches confidentiality, they will have still kept their promise, as it was qualified from the beginning. For some this may be compelling, but others may make the point that, given the long history of the practice of confidentiality in the medical establishment, one qualified promise, possibly buried in lengthy new patient paperwork, is not enough. Further, one may raise the objection that offering a qualified promise solves the problem of fidelity but does not offer an ethical justification for instituting a system of limited confidentiality. However, the second and third methods of determining the more stringent duty help to address this objection.

The second option to address this conflict of duties is to leave it unresolved. Initially this may sound outlandish but, in many ways, it is consistent with Ross's theory of prima facie duties. One benefit of this theory is its potential to align with the judgment of the moral agent (Ross 2013). Specifically, by not offering such explicit demands as Kantian ethics or utilitarianism, it leaves room for the moral agent to make decisions. In this situation, the moral agent is a mental health professional, and the moral question is, "What is a more stringent duty, keeping a promise to the patient, or protecting an endangered third party?" Depending on the details of the situation, the answer may vary. Hence, a theory that gives the moral agent some flexibility is appropriate. Thus, a system of limited confidentiality with permissive, but not mandatory, reporting is the best option. This system respects that there are two legitimate interests involved and defers to the mental health professional to make the best decision.

Thus far, deontology has been able to establish that there is a meaningful conflict between two of Ross's duties. I then defended as ethical a system of limited confidentiality because it is consistent with the Rossian deference to moral agents. However, to provide a more direct argument in favor of such a system, the paper shall further pursue an examination of its costs and benefits. Initially, this may seem to be an abandonment of deontological principles; however, through the introduction of a third duty, this exploration can be consistent with deontology (Gibson 2006).

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[2] The primary model for the framework I am adopting here comes from Rossian ethics. In his theory, Ross lays out several different prima facie duties that ought to be followed. However, he also acknowledges that in some cases these duties will conflict, in which case the moral agent must follow the more stringent of the two duties. I chose to employ this theory for my deontological argument rather than a stricter Kantian view for a couple of reasons. First, if one holds a strict Kantian view, then there is no ethical issue to resolve here since the duty of fidelity is a perfect duty and must always be respected. However, the reason why I disregard this view is not because it makes it difficult to uphold my argument, but rather because of how incongruent it is with the ethical codes of both the AMA and the APA. Neither the AMA's nor the APA's ethical guidelines demand absolute confidentiality in the way Kant's theory does. This lack of recognition of such an extreme view by either of the two relevant professional organizations further is an indication that such a view is outside of mainstream policy consideration. Thus, and moving to the second reason I opted to use a Rossian framework, this ethical theory offers results that are better adapted into policy. This is because it is a view that allows for consideration of multiple competing ethical interests as well as for some deference to the medical professional to adapt to the specific situation.

This third duty is that of justice, which requires an analysis of the distribution of benefits and or harms of a given action (Ross 2013).[3] Thus, the forthcoming conversation on the consequences of a limited confidentiality system, though consequentialist in nature, can be considered within the deontological framework as well.

A Consequentialist Perspective

The initial thought may be that, within a consequentialist framework, the justification for breaching the confidentiality of one individual to save the lives of several others is as easy as the classic trolley problem; however, this is not the case. In Tarasoff, both the majority and dissent made rule consequentialist arguments about the effects of a policy that allows for breaching confidentiality when there is an endangered third party. The majority, holding in favor of the psychiatrists' duty to protect third parties, stressed the benefits of saving the third party and minimized the cost of breaching confidentiality (Tarasoff 1976).

The dissent, on the other hand, focused more on the effects of limited confidentiality in the long term. The dissent asserted three reasons why there must be absolute confidentiality. First, the dissent argued that there would be a deterrence effect if confidentiality is not assured, thereby discouraging those who need help from seeking it. Second, for treatments to be effective, patients need to feel comfortable sharing all of their thoughts, which, if confidentiality is not guaranteed, they will not do. Third, the relationship between therapist and patient is one predicated on trust, which demands confidentiality (Tarasoff 1976). Therefore, the concern is that if there is a system that demands that therapists breach confidentiality, it may discourage those who need help from seeking it (Tarasoff 1976). This system, in turn, would lead to the commitment of more violent crimes, and hence, a system that is seeking to protect third parties may end up putting them in more danger in the long run. Although Tarasoff is only one case, the arguments made in each opinion are rather representative of the consequentialist arguments on both sides of the issue.

Underlying the argument that a system of absolute confidentiality is the best system is the belief that preventing the discouragement of patients from seeking help is enough to ensure less harm. This is a major, yet faulty assumption. The problem with this is it assumes that future harm will be prevented simply because a patient sees a mental health professional (Baker 2006). This surely cannot be the case, as even the best therapists cannot be assumed to be able to break through to 100% of their patients. On the other hand, a system of limited confidentiality may have a slight discouraging effect on individuals with violent inclinations from seeking help. However, it ensures that, in the instances in which they do, therapists are empowered to prevent harm by breaching confidentiality and subsequently warning the at-risk individual or the police.

In short, the argument put forth by the dissent confuses a metric with the goal. The metric is the number of patients seeking therapy. The goal, sought by both the majority and the dissent, was to prevent harm to third parties. Thus, the metric of examining the number of patients seeking help is only one aspect, since it cannot be assumed that mental health professionals will cure everyone who seeks help. Therefore, simply because absolute confidentiality results in more individuals seeking help, it cannot be understood to result in an equal increase in the prevention of harm to third parties. The other major issue with the arguments in favor of absolute confidentiality is that they neglect to consider all affected by the action. Due consideration of all parties is vital, as it is demanded by the consequentialist framework, they use to advance their arguments (Mill 2013).

Considering all the Stakeholders

Of all the involved stakeholders, the interests of the endangered third party are most easily understood. They benefit from a system in which all serious threats to their wellbeing, even those made in a confidential setting, are disclosed, and their safety ensured. Some may raise the Kantian objection that supporting such a system is a contradiction of will. In other words, if the third party were on the other side—the one expressing violent intentions— they would not want their therapist to make such disclosures since it may result in actions against them, like involuntary hospitalization. I assert to the contrary, however, that a contradiction of will explains why the individual most likely to be opposed to limited confidentiality would still support the system. This is the individual expressing violent intentions in counseling, as they are likely to experience some consequences, as a result, of their therapist breaching confidentiality. For them, the contradiction of will would be considering if they were the endangered third party or, perhaps more compelling, if the endangered third party was someone they cared deeply, about like a child. In such a case, even though in that specific instance, it is to their detriment, it is to their benefit to exist in a society that ensures third parties are not subject to preventable harm (Robertson 2006). More broadly, one can understand this as failing the Kantian test of universalizability.

