Is it only August? As David Burr Gerrard quips on Twitter — “Future historians will be asked which quarter of 2020 they specialize in”? We write to you from Singapore (over 47,000 cases as of 17 July) and Victoria, Australia (which recorded a daily high of 428 new coronavirus disease 2019 (COVID-19) cases as we write!). From afar we watch whānau and friends in New Zealand happily travel during the school holidays, mask free; and it is like observing a parallel universe. We have watched the country fall in love, break up, and patch things up again with Dr Ashley Bloomfield. We smile (but, being New Zealanders, also roll our eyes just a little) as The Atlantic’s Uni Friedman gushes, “New Zealand’s Prime Minister May Be the Most Effective Leader on the Planet.” We wonder if we could still get home, if we needed to. In Melbourne, residents are hunkering down for round two of lockdown and healthcare staff are bracing for the peak in case numbers. We’ve realised that for every COVID-19 case there are hundreds left struggling; every infectious disease pandemic is closely stalked by a shadowy mental health pandemic as lives are upended. And now for a second time, we are deferring elective procedures, increasing ICU capacity, and holding our collective breath before the daily briefing from the Victorian Premier, hoping case numbers won’t climb again. The hope of a trans-Tasman bubble has become a distant dream. As advising which quarter of 2020 they specialize in? As advising which quarter of 2020 they specialize in? As advising which quarter of 2020 they specialize in? As advising which quarter of 2020 they specialize in? As advising which quarter of 2020 they specialize in?

One clear example is the contested process of developing intensive care unit (ICU) triage tools to manage an overwhelming increase in critically ill patients. Globally, ICU triage has become the sharp and highly visible end of pervasive and entrenched social inequity. Many clinicians and ethicists have prioritised utility as the key ethical value — save the most lives (or the most life years) and maximise efficient use of ICU. This makes a lot of intuitive sense. However, this “fast thinking” results in prioritising the healthy and the able-bodied. Internationally, this was met first by critique and legal action from disability rights advocates on the grounds that it would amount to unjust discrimination of people with disabilities. Triage tools also have the more subtle effect of prioritising the lives of the privileged, simply because the easier lives to save are those of people with better underlying health status; and health status is not evenly distributed amongst the population. In China the case fatality rate (CFR) for COVID-19 was higher for patients with pre-existing comorbid conditions—10.5% for cardiovascular disease, 73% for diabetes, 6.3% for chronic respiratory disease, 6.0% for hypertension, and 5.6% for cancer. In NZ, people living in areas of greater socioeconomic deprivation have higher rates of multi-morbidity; and prevalence of multi-morbidity differs by ethnicity: Pacific ethnic groups 13.8%, Māori 13.4%, and NZ Europeans 7.6%.

Around the world the pandemic is laying bare the consequences of the unequal distribution of wealth and power and highlighting the social fault lines to which we have become accustomed. Black Lives Matter protests have erupted around the world in a moment that hopefully, finally, forces us to acknowledge and address the legacy of slavery and colonisation. Dr Donna Cormack (Kai Tahu, Kāti Mamoe), a Senior Lecturer at Te Kupenga Hauora Māori, has called for racism to be declared a public health crisis in New Zealand. Both the costs and benefits of public health measures will be differentially distributed across communities.

Marginalised populations are typically hardest hit by epidemics, on multiple levels. The ability to sustain social isolation is a luxury. According to analysis of cell phone data in the United States (US), high income demographic groups have reduced their geographic movement more significantly than lower income groups. Australia, like other wealthy countries, is grappling with the social vulnerability of a casualised workforce stripped of employment protections; public health departments can’t exhort those with minor symptoms to stay home if they aren’t entitled to sick leave pay. Many essential workers face a ‘Sophie’s choice’ of risking their own lives and the lives of others to pay for rent and food. During severe acute respiratory syndrome (SARS) in 2002–2003, Toronto was unprepared to respond to the unique vulnerabilities of the homeless. As advice regarding masks has changed, African-Americans have pointed out that it is not safe for them to cover their faces in public as this may increase the chance they will be perceived as aggressive. Evidence shows that people of colour are at increased risk of police violence in the US, in part because they are perceived to be threatening and violent. Emerging data from New York City shows that Black and Latino people are dying from COVID-19 at twice the rate of white or Asian people. But in New Zealand Māori account for a disproportionately small number of COVID-19 cases, only 8% of the total (whereas 16% of the population is Māori). This success may be in part due to iwi-led checkpoints protecting isolated and vulnerable communities.

