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GLOBAL PANDEMICS: CONSIDERATIONS OF PUBLIC HEALTH, HUMAN RIGHTS, AND BIOETHICS

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Abstract

Pandemics threaten the health and lives of peoples worldwide, sometimes requiring the imposition of numerous, restrictive public health measures to diminish their impact and preserve health and life. Such measures, however well-intended, have the potential to contravene human rights and raise significant ethical questions at the individual, community, national, and international levels. This article explores the impact of public health measures adopted in an effort to ameliorate the transmission of COVID-19 on access to care, the right to privacy, protection of marginalized communities from discrimination, and violence against women. The discussion of bioethical concerns focuses on resource allocation, the presumed obligation of healthcare workers to provide care, and governmental obligations in the face of a pandemic. The discussion concludes with a review of lessons learned: the need for a coordinated response across levels of government and the private sector, attention to existing structural inequalities that may exacerbate the impact of the pandemic and/or the public health measures adopted to contain the pandemic, the protection of vulnerable and marginalized persons, a clear delineation of and support for workers deemed to be essential, and the provision of relevant training to law enforcement personnel.

Key words: bioethics, human rights, pandemic, privacy, public health, vulnerability

Introduction

The word "pandemic" derives from Greek: *pan*, meaning all and *demos*, referring to people. Pandemics occur on a large scale, involve an infectious/contagious disease, and sustained community transmission. It has been suggested that the frequency of pandemics has increased during the past century as the result of more widespread travel, urbanization, and environmental change. Many of the recent pandemics, including HIV/AIDS, SARS, and COVID-19 are viral diseases that originated in wildlife (Morse et al., 2012).

There have been numerous pandemics throughout recorded history, with varying impacts globally. Two widely known pandemics that have been the subject of both scientific literature and popular literature include the Black Death and the Spanish flu. The Black Death, also known as "The Great Dying," (1346-1353), caused by *Yersinia pestis*, led to the deaths of more than one-third of Europe's population (Cohn, 2002; Langer, 1964). It is believed that an H1N1 virus of avian origin was responsible for the 1918 "Spanish flu" epidemic, which caused approximately 500 million people to become infected, representing one-third of the world's population, and 50 million to die (Patterson and Pyle, 1991). Table 1 below provides a listing of various pandemics that have occurred since the mid-fourteenth century, their causes, and their impact.

Table 1. Selected Pandemics From the Fourteenth Century Onwards, Their Causes, and Impacts

tion		ort to control			Jt.			n measures	various		-th			vorld's		sances	inres	million		bal					0		gh 2018	ide	es	countries		5.555	1,770,695		0	
	Death of 1/3 of Europe's population	Expansion of state power in effort to control	transmission, e.g., quarantines	Economic stagnation	Geographically limited stoning of	physicians	Persecution and murder of Jews	Resistance to imposed prevention measures	Occurred in sequential waves in various	regions of the world	High fatalities Asia, Europe, North	America, Russia, Africa	24.7-39.3 million deaths	Highest death rates globally in world's	poorest nations	Imposition of public health measures	Resistance to public health measures	Impacted >20 countries; 0.7-1.5 million	GDP loss in numerous countries	Implementation by WHO of global	influenza surveillance network	1 million deaths		Impacted 37 countries	Negative economic impact due to quarantines and travel bans	150,000-500,000 deaths	58.3-98.1 million infected through 2018	23.6-43.8 million deaths worldwide	Decreased GDP in many countries	Leading cause of death in some countries	Impacted 76 countries	As of 30 December 2020, 80.316.555	million infected worldwide and 1,770,695	deaths	Negative economic impact due to	qualatitus and uaret cans
T diamete Causes	Punishment from God	Configuration of planets		Jewish poisoning of wells					In US, attributed to African Americans						uo	Bayer aspirin (German product)		Physicians and medical institutions									Divine retribution for sin		US and WHO	Identified by health authorities as						
Actual Cause	Yersinia pestis								Vibrio cholerae				HINI					H2N2				H3N2 subtype of	influenza A			HINI	HIV (retrovirus)									
Fandemic	The Black Death/ "The Great	Dying"							Cholera				"Spanish flu"					"Asian flu" /'Far East flu"				"Hong Kong flu"		Severe acute respiratory	syndrome (SARS)	"Swine flu"	HIV/AIDS				Zika virus	COVID-19				
Dates	1346-1353								1846-1860				6161-8161					1957-1958				8961		2003		2009	-1861	present			2015	2020-	present			