Although I am invoking deontological principles, these considerations remain consistent with consequentialism. For instance, applying the test of universalizability is beneficial because it prevents involved actors from considering things in a self-interested way and, instead, with equal consideration for everyone involved which consequentialism demands. Additionally, requiring stakeholders to make decisions that may not be the most beneficial to them in that

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[3] When arguing for the introduction of the duty of justice here, I am primarily doing so with a utilitarian theory of justice as the ensuing conversation offers an analysis of the likely consequences to society. However, given the more general nature of this discussion of justice, I think there is potential for agreement with other theories of justice as well including libertarianism, a capabilities-oriented approach, and Rawls' theory of justice.

situation, but are beneficial to society as a whole in general, is consistent with rule consequentialist theories. Even though deontological tests are employed, it is in an effort to demonstrate how a moral agent evaluating consequences in a manner that does not give priority to their interests might think. One should not take this to be a reversion back to deontological arguments.

The other major stakeholder in discussions about confidentiality is the mental health professional. Adding consideration of therapists into the equation changes the calculation significantly. As mentioned earlier, when discussing the benefits of absolute confidentiality, often in these arguments there is a faulty understanding that simply because more patients seek help, more harm will be prevented. Previously, I disputed this because therapists cannot help every patient that comes to them. It may seem that even if this is the case, it is still a net positive because at least it gives therapists a greater chance to intervene with more patients.

However, this ignores two critical factors. First, it reduces the power of therapists to guarantee the prevention of harm to third parties by warning them directly or alerting the police. From this, the second concern arises; it puts an immense amount of pressure on doctors to be successful (Baker 2006). This is because they are the only actors with the ability to prevent harm, since, in a system of absolute confidentiality, they cannot alert anyone else who may be able to use different tactics to prevent harm, such as the police. Rather, they are the sole party with the potential to stop their patient from acting on their expressed violent intentions. This puts a lot of pressure on mental health professionals, and one must consider these long-term effects in the consequentialist calculation. The negative effects of such a policy on doctors are evident when examining the nine years between 1903 and 1912. During that time, the AMA adopted a policy of absolute confidentiality, which was eventually abandoned in favor of a standard that allowed for some exceptions. This was reversed because of the guilt physicians felt for failing to protect individuals from communicable diseases (Baker 2006). Because of the immense amount of pressure a system of absolute confidentiality would put on therapists, as well as the contradiction of will for patients not to support such a system, it becomes clear that a system of limited confidentiality best balances the consequences for all involved.

Putting it all Together

Before testing the limits of this argument by applying it to a New York gun control law, I think it is important to review what I have argued thus far. Initially, I made a deontological argument for a system of permissive confidentiality, primarily regarding the prima facie duties of beneficence and fidelity. Then, there was an exploration of several different methods of determining the more stringent of the two duties. The first method was mitigating the duty of fidelity by expressing limits to confidentiality at the outset of therapy consistent with both AMA and APA codes. Doing so would allow the therapist to breach confidentiality without breaking their promise to their patient. However, it was acknowledged that given the longstanding understanding of confidentiality in medicine, simply making patients aware of exceptions may not be enough. Further, offering a limited promise of confidentiality does not resolve the underlying question of the ethics of limited confidentiality, as much as it tries to avoid the problem.

The second method proposed was to embrace the flexibility of the Rossian framework that allows for decisions to be consistent with the judgment of the moral agent. In this case, this demands that the decision of deciding the more stringent duty be left up to the therapist. Thus, a system of limited confidentiality was proven to best allow for this. The third proposed method added the prima facie duty of justice into the equation. Since an examination of the distribution of benefits and harms was necessary, this duty provided for a transition to a consequentialist examination of the issues.

Much of the consequentialist argument was a response to the counterarguments about the negative effects of permitting breaches of confidentiality in medicine. The arguments against limited confidentiality claimed that it would result in more harm because of the discouraging effects on possible patients. I conceded the potential for these discouraging effects but asserted that this was not equivalent to more harm. For this to be true, it would require that more harm was prevented simply because a doctor saw more patients. This does not follow, as seeing patients and curing patients are not equivalent. Essentially, in pursuing a policy of ensuring the most patients get seen by therapists, cases in which there is a guarantee that harm can be prevented are sacrificed. This is because, in a system of absolute confidentiality, a therapist cannot appeal to an outside source, such as the police, for help. In turn, this puts all the pressure on them personally to successfully intervene. Since this is not possible in all cases, this will have negative effects on therapists, whose interests, as an affected party, must be considered. I also demonstrated using Kantian principles, which are broadly consistent with the ideas of rule consequentialism, that it is also in the patient's best interests to institute a system of limited confidentiality. Thus, when all involved stakeholders' interests are considered, as consequentialism demands, limited confidentiality will yield the best results.

Lastly, a point that has not been explicitly argued for, but has been implied through much of this paper, is the superiority of permissive rather than mandatory reporting requirements. While both have advantages over absolute confidentiality, mandatory reporting detracts from some of those advantages, with minimal benefits. This may seem contradictory at first - if it is beneficial to allow therapists to breach confidentiality to protect third parties, it would seem to make sense to require breaches. However, this is not the case. First, the deontological argument regarding deference to the moral agent disappears when instituting mandatory policy. This is problematic as it puts the policy at odds with one of the benefits of adopting a prima facie duty framework.

Second, even in states with mandatory reporting requirements, it is the therapist who decides if the patient meets the standards set by the law. As a result, arguments which assert that mandatory reporting relieves some of the burden for mental health professionals by eliminating discretion do not follow. Therefore, even if the intent is to reduce therapist flexibility, mandating reporting is likely to have little effect. A system of mandatory reporting yields minimal new benefits over permissive reporting, while detracting from some of the benefits of limited confidentiality. Thus, a system of permissive limited confidentiality is superior to a mandatory one reporting.

Testing the Limits Using Gun Control

Having established the ethics of a limited confidentiality system to guarantee the safety of third parties, I wish to test the limits of this argument by applying this system to a lower risk threshold. In New York, the SAFE Act gives mental health professionals an avenue to report if someone is a danger to themselves or others, which then allows for confiscation of any guns they own. This law does not involve a duty to warn potential victims or alert the police. As such, this law entails a lesser threat to liberty than more traditional duty-to-warn laws and consequently the there is a lower risk threshold that must be met to justify breaching confidentiality. More specifically, the law itself does not require that the threat be imminent (Safe Act 2013). This makes sense since a lesser infringement on liberty corresponds to a lower standard.

Having established the difference between this law and duty to warn laws, the previously expounded framework must now be applied to the New York law. Concerning the deontological reasoning, the conflict of duties remains, although the balance between the two duties may change since there is no longer the requirement of an imminent threat. The major difference lies in the consequentialist arguments for such laws. In the case of limited confidentiality, with duty-to-warn laws there was a much greater likelihood that the threat to a third party was eliminated as a result of the ability to warn the potential victim or the police. However, with the SAFE Act, the threat to the third party is not eliminated; all that is removed is a specific tool for carrying out violence. I am by no means contending that eliminating a gun from the situation does not reduce the potential magnitude of the violence. Nevertheless, the individual would still be free to commit violent acts; they just would have to do so with less effective tools. This runs into similar problems as absolute confidentiality, where there is a much lower guarantee of harm prevention. Thus, within the consequentialist framework, the potential for the SAFE Act to fail at preventing harm seems likely, and, as such, cannot be justified.

