COVID-19 and World Order

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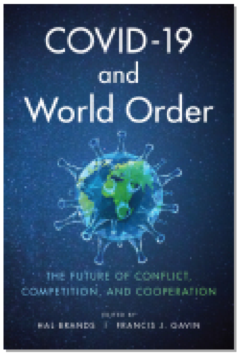

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Chapter Six

Bioethics in a Post-COVID World

Time for Future-Facing Global Health Ethics

Jeffrey P. Kahn, Anna C. Mastroianni,
and Sridhar Venkatapuram

The global COVID-19 pandemic posed a multitude of ethics challenges as the realities of the public health emergency became apparent. Issues confronted ranged from the allocation of scarce medical resources to questions about the proper balance of civil liberties and public health–related restrictions to concerns over the harms and benefits of social distancing weighed against those of reopening certain parts of societies. Many faculty in academic bioethics programs across the United States and around the world were asked to help address these and other issues, creating an unprecedented demand for ethics input and analysis. Some issues were familiar to American bioethics scholars. Others were beyond the range of issues and contexts that they typically consider, leading to requests for help from colleagues and participation in collaborative efforts that reflected multidisciplinary perspectives necessary to tackle the problems' complexities. These efforts helped respond to the issues faced by institutions and states, and to

Jeffrey P. Kahn, PhD, MPH, is the Andreas C. Dracopoulos Director of the Johns Hopkins Berman Institute of Bioethics, the Levi Professor of Bioethics and Public Policy, and a professor in the Department of Health Policy and Management in the Johns Hopkins Bloomberg School of Public Health. Anna C. Mastroianni, JD, MPH, is a professor of law at the University of Washington School of Law and associate director of the University of Washington Institute for Public Health Genetics. Sridhar Venkatapuram, PhD, FFPH, is an associate professor of global health and philosophy at King's College London and director of global health education and training at King's Global Health Institute.

a limited extent the federal government, but left unaddressed issues at the international and global levels.

COVID-19 raises global challenges, however, and in this chapter we reflect on the need for the field to address the real and pressing challenges in the global arena. The pandemic has highlighted our interconnectedness and interdependency; it has compelled thinking about ethics and its relationship to health within and across countries, which requires greater coordination and cooperation in a world that seems geopolitically fractured. It has also exposed the limitations of the historically dominant approaches to bioethics, pointing to a need for approaches that take seriously and engage deeply the concerns of social justice and health equity—concerns that, during the COVID-19 response, have relevance for everything from decisions about the triage of lifesaving resources to global health policy. Bioethics needs to do better, and we argue in this chapter that this means a renewed focus on a global health ethics that recognizes and takes account of the realities highlighted by the pandemic: focusing on health, not just health care; health equity, not just allocation of scarce resources; and social justice, not just distributive justice.

Bioethics Challenges during the COVID-19 Pandemic

The pandemic has brought many issues to the surface that the majority of bioethics scholars were not mindful of or thought were not core to their work. The work of bioethics evolved for good reasons to focus on biomedical ethics and research ethics, mostly distinctive from the ethics of public health and health policy. As a function of the evolution of the field, the professionals working in it were primarily appointed in academic medical centers. In these environments the work of bioethics has been primarily, if not exclusively, focused on clinical ethics and on researching questions amenable to empirical research projects, and it has had little to do with scholars working on questions of health policy and public health practice, who are often appointed in completely different parts of universities. The field's functional divisions have created a false but understandable dichotomy between clinical or bedside ethics issues and issues of policy, thereby reifying unhelpful silos.

The effects of years of disconnection and narrow focus were made obvious when the pandemic and its consequences uncovered numerous urgent ethical issues that needed to be addressed, and bioethics scholars were asked to lend their expertise and, in some cases, to help guide the response. Some issues appeared on their surface to be familiar for bioethics, such as the allocation of resources made scarce by insufficient supply (such as personal protective equipment) or by unprecedented demand (such as ventilators and beds in intensive care units). Those are matters that parallel long-standing work on how to equitably distribute the limited number of solid organs available among the many patients whose lives could be saved by transplants. But while allocation of kidneys is amenable to a national waiting list, and access to livers relies on a system of increasing priority that allows patients to wait their turn until they become sickest and therefore first in line, COVID-19 required a plan for triage rather than allocation.