Sources: Blakely, 2003; Cohn, 2002; Desmond, Lieberman, Alban, and Ekström, 2008; European Centre for Disease Control and Prevention, 2020; Galishoff, 1969; Henderson, Courtney, Inglesby, Toner, and Nuzzo, 2009; Langer, 1964; Morse et al., 2012; Paluzzi and Farmer, 2004; Patterson and Pyle, 1991; Pollitzer, 1959; Slack, 1988; Tognotti, 2013

*AIDS was initially attributed to members of four subgroups: Haitians, hemophiliacs, homosexual, and heroin addicts. This became known as the "4-H theory" or "4-H club" (Paluzzi and Farmer, 2002).

Strategies for Pandemic Management

Public health measures for pandemic management focus on containment, mitigation, and suppression. The implementation of these strategies varies depending upon a variety of factors.

Containment is utilized during the early stages of a pandemic to minimize the risk that infected persons will transmit the infection to noninfected individuals. Measures include contact tracing and the isolation of individuals who are known to be infected.

Mitigation strategies are those that are used to slow the spread of the disease and reduce the peak of demand on health care services, i.e., "flattening the curve." Depending upon the cause of the pandemic, mitigation strategies may include personal preventive measures such hand washing and the use of protective materials, for example, condoms in the case of HIV/AIDS and face masks in the case of respiratory transmission. distancing between individuals may also be utilized; this may be done voluntarily or, in some cases, authorities may impose limited curfews or mandate staggered or limited work hours in an effort to limit physical contact between persons (Aimone, 2010). Environmental measures may also be helpful, such as the physical distancing of seating and the reconfiguration of air flow. During the 1918 influenza epidemic, New York City enacted measures that required individuals to protect their nose and mouth while sneezing and coughing and to cease spitting in public (Aimone, 2010). Immunization constitutes a critical mitigation strategy when it is available (Henderson, Courtney, Inglesby, Toner, & Nuzzo, 2009). Research suggests that the use of containment and mitigation measures together may be most effective for slowing the spread of disease (Organisation for Economic Co-operation and Development, 2019).

Suppressive measures are necessary in situations in which the infectious contagion has led to widespread infection. Measures may include population-wide physical distancing, such as travel bans, the isolation of cases, and large-scale quarantine of a population. The 1918 flu pandemic illustrates how population movement may facilitate or exacerbate viral transmission. The flu pandemic occurred during wartime; transmission was facilitated by troop movement, wartime disruption, and improved railroad networks (Patterson & Pyle, 1991)

Although these public health measures may be important to slow or halt the transmission of an infectious agent, their imposition may lead to tensions between individual rights and measures for the collective good. Foremost among these are the rights to freedom of movement, the right to health, and the right to privacy. Additionally, measures that are implemented in an effort to protect the public health may inadvertently increase risks to subgroups within a population.

Human Rights and Public Health

There appears to be widespread agreement that specified rights may not be derogated (Council of Europe, 1950). These include the right to life, a prohibition against torture and ill treatment, the prohibition against slavery, and the requirement that punishment be premised on law (Lebret, 2020). Other rights may be curtailed only under specified circumstances. Article 4(1) of the International Covenant on Civil and Political Rights provides for the derogation of derogable rights in the "time of public emergency which threatens the life of

the nation." The American Convention on Human Rights suggests in Article 27(1) that some rights may be curtailed in "time of war, public danger, or other emergency that threatens the independence or security of a State Part." The European Convention for the Protection of Human Rights and Fundamental Freedoms in Article 15 permits the implementation of measures that are "strictly required by exigencies of the situation," if they are not inconsistent with other international law obligations and do not discriminate between nationals and non-nationals (Council of Europe, 1950).

Accordingly, some rights may be limited in the face of emergency situations. Even then, however, deprivations of liberty must be reasonable, necessary and proportionate (UNAIDS, 2020). Any limitations are to be specific, time-bound, and evidence-based, with adjustments made in response to new information. The promulgation of criminal laws as a mechanism to enforce public health measures presents the risk of discriminatory enforcement against members of stigmatized or marginalized groups. (UNAIDS, 2020. See Chamas, 2020 for an example of where this has occurred.)