Furthermore, this law, in many ways, seems to occupy an awkward middle ground. If the patient was deemed to be a significant risk to others, they would be covered under regular duty to warn laws. On the other hand, if the patient does not reach the higher standards of those laws, then simply taking away their weapons without a guarantee of harm prevention is problematic since the third party is still in danger. Because mitigating harm to the third party has been the bedrock argument of this paper, this aspect of the law is of much concern. There is also a chance that the risk of harm increases because the individual whose guns were taken away may feel wronged by the process, and their anger may intensify. It should also be noted that if an individual was institutionalized under more traditional laws, that is one of the few exceptions in this country that would prevent them from owning guns (Categories of Prohibited People 2019).

Another point to consider when examining this law is its general effectiveness in preventing gun deaths. Because laws like New York's are not common, this is hard to ascertain, but some conclusions can be drawn by looking at Red Flag laws, which are more common and based on the same underlying principles. These laws empower family members, teachers, and social workers to report individuals whom they fear are likely to commit violent acts and result in the initiation of proceedings to confiscate their guns. Although these laws have frequently been passed in the wake of mass shootings, evidence shows, they primarily function to take guns away from suicidal individuals (Kivisto and Phalen 2018).

Even though combatting suicide is an important issue, when these laws are passed, they are advocated for with the premise of helping to prevent mass shootings. This, in effect, has allowed for politicians to claim bipartisan victories and, specifically, for Republicans to say they are willing to take some action to reduce mass shootings. However, as studies have demonstrated, these laws are not used to do this (Kivisto and Phalen 2018). Thus, when taking into account the consequences of Red Flag laws, as well as the New York law, it is important to consider the distracting effects they may have. Related to this is the potential for stigmatization of those with mental illness who are overwhelmingly non-violent, but frequently used as scapegoats by politicians to avoid more effective and controversial measures of gun control.

Conclusion

In this paper I have justified the ethics of a system of limited confidentiality under both a deontological and consequentialist framework. While this paper focused on a very specific issue, I believe there are several broader implications for the arguments I set out here. First, the congruence of my argument with two major ethical theories demonstrates its broad appeal and strong ethical justification for adopting the policy. Thus, this general framework of appealing to numerous ethical theories may be useful in establishing strong ethical reasoning for adopting a specific policy.

Second, when making the consequentialist cause for permissive limited confidentiality I placed a great emphasis on considering all stakeholders. As was seen in this paper, when such considerations are made, the consequentialist calculation can be altered significantly. A similar effect seems likely in several other bioethical issues. For instance, consideration of those whose livelihood depends on animal research or, in the study of health care reform, a question of what would happen to the thousands of individuals who work for health insurance companies.

Finally, when I tested the limits of these frameworks by applying them to the SAFE Act it became clear that for a law allowing for a breach of confidentiality to be justifiable, the likelihood of prevention of harm to a third party must be almost guaranteed. Thus, confidentiality breaches, as allowed by a system of permissive limited confidentiality, were justifiable for traditional duty to warn laws, but not the New York gun control law. It is important each issue be examined on its own merits because as the gun control law demonstrated two seemingly similar questions can be ethically distinct.

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Article

Unequal Access: The Bioethics of Racism During the Time of COVID-19

Ashley Anumba, Tanvi Kongara, Abdul-Rakeem Yakubu, and Hannah Yusuf*

Introduction

It is well known that Black people in the US have received unequal medical treatment since the 1600s. What is seldom interrogated is the ethical basis that has historically shaped—and continues to shape—the decision-making process behind this unequal distribution of resources. Such study is urgently needed if we are to identify, understand, and thereby change the ethical system that has enabled the unequal distribution of health care resources to the Black community and the inadequate, at times even harmful, medical treatment that Black communities have received.

This white paper will show how the ethical principles that determine the distribution of medical resources are inherently racist and have their roots in the unethical decision-making process used by slaveholders in the 18th and 19th centuries. As long as these harmful principles remain in the shadows, they will continue to silently shape and inform the kinds of decisions healthcare providers make when serving Black patients.

Background

While the formal field of bioethics emerged in the late 20th century, discussions about who does and does not deserve care have always been around. In this section, we will trace the history of a few key historical healthcare decisions that negatively affected the treatment of Black people in the US, along with the ethical principles that supported such treatment. We aim to highlight how these unethical practices and their justification are deeply ingrained and continue to inform decision-making in the present.

In order to ensure the functionality of the new economy fueled by slave labor, colonial lawmakers developed rules to address the dual status or more accurately the profound contradiction between treating Africans (and others) as persons held to labor—in which case as persons they were deserving of healthcare and other human rights—or as property owned by other people, and as such undeserving of human rights, including health care.[1] From the beginning, lawmakers struggled with how to address this contradiction because there were free Africans in some states; because some Africans were Christians; and because some Africans rebelled and refused to accept enslavement—all of which were indications of personhood. Moreover, in the 1700s, the South, after initially denying personhood to the enslaved, reversed its position when they realized that by granting partial personhood (the 3/5ths person rule), they could increase the political representation of Southern states in the electoral system.

However, in all cases of treatment of the enslaved, lawmakers regarded enslaved Black people as property. Famously, the Supreme Court case Dred Scott vs. Sandford denied all present and future Black people personhood, citizenship, and thus moral human rights.[2] As a result, slave owners had no legal obligation to attend to the health care of their "property." By denying personhood to Black individuals, they were able to deny Black individuals the right to health care accorded others, making it socially, ethically, and legally justifiable for slaveholders to withhold medicare care. This elaborate circumvention of moral reasoning would become the uninterrogated basis of many decisions regarding medical treatment for Black people in the United States made thereafter.

The ratification of the Thirteenth Amendment in 1865 put an end to slavery and to African Americans being legally regarded as property. However, the health needs of the Black community remained unaddressed by the government and medical practitioners. Despite no longer being viewed as property, false medical narratives of Black people having higher pain thresholds, thicker skin and skulls became commonplace in an effort to retain hierarchies of labour and citizenship as well as a means of denying care. This racist, essentialist "research" contributed to the pseudo-ethical justification for lower quality of care.[3]

The neglect faced by Black people was yet again justified in 1896 by the "separate but equal" doctrine of the Plessy v. Ferguson court case, where it was held that the 14th Amendment applied to only political and civil rights.[4] Therefore, it remained acceptable to have separate medical facilities for

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*Ashley Anumba (Health and Societies), Tanvi Kongara (Healthcare Management and Business Analytics), Abdul-Rakeem Yakubu (Mathematics and Biology), and Hannah Yusuf (Political Science) are students at the University of Pennsylvania. They can be reached at aanumba1@sas.upenn.edu, tkongara@wharton.upenn.edu, abya@sas.upenn.edu, and hyusuf@sas.upenn.edu, respectively.

whites that were better equipped and funded, and able to turn away colored patients.[5] Black people were left with hospitals that were severely underfunded and understaffed. Once again, unequal treatment of Black people was rationalized and justified by the U.S. Supreme Court, and the moral ethics shaping medical treatment was allowed to remain unchallenged.