Physicians, nurses, hospital administrators, and clinical ethicists are steeped in prioritizing the best interests of individual patients and in promoting autonomous decision making by patients. But they were suddenly faced with the prospect of a surge in COVID-19 patients so large that it would swamp supplies of lifesaving resources and force triage decisions on a scale incompatible with patient-centered decision making. The questions that hospitals and health systems faced were more like population-level questions familiar to public health policy experts than like the decisions typically made in tertiary care medical centers. Discussions focused on how to balance the interests of individuals against societal goals such as saving the most lives possible. Those questions are much more tractable when applying utilitarian, communitarian, and other distributive and relational justice approaches to ethics than when applying mainstream bioethics principles such as respect for persons and beneficence. To take on these unprecedented challenges, teams with relevant expertise were rapidly convened. Clinicians, hospital leadership, attorneys, clinical ethicists, and scholars in ethics and public health policy worked together for the first time in their careers to take up questions of how to allocate scarce resources, whose input to seek, what frameworks to apply, how to implement the application of consensus approaches, how to do so consistently and across hospitals and systems, and how to resolve who should bear ultimate responsibility for what were likely to be life and death decisions.

The bioethics community has learned several important lessons as a function of the time spent working on these issues. First, connections between work on clinical ethics and hospital system or government health policy questions, which had seemed forced or manufactured at best, now seem critically entwined and integral to answering the ethical demands of the pandemic. Second, the dominant approaches to bioethics cannot adequately address questions that combine taking account of the individual needs of patients and the interests of others in society, including the gross inequities caused by health and income disparities. Doing so requires much deeper consideration and inclusion of community- and population-level perspectives and approaches for incorporating them. Those two lessons amount to a sort of reckoning for bioethics, demanding a reconsideration of how bioethics work is conceptualized, its proper areas of focus, and the approaches needed to address them.

A Pivot for Bioethics

We propose that the answer is health ethics, to encompass clinical ethics, research ethics, public health ethics, population health ethics, and global health ethics. Health, in this context, is not limited to health care but instead comprises a broader concept about populations and individuals being able to protect themselves from harm and be free from illness or injury. Such abilities are much more influenced by pervasive social determinants than by access to medical care.[1] That pivot requires applying a broader lens of a social contract and its implications for distributing the benefits and burdens of living together in a society; it encompasses more than individual rights and, in particular, more than the focus on negative rights (liberties) that is a feature of American social policy and public discourse. It means a renewed focus on health equity, on the social sources of health disparities and their disproportionate impacts, and on the issues of social justice that they invoke. The decades-long attention to global health security is germane in that it acknowledges the relevance and importance of securing the health of populations. But it is animated by interests of national security and a watchfulness for new and resurgent threats rather than by social justice for the populations experiencing endemic health deprivations and likely to be most affected by new health threats.

To make this pivot, however, requires increased social recognition of the importance of protecting and improving the health of individuals and populations on par with other social goals such as growing the economy, ensuring national security, and protecting civil liberties. The health of the American population lags behind that of most wealthy countries and is not commensurate with the outcomes expected from such lavish annual spending on health care. At over $3 trillion per year, the United States spends far and away more money on health care than any country in the world. Yet the average level of health and health inequalities is worse than in other countries, including some low- and middle-income countries (LMICs). Part of the reason is that not every citizen in the United States has access to health care, which is also where the US stands apart from all other industrialized countries. At the same time, good health is not the same as having access to health care. The persistence of health inequalities in other countries with universal access to health care evidences that lesson. It would be easy to say that the United States does not value health as much as it does other social goals such as economic growth or domestic and national security, but then why spend so much on health care? One possible explanation is that, in the United States, health has become a personal consumption good. That is, health is seen as something that is an attribute of the individual, and good or bad health is largely a function of the natural lottery combined with personal behavior. Health care is therefore a personal good to be consumed and is accessed by the ability to pay for it, either individually or through government provision. This account of the "American health disadvantage" gives little attention to the profound and pervasive social determinants of health.[2] This may in part explain why social support programs and public health infrastructure are relatively neglected. Research in the United States about the health impacts of social conditions and relationships has largely been a niche subject of public health academics, health foundations, and government reports.[3]

Mounting evidence of the health and social effects of the pandemic in the United States and around the world makes clear the need for new priorities that take into account how health disparities, food and housing security, employment, schools, and basic nutrition have an outsize impact on health separately and almost always in combination. From a traditional bioethics perspective, there are limited intellectual resources to analyze or support a focus on health ethics as we describe it, even with a focus just on the United States, let alone a transnational or global focus. Even with a more expansive intellectual scope, the traditional domain of American bioethics is health care and biomedical research done in institutions with policies discussed locally and nationally but rarely globally. What can bioethicists say about the relations within a country during an infectious outbreak or about how different countries and international organizations should relate to each other during a pandemic? To answer such questions we must first understand how bioethics came to focus on the range of issues it does.