The World Health Organization in 1946 recognized "the highest attainable standard of health as a fundamental right of every human being." The Committee on Economic, Social and Cultural Rights (2000) recognized that [h]ealth is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.

Numerous international documents have indicated that states have an obligation to ensure access to timely, acceptable, affordable health care of appropriate quality, and/or to address the underlying determinants of health (Committee on Economic, Social and Cultural Rights, 2000). These include, as examples, the Universal Declaration of Human Rights (1948), the European Social Charter (1961), the Convention on the Rights of Persons with Disabilities (2007), the American Declaration on the Rights and Duties of Man (1948), the Convention on the Rights of the Child (1989), and the International Covenant on Economic, Social and Cultural Rights (1966). This right is central to, and necessarily dependent on, the realization of other human rights, including the right to food, housing, work, education, information, and participation (International Covenant on Economic, Social and Cultural Rights) and, as indicated in the International Convention on the Elimination of Racial Discrimination (1965), is to be enjoyed without discrimination due to race, age, ethnicity, or any other status.

Although measures such as quarantines and lockdowns may be imposed as part of a strategy to reduce disease transmission and protect public health, they may also lead to the deterioration of patients' health and an exacerbation of their existing difficulties accessing care (UNAIDS, 2020). Patient health may be threatened and their access to health care may be curtailed because the imposed lockdowns and quarantine measures require that they remain at home, even when needing emergency care (Biryabarema, 2020; Landman & Okereke, 2020). Health care workers may be unable to travel to their places of employment as a result of these measures, placing additional strain on already overburdened and overwhelmed health care systems (UNAIDS, 2020).

The right to privacy is reflected in the International Covenant on Civil and Political Rights (1966), which recognizes the obligation to protect individuals from unlawful, arbitrary interference with privacy, home, family, and correspondence. The use of drones, cell phone tracing, and contact tracing to detect infected individuals and warn others of possible contact clearly conflict with this right to privacy (CBSNews, 2020; Halpern, 2020; Kharpal, 2020).

The imposition of public health measures such as isolation, quarantine, and lockdowns may disproportionately impact vulnerable populations and lead to the inadvertent contravention of human rights. Groups most likely to be adversely impacted include the aged, the very young, those with pre-existing medical problems, prisoners, women, and

socially disadvantaged and marginalized groups (Ontario Human Rights Commission, 2020; UNAIDS, 2020). As one example, researchers have found in their examination of public health measures adopted to control the spread of COVID-19 measures that women in particular have been adversely impacted. The pandemic is expected to push up to 96 million people into poverty during 2021; 47 million of these individuals are women. Women-run businesses have been particularly impacted by the public health measures. Additionally, responsibilities for caregiving and home schooling, made necessary due to governmentimposed quarantines and lockdowns, have fallen disproportionately on women, often impacting their careers. The Convention on the Elimination of All Forms of Discrimination Against Women (1979) prohibits gender-based violence, but violence against women has increased due to the pandemic with its associated lockdowns and quarantines, leaving many women isolated from supportive resources (Abramian, 2020), a phenomenon that has been called the shadow pandemic (United Nations Women, n.d.). As an example, cases of partner violence against women have increased by 50 to 60 percent in the Eastern Mediterranean region and 30 percent in France (United Nations Department of Global Communications, 2020; World Health Organization Regional Office for the Eastern Mediterranean, 2020).

Roma individuals have been adversely impacted not only by the COVID-19 pandemic, but by the public health measures that have been implemented in an effort to control transmission (European Commission, 2020; European Union Agency for Fundamental Rights, 2020). Approximately 30 percent of Roma individuals live in housing that lacks tap water, and 40 percent lack sanitary facilities inside their dwellings. In some areas, up to 80 percent of the Roma population lives in cramped overcrowded neighborhoods, and many must migrate to work. The imposition of quarantines leads to individuals' confinement in already cramped spaces, and travel bans lead to individuals' inability to earn wages sufficient to provide adequate food and water. Because much of their work is in the informal sector, they may be unable to access unemployment benefits (European Commission, 2020; European Union Agency for Fundamental Rights, 2020).