The negative health consequences facing Black communities due to lack of funding, resources, infrastructure, and trained physicians were only exacerbated in the 1900s. Politicians and local health authorities, such as branches of the American Medical Association (AMA), continued to neglect the needs of minorities, and justified this position on the basis that medical care was available to anyone in need--a position that was far from the truth as shown with future pieces of health policy [6] such as with the Hill Burton Act of 1946.[7]

Modern Day

Centuries of intentionally distributing medical resources unjustly, neglecting the needs of minorities, and naturalizing racist stereotypes have only widened the health divide over time. According to the United States National Center for Health Statistics in 2003, over 40% of Black beneficiaries rated their health as poor or fair, whereas only 25% of their white counterparts similarly rated their health as poor or fair.[8] Other studies have shown that, compared to their white counterparts, African American adults are 40% more likely to have high blood pressure, three times as likely to die from an asthma-related complication, and 60% more likely to be diagnosed with liver cancer. They also account for 44% of HIV cases in the United States.[9]

Figure 1 below highlights the prevalence of comorbidities among different racial groups in COVID-19 hospitalizations and death. The data clearly shows that black patients experience comorbidities at a much higher rate compared to the broader sample population of White patients and patients of other races. For example, 74.6% of hospitalized Black patients and 86.7% of Black patients who died had comorbidities. Across all racial groups, patients who were hospitalized or who died had higher rates of comorbidities than the overall sample population, which highlights how comorbidities within the Black population contributes to their increased COVID-19 infection and death rate.

In addition to current comorbidities within the Black population, the theme of disproportionate attention and increased access to testing given to wealthier, whiter communities continues to shape the present.[11] When COVID-19 reached the U.S. and business closures began happening in March of 2020, resources were already scarce, and a centuries-old pattern of unequal allocation showed its face once again. Hospitals in minority communities were left in dire need, while other hospitals in wealthier communities were getting necessary supplies. Data from New York City, for example, point to disparities in terms of who had access to testing. The total number of tests administered rose in direct correlation with the percentage of white residents; in turn, the proportion of positive tests decreased with white population.[12] The overall death rate from COVID-19 among Black communities due to poor health and lack of equitable healthcare has been disproportionately high across cities and states in the U.S. In Chicago, Black people made up 68% of COVID-related deaths despite only being 30% of the city's population.[13] In Michigan, Blacks make up 15% of the state population but represent 35% of people diagnosed with COVID-19 and 40% of the total COVID-19 deaths in the state.[14]

The COVID-19 pandemic has shined a harsh light on medical resource allocation and guidelines, suggesting that decision-making must shift from a racist, white-privilege notion of ethics in order to address the health needs of minority communities. In the next section, we will explore the typical bioethical principles of medical resource allocation in order to determine how they facilitate racist ethics, and how they might be reconfigured to be fairer and more inclusive in this pandemic and in the future.

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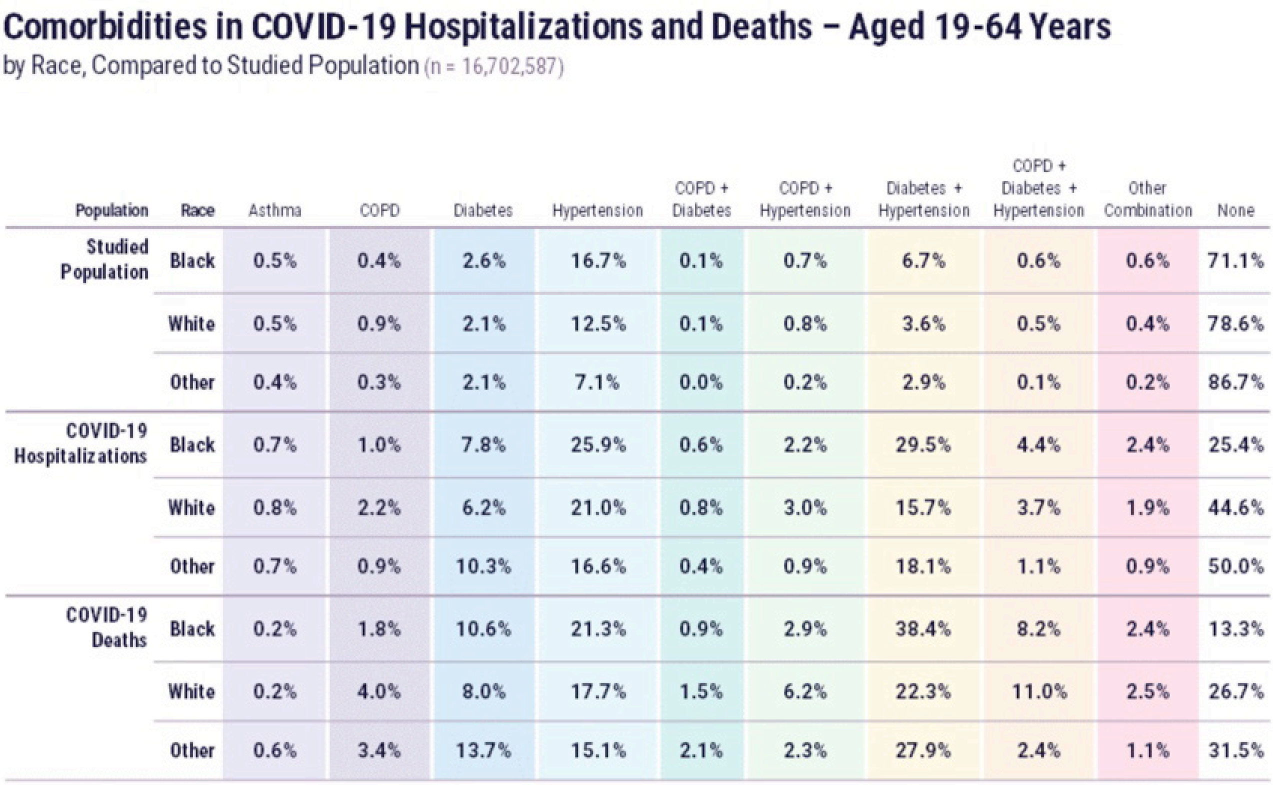
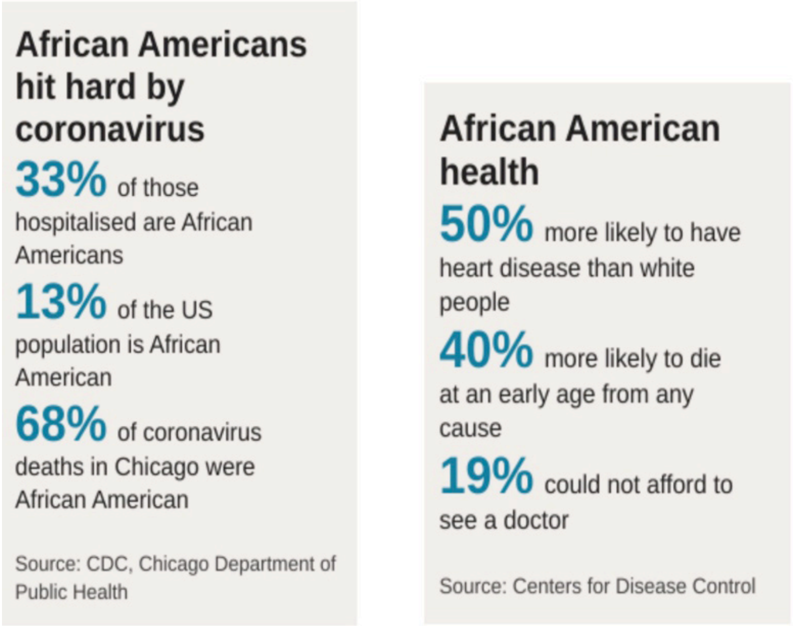