Implicit racism may also have contributed to the slow response of many Western countries to coronavirus. Dr Marius Meinhof, a German sociologist argues that “we did not see a great threat, because ‘we’ perceived the virus as something related to the Chinese…other, disconnected from the West.” Persistent orientalism (the representation of Asia in a stereotyped way that is regarded as embodying a colonialist attitude) and post-colonial arrogance may have given the West a false sense of security. As Dr Pavesi, an Italian anaesthesiologist, wrote in March, “We always think of calamity as something that will happen far from us, to others far away, in another part of the world…But not this time. This time it happened here.” NZ had an advantage in this respect because by the end of March we could already see coronavirus as a health threat for ‘countries like ours’.

There are questions of international justice at play here as well. Economic analysis suggests that the global lockdown has slowed the
Adhanom Ghebreyesus, World Health Organisation Director-General -

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Where might the silver lining be here? The global response to

— a stark reminder of our global interconnectedness, and together we have taken remark-

After years of delay, deflection, and dispute about climate change, it

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We hope that this solidarity and sense of social responsibility provide a platform for

— a matter for ministries of health alone. The National Health Service was under threat in the United Kingdom, and now people are clapping in the streets. The US is fi-

— is more obvious than ever that our health depends on the health of our neighbours — their food security, mental wellbeing, ability to self-isolate, and access to medical care. The health of our community depends on the health and security of the most vulnerable. We hope this solidarity and sense of social responsibility provide a platform for climate change action.

In this now feels like a prophecy from the distant past, Dr Tedros Adhanom Ghebreyesus, World Health Organisation Director-General, wrote in mid-January, “Public health is ultimately a political choice. We need to realise that health is an investment in the future...A pandemic could bring economies and nations to their knees. Which is why health security cannot be a matter for ministries of health alone.” The National Health Service was under threat in the United Kingdom, and now people are clapping in the streets. The US is finally seeing the impact of decades of underinvestment in public health and millions of people without medical insurance or access to healthcare. In some ways, the world is experiencing a natural experiment in the effectiveness of different political regimes, public management structures, and health systems. We hope that world invests in public health, primary care, and addresses health disparities with urgency.

The health workforce internationally has taken on an extreme burden in the face of this pandemic. Some ethicists have argued that doctors have no obligation to work in unsafe conditions. Harvard University medical school professor Michael Gibson is trying to track the healthcare professionals who lost their lives as a result of COVID-19 infection. Health providers in Australia sit and wait, unclear whether they have successfully avoided catastrophe or if the worst is yet to come. Many health providers feel like Cassandra in Greek mythology, blessed with the gift of prophecy but cursed to never be believed. They know first-hand the fragility of the health system at the best of times and have predicted for years the potential for catastrophe. Constrained public health spending means the health system runs at or close to capacity, with even predictable bumps in demand like seasonal influenza outbreaks putting strain on the system. In Australia early in the pandemic health workers have been making their own hand sanitisers, re-using masks, and trying to source their own PPE — by making, borrowing, or competing on the open market. This entails mixed emotions — anger at the lack of preparation, feeling simultaneously vulnerable and yet enormously privileged, and some vindication when the predicted crisis comes knocking. Health providers bear witness to so much suffering and at the same time are inoculated against so much of it.

But within this chaos, health professionals have continued to care with compassion. PPE, especially hazmat suits, create a formidable barrier between the patient and the provider; often adding to the patients sense of isolation and fear. In NZ and overseas, doctors have taken photos of their faces and taped these to the front of their PPE so that patients can “see” their face. — In Singapore all patients who test positive for coronavirus are hospitalised until they receive two consecutive negative tests. Patients may be isolated in for several weeks, unable to leave the ward or receive visitors. To help ease this burden on patients, health providers have dubbed themselves the “second family” and gone out of their way to provide care as well as treatment. We hope these doctors provide inspiration and hope for you.

There have been persistent calls for bioethics to focus less on high technology interventions and autonomy, and focus more on issues of justice — both epistemic justice (who controls the narrative, whose voice is heard as a legitimate authority) and just distribution of resources (who gets access to PPE, vaccines, and ICU). We hope that fairness, solidarity, and care become core values in our work, and that we more systematically account for the social and political contexts about which we write.

A liminal space is one of transition — waiting, transformation, sitting on a threshold. Liminal spaces may be physical (an elevator or an airport lounge), or moments in a life story (a break up, a job loss). They involve a feeling of uncertainty, opportunity, and change. Incredibly, much of the world is currently sitting in liminal space, together. We have been forced to do the difficult work of breaking established habits — consumption, flying, endless productivity. Now we have the opportunity to think strategically about how we want to live moving forward. This moment is critically important for your generation. We won’t be going back to a pre-COVID-19 world order.

References


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