In the United States, public health measures implemented in an effort to slow or halt the transmission of COVID-19 have had a disproportionate impact both on members of minority groups and on women (van Dorn, Cooney, & Sabin, 2020). Many minorities live in higher-density spaces, making it difficult to physically distance in response to quarantine measures (Wilder, 2020). Some minority individuals may be unable to quarantine because they work in essential occupations (Gordon, 2020; Wilder, 2020). Business closures in response to public health concerns have led to the furlough or termination of workers who were not deemed to be essential, leaving many women in lower-paying jobs furloughed or terminated (Bateman & Ross, 2020). Women have had to assume a disproportionate share of the consequences of school and day care closures, e.g., home schooling and heightened child care demands.

Bioethical Issues in Pandemic Management

Pandemic management raises numerous bioethical issues in both the clinical and research contexts at the individual, community, national, and global levels. Table 2 below provides a listing of many of the issues at each level. It is beyond the scope of this manuscript to examine each of these various issues in detail. Accordingly, this discussion focuses specifically on the issues of resource allocation at the individual, community, national and global levels; the asserted obligation of health care workers to provide care; and the obligations of government vis-à-vis those within its borders.

Table 2. Listing of Bioethical Issues Arising in Pandemic Situations

Table 2. Li	Sting of Dioetifical Issues A			CI I I
	Individual	Local Community	Nation	Global
Clinical	Autonomy	Fair resource	Fair resource	Fair resource
context	Resource allocation	allocation/ sharing	allocation/ sharing	allocation/ sharing
	Availability of and	Availability of and	Availability of and	
	access to non-validated	access to non-	access to non-validated	
	treatments	validated treatments	treatments	
	Health care worker			
	obligation to treat			
Research	Protection of individual	Research	Acceptability of	Data sharing
context	vs. individual autonomy	collaboration as	challenge studies and	Balancing of
	Protection of	means of maximizing	deferred consent	resources needed
	participants and	resources	Data sharing	for pandemic
	communities in context	Data sharing	Balancing of resources	control and research
	of need for expedited	Community	needed for pandemic	Obligation to
	review	engagement	control and research	support other
				nations

Sources: Smith and Upshur, 2019; World Health Organization, 2020 (May 6) Resource Allocation

As indicated in Table 2, issues of resource allocation arise at the individual, organization, national, and global levels. As an example, in the context of the COVID-19 pandemic, we find that there are a limited number of beds, intensive care beds, ventilators, and certain potentially beneficial treatments to be had. Health care providers frequently confront a situation in which they must decide which of their patients are to receive these potentially lifesaving resources. Resource allocation is also impacted by service priorities at an organizational or institutional level; is the hospitalization and treatment of COVID-19infected patients to take precedence over that needed by patients with non-COVID-19-related health concerns? Given that the availability of ventilators, specific treatments, and trained health care workers is limited, how is a nation to allocate these resources to the many areas of need? And, in view of the vast disparities between countries of wealth and those with fewer resources, how are the available resources to be made available and distributed globally? How such questions are answered may not only enlarge or reduce currently existing health disparities between individuals, communities, populations, and nations, but also challenge the precept of "the highest attainable standard of health" as a human right (van Dorn, Cooney, & Sabin, 2020; Olivarius, 2020).

Numerous frameworks have been devised as ethical guides to a pandemic response (Daniels, 1994; Persad, Wertheimer, & Emanuel, 2009). The University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group (2005) has suggested that an ethical response requires consideration of both substantive and procedural values. Substantive values include individual liberty, protection of the public from harm, proportionality, privacy, a duty to provide care, reciprocity, equity, trust, solidarity, and stewardship. Procedural values encompass reasonableness, transparency, inclusivity, responsiveness, and accountability.

Adoption of such a framework would require that a schema for the allocation of resources reflect consideration of each enumerated value. A variety of approaches to resource allocation have been proposed:

- allocation to save the most lives (Manelli, 2020)
- prioritization of the sickest individuals (Christian et al., 2020)
- allocation to those with shorter lives (Christian et al., 2020; New York State Task Force on Life and the Law, New York State Department of Public Health, 2015)
- allocation to maximize the total number of life years or quality-adjusted life years (see Melnychuk & Kenny, 2006)

- distribution first to the most vulnerable
- priority to those who are instrumental to the pandemic response (New York State Task Force on Life and the Law, New York State Department of Public Health, 2015)
- allocation based on a lottery system (Brock, 1988).