Comorbidities in COVID-19 Hospitalizations and Deaths – Aged 19-64 Years

by Race, Compared to Studied Population (n = 16,702,587)

Population	Race	Asthma	COPD	Diabetes	Hypertension	COPD + Diabetes	COPD + Hypertension	Diabetes + Hypertension	COPD + Diabetes + Hypertension	Other Combination	None
Studied Population	Black	0.5%	0.4%	2.6%	16.7%	0.1%	0.7%	6.7%	0.6%	0.6%	71.1%
	White	0.5%	0.9%	2.1%	12.5%	0.1%	0.8%	3.6%	0.5%	0.4%	78.6%
	Other	0.4%	0.3%	2.1%	7.1%	0.0%	0.2%	2.9%	0.1%	0.2%	86.7%
COVID-19 Hospitalizations	Black	0.7%	1.0%	7.8%	25.9%	0.6%	2.2%	29.5%	4.4%	2.4%	25.4%
	White	0.8%	2.2%	6.2%	21.0%	0.8%	3.0%	15.7%	3.7%	1.9%	44.6%
	Other	0.7%	0.9%	10.3%	16.6%	0.4%	0.9%	18.1%	1.1%	0.9%	50.0%
COVID-19 Deaths	Black	0.2%	1.8%	10.6%	21.3%	0.9%	2.9%	38.4%	8.2%	2.4%	13.3%
	White	0.2%	4.0%	8.0%	17.7%	1.5%	6.2%	22.3%	11.0%	2.5%	26.7%
	Other	0.6%	3.4%	13.7%	15.1%	2.1%	2.3%	27.9%	2.4%	1.1%	31.5%

Figure 1[10]



African Americans hit hard by coronavirus

33% of those hospitalised are African Americans

13% of the US population is African American

68% of coronavirus deaths in Chicago were African American

Source: CDC, Chicago Department of Public Health

African American health

50% more likely to have heart disease than white people

40% more likely to die at an early age from any cause

19% could not afford to see a doctor

Source: Centers for Disease Control

Figure 2[15]

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[15] "Coronavirus: Why Has the Virus Hit African Americans so Hard?" BBC News, April 11, 2020, sec. US & Canada.

Bioethical Principles

It is generally held that bioethical principles provide guidance to healthcare providers to guide their moral decisions in treating patients. Obviously, there is a problem with the application of these principles, or with the principles themselves, insofar as there are clear and longstanding disparities that disproportionately harm racially disadvantaged communities (especially Black communities).[16] In this section we will explore the basic ethical principles that most health care providers and bioethicists rely upon for moral guidance: nonmaleficence, beneficence, and distributive justice. Providers are asked to balance the demands of these three principles in their decision-making. However, as we will demonstrate, these principles have never addressed disparate treatment of disenfranchised Black communities. In examining these principles, we will ask whether they have the capacity to be inclusive, or whether they are inherently racist.

Nonmaleficence – Do No Harm

In medical ethics, a healthcare provider's guiding principle is "First, do not harm," otherwise known as nonmaleficence. This principle asserts that patients have the right to expect that their healthcare provider will not intentionally harm or injure them, whether through acts of commission or omission. Although medical mistakes do occur, nonmaleficence emphasizes the commitment of healthcare providers to protect their patients from a careless and unreasonable risk of harm. When some risk of harm is inevitable, health care providers are morally bound to administer the lesser evil at the patient's discretion. In such cases, the patient determines what is considered a "lesser" or "greater" harm.[17] Nonmaleficence, in other words, acts as a threshold for treatment. According to this tenet, if the harms of the treatment are greater than the benefits, then the treatment should not be administered. For instance, a patient might choose to forgo life-saving measures to avoid suffering from a painful and debilitating condition because the harms of the treatment outweigh the gains of a prolonged life.[18]

Despite the principle of nonmaleficence, Black people suffer from a compromised quality of treatment due to discriminatory attitudes or practices which variously lead to misdiagnosis or improper treatment.[19] In the book Unequal Treatment, a panel of experts document their evidence from a focus group with minority patients and physicians. An African American psychiatrist, for example, describes his experience with the health inequality faced by Black people:

> "Of course, in psychiatry we see this ... Patients are inappropriately diagnosed, and medications prescribed for the patients. We see errors in that. Minority patients will often be diagnosed inappropriately as being schizophrenic."

The Harvard Medical Practice Study also found that Black people were more likely to be hospitalized at places with higher rates of negligence.[20]

Such evidence suggests that Black people are not benefitting from the principle of nonmaleficence and indeed are being subjected to racist negligence by healthcare providers.. The vagueness of this principle does nothing to challenge the unequal values fostered by our country's legacy of slavery, racism, and colonialism.[21]

Beneficence – Maximizing Patients' Best Interest

Beneficence states that healthcare providers must do everything in their power to benefit the patient in each situation, as well as prevent and remove harm for the patient. Under this principle, all recommended treatments and procedures must be in the patient's best interest.[22] A patient coming to a healthcare provider has the right to expect that their provider's chief objective is to help.

However, the ethical principle of beneficence is meant to apply not only to individual patients but also to society as a whole. Unlike nonmaleficence, which is considered to be a constant duty, beneficence is thought of as a limited duty--a moral obligation that only arises when a person becomes a person or patient of the healthcare provider. For example, a healthcare provider is free to choose whom to admit into his or her practice; they do not have an obligation to benefit all persons, just their own patients.[23] Thus, healthcare providers may need to weigh the value of different benefits in an effort to maximize overall benefits to society.

This discretion on behalf of the healthcare provider can be exercised in a manner that discriminates based on race. Healthcare providers report, for example, that institutions mandate policies that have a significant negative impact on the provision of and access to services for racial and ethnic minority patients.[24] In the same focus group from Unequal

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Treatment, one African American physician recounts how, "[b]ecause [some doctors] didn't want [minority] patients, they just excluded people from certain ZIP codes, from certain sections of the city." A person's perceived socioeconomic status based on race can also be an obstacle to obtaining quality health care services. Another participant recounts this attitude in his experience with healthcare providers:

> "Oftentimes, the system gets the concept of black people off the 6 o'clock news, and they treat us all the same way. Here's a guy coming in here with no insurance. He's low breed."

As this suggests, beneficence has clear limitations, as it enables discrimination and thus facilitates unequal access to medical resources and care. It is not considered a universal obligation but rather a principle based on non-obligatory morals ideas of altruism and humanity left to the discretion of the healthcare provider. Racist judgment on the part of healthcare providers will lead to unequal medical services for the Black community. Similar to nonmaleficence, beneficence leaves racism undisturbed and clouded by unequal values that disproportionately affect Black people. Perhaps there is some possibility that beneficence can be reconsidered in light of its concern for providing benefit to society as a whole. Through awareness and education for healthcare providers on how racism is a public health issue and a cause for chronic illness and psychological/physiological affronts, race might be explicitly added to the list of considerations of what constitutes beneficence, compelling physicians to provide equitable access to care to maximize benefits for Black communities.[25]

Distributive Justice – Equal Outcomes

Distributive justice is defined as "the fair and appropriate distribution of benefits, risks and costs within a society."[26] In the field of medical access, distributive justice has generally been interpreted as granting equal access to care for all. Distributive justice is oftentimes used to justify an individual's right to health care. The most popular approach to distributive justice is philosopher John Rawls' theory, which is centered around three core ideas: the equality of people in rights and liberties, the equality of opportunities for all, and the arrangement of economic inequalities that maximizes benefits for the least advantaged.[27] As such, distributive justice appears to hold the most promise as an ethical principle capable of addressing race-based disparities in medical treatment and resource allocation.

While Rawls is often somewhat contentious and does not focus on shelter or health care as ways to compare members of different social groups, other bioethicists, including N. Daniels, have subsequently built upon Rawls's work, arguing that the distribution of healthcare is a matter of social justice and that healthcare is a right.[28] Daniels argues that some basic needs are roughly equal through "an unpolluted environment, immunization, [and] antibiotics."

Under Rawls' theory, a system that allows inequality should be examined to determine whether the worse off are maximally well off. As such, distributive justice has great promise in approaching racial inequality by addressing race- and income-based disparities in a health context. For instance, Shelby argues that the principle of distributive justice would require "considerable redistribution of wealth, the expansion of educational and employment opportunities and aggressive measures to address discrimination in employment, housing, and lending." Removing such socioeconomic burdens would inherently improve health outcomes.[29]

There is still much debate among the bioethics community about whether the emphasis should be on equal access or on equal outcomes. While equal access, or distribution, ensures that everyone receives the same access to health care, equal outcomes attempt to achieve equal health. Many scholars in the field prioritize equal access among health disparities. For instance, Shelton writes, "the moral right to health care is best claimed in terms of equal opportunity and access."[30] On the surface, ensuring equal access is beneficial to everyone, including Black communities. After all, such access secures equal access to health insurance, which would place initiatives like expanding Medicare or universal health care at the forefront. There would be initiatives to expand access to hospitals and health facilities in more areas, which are all objectively good.

But if we ignore outcomes in favor of sole guarantees on equal access, existing inequalities will only be exacerbated. For instance, it should be equally important to ensure that individuals choose to use this access, especially in the field of healthcare. In the Black community, there is distrust in the health system due to a history of abuse,[31] examples of which are outlined in the introduction. If past harms prevent usage of such equal access, then the issue of health disparities remains largely unaddressed.

It's clear that focusing solely on equal access is not

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enough to remedy the deep-rooted harms of racism to health care. With a focus on equal outcomes, resources must be given to the worst-off communities to ensure that they are achieving health outcomes on par with the best off communities. In other words, the social determinants of health would have to be addressed. This includes "policy interventions targeted at education and early childhood; urban planning and community development; housing; income enhancements and supplements; and employment." [32] The pursuit of equal outcomes should result in equal access. Therefore, the goal and focus of distributive justice should be equal outcomes, and not equal access.

Bioethical Principles During COVID-19

Bioethics comes into play during COVID-19 when, for example, the need for ventilators and ICU beds exceeds capacity. That is when doctors and hospitals must determine who gets the lifesaving treatments. While numerous proposals have been made to rationalize the allocation of resources with ethical justifications, the imbalance between societal and individual ethics during the pandemic has brought to light some critical ethical choices confronting healthcare providers. Bioethicists argue that during a pandemic, where everyone is at risk and no one is protected from catching the virus, ethical considerations focused on individual lives are not an effective tool for making public health policies.[33] Therefore, ethical principles such as nonmaleficence, beneficence, and distributive justice must be adapted as considerations to provide the greatest good for society.

Nonmaleficence

Nonmaleficence requires healthcare providers to not intentionally harm or injure their patients and serves as a threshold to determine whether the benefits of a treatment outweigh the harms. Patients have the right to expect that their healthcare provider and hospital will take every reasonable measure to provide fair medical treatment. In the case of emergency situations, minimizing overall harm to society is equivalent to giving priority to worst-off. The rule of rescue, which claims that "our moral response to the imminence of death demands that we rescue the doomed," exemplifies this principle.[34] For example, transplantable livers and hearts, as well as emergency-room care, are often allocated to the sickest individuals first.

However, as indicated by our opening statistics about poorer health among Black communities a question arises concerning the nonmaleficence principle: Why are black people generally sicker, and why do they die earlier, than other racial groups? Priority to worst-off is broadly defined, and usually focuses on either the sickest or the youngest. Neither of these terms is race specific. Thus the principle of nonmaleficence would generally center its debates around whether the oldest, youngest, or sickest are "worst off" unless race is specified as a consideration.[35] Preliminary research suggests that "race," despite the established health disparities and problems, has never been one of the "worst off" factors included in the criteria for determining who gets resources.

Beneficence

Beneficence requires healthcare providers to work in the patient's best interest. This includes the responsibility to take reasonable steps to ensure good outcomes for their patients and maximize overall utility for society, which can be interpreted as saving the most lives. Beneficence has previously motivated policies on the scarce allocation of influenza vaccines and preparedness for bioterrorism attacks.[36] When there is no public health emergency, the allocation of the resources would be guided by the role to reduce overall mortality within the population. However, with scarce resources allocation, a different criteria focused on maximizing total public health benefit is recommended.[37] Therefore, during COVID-19 pandemic, approaching allocation of resources with a beneficence focus would result in giving resources to patients with the fewest comorbidities and best health in order to save the most lives. Many healthcare experts are in favor of this particular principle as it is the best means to maximize the benefits of limited COVID-19 resources equitably and effectively.