A specific resolution to questions of resource allocation may necessarily vary depending upon a constellation of factors including, but not limited to, the clinical characteristics of the population requiring the care and the level of scarcity, and understandings derived from community engagement,

The Obligation to Provide Care

It is often assumed that health care workers, and physicians in particular, have a duty to provide care in the context of a pandemic (see, e.g., New York State Task Force on Life and the Law, New York State Department of Health, 2015). This assertion derives from several arguments: that they expressly agreed to provide care as a necessary condition of their employment; that having entered into medicine, they gave their implied consent to provide care and society has a legitimate moral expectation that they do so (Fleck, 2003); that, having received specialized training, health care workers have an obligation to provide care; that providers have a reciprocal duty to provide care having received benefits and/or privileges associated with their education and/or employment; and that physicians have taken an oath and are bound by a professional code of ethics that requires that they provide care (Clark, 2005). Others, however, have argued that any of these grounds is inadequate to support the proposition that a healthcare worker has a duty to treat in the context of a pandemic (Malm, May, Francis, Omer, Salmon, & Hood, 2008). Indeed, although many physicians have provided care even at great risk to themselves (Shanks, MacKenzie, Waller, & Brundage, 2011; Walker & Whitty, 2015), history also presents us with numerous examples in which physicians chose to refuse or withhold care for fear that they or their family members might become infected (Jauhar, 2020; Zuger & Miles, 1987).

At least one author has suggested that, if such a duty exists, it is not unconditional but is rather reciprocal (Jauhar, 2020). Reciprocity would suggest that members of the public have a concomitant obligation to act responsibly, in conformity with public health recommendations designed to reduce the risk of transmission; that health care institutions and governmental entities have an obligation to ensure an adequate infrastructure through, for example, the provision of necessary personal protective equipment to reduce providers' risk of infection; and that providers, should they become ill, are provided with adequate treatment. In the context of the COVID-19 pandemic, the dedication demonstrated by health care workers, at times even at the expense of their own health and lives, has not been evenly reciprocated by members of the public, governmental personnel and entities, and healthcare institutions. Members of the public, even governmental officials, have refused to adhere to public health recommendations to reduce transmission; personal protective equipment has been scarce and sometimes completely unavailable (Finkenstadt, Handfield, & Guinto, 2020; Glenza, 2020; World Health Organization, 2020, March 3); health care institutions and governments have sanctioned health care workers for making their needs known publicly (Scheiber & Rosenthal, 2020); and governments have failed to develop the networks and infrastructure critical to efforts to control the pandemic and protect health care providers and the general populace (Amnesty International, 2020; Carville, Court, & Brown, 2020; Finkenstadt, Handfield, & Guinto, 2020).

Government Responsibilities

Various frameworks have been proposed in an effort to assist governments with the formulation of an ethical response to pandemics. One proposal suggests that the principle of

equal concern and respect, comprising the minimization of harm, fairness, collaborative action, proportionality, flexibility, reciprocity, and good decisionmaking, should guide all decisionmaking (Gad, 2020). Adoption of this framework would seem to require transparency and openness, community engagement, a willingness to modify course as new information becomes available, coordination and collaboration between levels of government and the private sector, and the provision of support to both those who are asked to bear a disproportionate share of the responsibility during the pandemic and those who are especially vulnerable. As an example, government support likely would, under this framework, include the provision of housing for homeless persons, both to protect that subset of the population and to protect the population as a whole (Holmes, 2020). Others have framed the principle of collaborative action in terms of solidarity, said to encompass the sharing of data and the deployment of human and material resources (Ireland Department of Health, 2020).

Additional values have been identified as critical to the formulation of ethical decisionmaking during a pandemic. These include inclusiveness of stakeholders to the greatest extent possible, accountability of decisionmakers at all levels, and appropriate systems to foster accountability (French, 2011; Ireland Department of Health, 2020; Singer et al., 2003).

Lessons Learned

The historical experience of pandemics suggests that several elements are critical components of an effective public health response that is both ethical and consistent with human rights. These include: a coordinated response across levels of government and the private sector, attention to existing structural inequalities that may exacerbate the impact of the pandemic and/or the public health measures adopted to contain the pandemic, the protection of vulnerable and marginalized persons, and a clear delineation of and support for workers deemed to be essential. The various excesses that may occur through the enforcement of public health measures such as quarantine and isolation and that lead to individuals' inability to access care and increased stress on the health care system may be reduced by providing relevant training to law enforcement personnel.

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