In hopes of maximizing benefit for the greatest number of people, the theoretical risk of "sacrificing the most vulnerable patients" will disproportionately affect Black communities. Black people tend to have poorer health and a higher rate of comorbidities because of systemic racism in society and more specifically healthcare. While beneficence aims for overall public health benefit, a healthcare policy that penalizes comorbidities will ultimately fail minority communities that are already more vulnerable to COVID-19.[38] As a result, this principle works as a cyclic mechanism to ensure continued discrimination against

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Black people, causing them to be denied access indefinitely. Not only are they unable to get treatment due to their comorbidities and overall poorer health, but they also have a greater rate of comorbidities due to the lack of treatment and access. In short, the ethical principle of beneficence creates, maintains, and ensures continued inequity while rewarding those who are privileged.

Distributive Justice

Based on the definition of distributive justice, in theory, it would be an ideal principle for including minorities, but preliminary research suggests that race is not part of the criteria for defining what would entail "equal" distribution of medical resources.

Historically, the principle of distributive justice has not been applied fairly, and some might argue that it has not been applied at all, especially now with the pandemic. There has been a failure to provide both health and economic resources to Black people, leading them to disproportionately experience the pre-existing conditions that lead to higher morbidity rates from COVID-19 as exhibited in Figure 3.

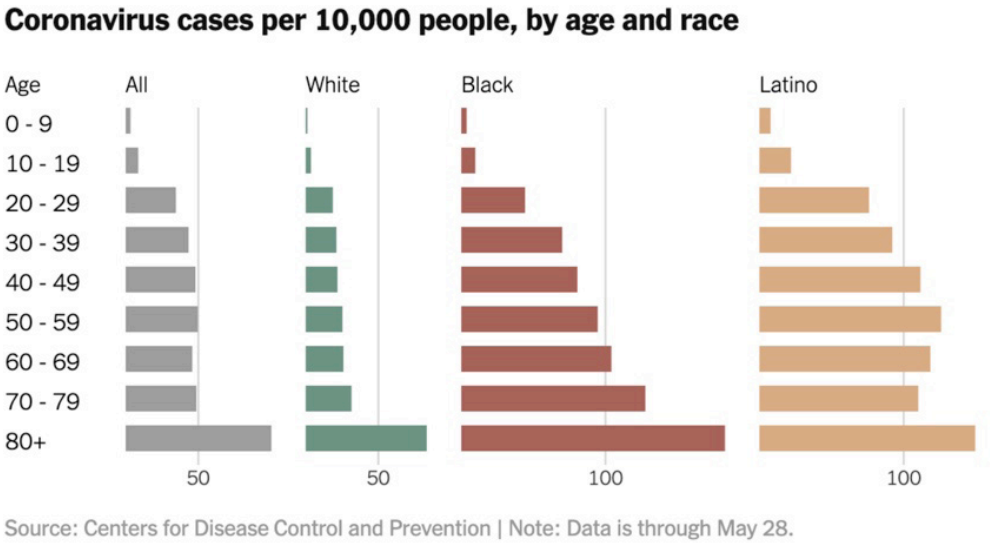

Figure 3[39]

Because of the failure to provide economic resources to Black people, and specifically, "a history of discriminatory policies around housing, land use, property rights, criminal justice, and health care," Black people have higher rates of both homelessness and housing insecurity.[40] Lost wages and wealth inequality, along with COVID-19, have made it difficult for families to afford rent and bills. Black workers are overrepresented in low paying jobs and the industries most impacted by COVID-19. They have less access to paid family and sick leave than white workers. As a result, workers must choose between risking exposure or even going to work while sick or staying home. At every turn, this lack of resources has hindered access to high quality health care and grants Black people increased exposure to coronavirus along with increased likelihood of having pre-existing conditions.

If distributive justice aims to provide just outcomes, then by definition, this would entail granting greater allocation of resources to Black people in order to promote true equality. If Rawls' principles can potentially be used to address racial inequality, and thus, health disparities, then distributive justice becomes an imperative principle in encouraging equality in health outcomes between Black people and other racial groups.

However, measurements used to dictate equality are "race blind," and are centered on ensuring that there is equal access. For instance, during the COVID-19 crisis, hospitals are using triage scores in order to save the most lives possible. One such score is the Sequential Organ Failure Assessment (SOFA), which is used as a mortality prediction tool. On the surface, this tool appears to be an objective device for triage—but it is actually unfair towards Black people. For instance, with sepsis, Black people have worse sepsis symptoms and higher sepsis rates compared to their White counterparts, and this leads to unfavorably higher SOFA scores amongst Black people.

Triage scores, including SOFA scores, reinforce and even multiply the effects of existing systemic inequalities,

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[39] Oppel, R. A., Gebeloff, R., & Rebecca, K. K. (2020, July 05). The Fullest Look Yet at the Racial Inequity of Coronavirus.
[40] Badger, E. (2013, August 16). The Dramatic Racial Bias of Subprime Lending During the Housing Boom.

which discourages the allocation of resources to Black people. Distributive justice calls for an arrangement of economic inequalities that maximizes benefits for the least advantaged—but with this current, race blind method of measurement, it does not maximize benefits for the least advantaged.[41] In addition, this shows another issue with Rawls's race blind ideology. When forming an index, Rawls calls for its formation to be based on an ideal society and to be race blind. Yet, as seen here, forming an index or a measurement system without indication of race does not solve the inequalities that already exist.

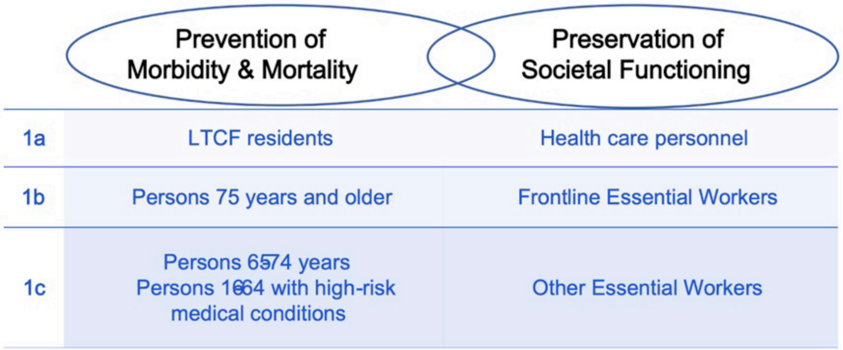
Thus, we need solutions that address equal outcomes, and not just equal access. By focusing on equal outcomes, as stated earlier, resources will be allocated to communities in need—specifically Black people. For instance, with the example of SOFA scores, Galiatsatos et al. suggest "abiding by health equity principles," thus resulting "in establishing frequent checkpoints to assess current trends in resource allocation and clinical outcomes." This not only allows for the identification of health disparities, but also clarification on whether allocation strategies are increasing disparities. This shifts the mode measurement towards focusing on equal outcomes. The authors also suggest that resources provided to patients with COVID-19 should be reviewed on the basis of varied sociodemographic variables such as race, insurance and access to health care, health literacy, and ability status to name a few. Again, with this new approach, there is a clear focus on maximizing benefits to the least advantaged, and focusing on not just equal access, but also ensuring equal outcomes.[42]

Current Proposed Solutions

In order to better serve Black communities during COVID-19, there needs to be a method of allocating resources in a more equitable manner. For this reason, we are advocating that distributive justice be considered when discussing what zip codes should receive medical resources and in what amount, while beneficence should be considered when determining allocation of resources to individual patients in hospitals.

A few institutions are rethinking their current value systems and are actively including new policies that address historical injustices by allocating resources to communities more proportionately. For example, the current allocation of COVID resources does not account for neighborhood disadvantage, especially in Black communities, and may be ineffective in curbing the outbreak.[43] A solution is the Area Deprivation Index (ADI), which ranks neighborhoods based on socioeconomic disadvantage on a national level.[44] Therefore, the government and healthcare systems can use the ADI to target resource delivery to specific geographic locations based on the greatest need and the greatest disadvantage. Given the high rate of COVID infection and mortality in Black communities, utilization of the ADI will facilitate the allocation of resources to them to help control and contain the outbreak. The ADI is a mechanism that ensures a more ethical distribution of resources to disadvantaged communities.

An example of where distributive justice would be effective is with vaccine allocation. The current ethical principles being used for vaccine allocation are "maximizing benefits and minimizing harms, promoting justice, mitigating health inequities,[45] and promoting transparency." In line with these ethics, the CDC has proposed the allocation seen in Figure 4. The CDC argues that this is addressing the principle of "mitigating health inequities" because racial and ethnic minorities over the age of 65 have a disproportionate number of hospitalization and death rates, are disproportionately represented in essential industries, and there is an increased presence of high risk medical conditions amongst racial and ethnic minorities. However, even they acknowledge that having a diagnosis of medical conditions requires access to health care.



	Prevention of Morbidity & Mortality	Preservation of Societal Functioning
1a	LTCF residents	Health care personnel
1b	Persons 75 years and older	Frontline Essential Workers
1c	Persons 6574 years Persons 1664 with high-risk medical conditions	Other Essential Workers

Figure 4[46]

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[41] Galiatsatos, P., Kachalia, A., Belcher, H. M., Hughes, M. T., Kahn, J., Rushton, C. H., . . . Golden, S. H. (2020). Health Equity and Distributive Justice considerations in critical care resource allocation. The Lancet Respiratory Medicine, 8(8), 758-760.

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We propose that resources, like the vaccine, should be allocated towards underserved communities using the Area Deprivation Index (ADI), in keeping with distributive justice. The CDC has called for LTCF residents and health care personnel to get the vaccine first. But this logic is flawed: not all healthcare workers are equally at risk of contracting the coronavirus. For instance, Penn Medicine reports that with the usage of PPE, the rate of transmission from patient to doctor is zero.[47] In contrast, other doctors report that their hospitals lack PPE, making their risk very high. These hospitals that lack resources like PPE or ICU beds tend to be in disadvantaged neighborhoods, suggesting that it makes the most sense to prioritize these healthcare workers in vaccine allocation, and not all doctors.[48]

While prioritizing health care personnel may allow the workers to be safer, this doesn't address ICUs being overwhelmed with patients, and oftentimes not having the resources to treat them all.[49] As stated previously, Black patients are more likely to be hospitalized than other groups. If disadvantaged groups were vaccinated first, and therefore were being infected at lower rates, this would lower the number of patients in ICUs. This allows doctors to expend more resources on the patients that do end up in ICUs, and lowers the rate of death nationally overall.

On a microscale, when physicians are caring for individual patients, distributive justice may be impractical because at bedside both patients are at risk of dying. In order to fill the single patient need, we recommend that physicians apply the principle of beneficence to maximize total number of lives saved. Physicians should actively work in their patients' best interests, paying keen attention to the interests of minorities. Many healthcare experts are in favor of this particular principle as the most equitable and effective means to maximize the benefits from limited COVID-19 resources. Instead of determining who is worse-off in terms of ambiguous factors and individual cases, healthcare providers in such emergency situations can turn to the beneficence principle, which allows healthcare providers to rely on simple sets of metrics to determine who is most likely to survive and flourish if given the resources needed. By considering the overall benefit to society, healthcare providers can save the most lives by allocating resources to those who have the fewest comorbidities and best health.

As mentioned previously, in the past and even now, the treatment that many physicians have given Black patients has been neglectful. If they understand how society is actively working against this community and the health effects that this has had, physicians would be better prepared to serve the Black community, especially during the COVID-19 pandemic.

Conclusion

As the disparities in health care among Black citizens become increasingly more apparent during the COVID-19 crisis, it becomes important for hospitals and the field of bioethics overall to focus on inclusive public health centered policies during the pandemic that better address the needs of disadvantaged populations.[50] A shift of this degree will be very challenging for healthcare professionals that are not used to practicing under emergency conditions — let alone when dealing with scarce resources. However without healthcare equality, we run the risk of exacerbating disparities faced by Black communities. Our healthcare system will continue to fail disadvantaged populations especially during critical times such as the COVID-19 pandemic if we do not address the holes in our current frameworks.

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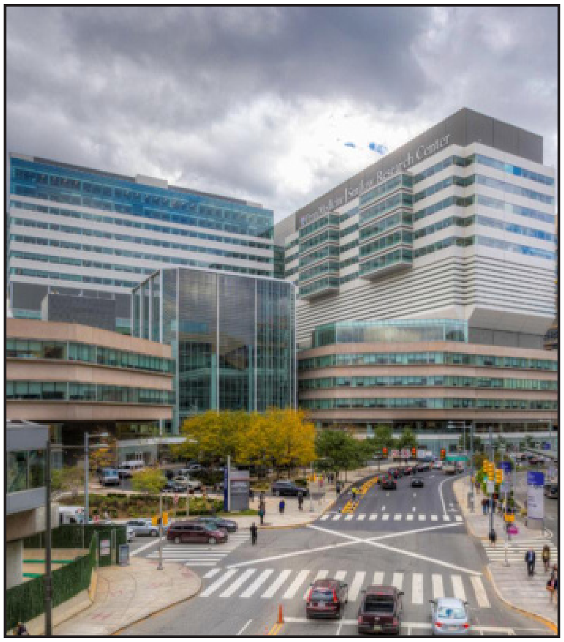

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