The Limits of American Bioethics

Bioethics is a relatively young interdisciplinary field, with most accounts pointing to its emergence in the United States in the late 1960s.[4] It was a time of social, cultural, and political change in the aftermath of World War II, marked by many features including a new emphasis on individual rights—civil rights, consumer rights, patient rights—and their protection. The same postwar period also saw an explosion in government-funded biomedical research and an ensuing recognition of the need for ethics guidelines for its conduct.

An important aspect of the early history of American bioethics is how its emergence and evolution were greatly influenced by biomedical research scandals. Most notable is the 1972 exposé of a forty-year US government study of untreated syphilis in African Americans in the rural South, often referred to as the Tuskegee Syphilis Study.[5] The revelations that impoverished African American men were deceived into participating in a research project with no benefit to them and that the men involved were deprived of available treatment in the pursuit of biomedical knowledge about syphilis prompted the US Congress to pass the National Research Act of 1974 to address ethical oversight in human subjects research. This law included the establishment of the influential National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1974–78), which was asked "to identify the basic ethical principles that should underlie the conduct of biomedical and behavioral research involving human subjects and to develop guidelines which should be followed to assure that such research is conducted in accordance with those principles."[6] The commission also produced a seminal document, commonly referred to as the *Belmont Report*, which articulated ethical principles that would not only inform the outcome of the commission's task but also would have an outsize influence on the evolution of the field.

In at least one telling, as the members of the commission trained in philosophy and theology worked to identify relevant basic ethical principles, they realized that their training and individual commitments to particular theoretical approaches to ethics made it unlikely that they could all agree on one conceptual approach that would then help in deriving basic principles.[7] Eschewing the selection of one ethical theory, they instead achieved consensus on midlevel principles that would be consistent with a range of theoretical approaches. These principles included respect for persons, beneficence (providing benefit and minimizing harm), and justice. This principle-based approach worked well in answering the particular research ethics questions posed to the commission, and an expanded and more deeply developed version was then used to address other applied ethics questions across biomedicine.[8]

As new rules were promulgated for research, new ethics requirements were also established for the accreditation of hospitals, and new educational requirements were established to include ethics in medical school curricula, often with the principle-based approach at their core (autonomy, beneficence, nonmaleficence, and justice). Bioethics as a field became professionally embedded in academic medicine, emphasizing issues arising in clinical ethics and research ethics. As professors of bioethics advanced in their careers as medical school faculty, success often required research funding from the US National Institutes of Health, which meant focusing on research priorities as articulated in calls for research, dominated by ethics and genomics and ethics and biomedical research. Bioethics faculty joined a growing group of professionals who could help apply policies, lead ethics committees, teach ethics to health professionals, and successfully compete for government grants, all while using the approach that had become dominant if not standard.

American bioethics, and to the extent it was adopted outside the United States, is in part a product of all these factors—its US origins in biomedical research and reactive policy making, the dominance of the principle-based approach, its emergence during a time of growth of individual rights, its professionalization, and its embeddedness in the academic biomedical enterprise. The demands and incentives created by those factors would affect the framing and choices in bioethics as a field in the coming decades—a framing that would, for the most part, ignore a conceptualization of bioethics approaches that could accommodate a more expansive view of health as a global and social justice issue. For example, issues of power, vulnerability, privilege, and systemic disadvantage have not been framed as central to the work of mainstream American bioethics. Many in bioethics have wrongly and comfortably assumed that the empowerment of individuals through informed consent processes and through applications of the ethical principle of respect for autonomy would adequately address power imbalances.[9] This presumably included systemic power differentials related to gender, race, disability, and other social categories of disadvantage. Feminist bioethics scholars, among others, have challenged the principle-based approach as it fails to adequately account for relationships of power and authority.[10] But even those challenges tended to be framed by issues of ethics and medicine, not health and society.

Appeals to broaden bioethicists' attention to a broader conceptualization of health and social justice have also come from individuals concerned about the racism and health inequities experienced by African Americans. Such pleas, for the most part, have been acknowledged but not been considered core issues to be addressed by mainstream bioethics. Annette Dula, for example, argued in 1991 for paying attention to issues of social equity, contending that the demographic makeup of bioethicists, dominated by "white, male, middle-class professionals and academics," narrowed the priorities and foci of the field to the exclusion of issues and perspectives relevant to racial and ethnic groups, poor people, and women.[11] And, prior to the pandemic, Marion Danis and colleagues used incidents of police violence against Blacks to draw attention to the urgent need for bioethicists to address structural injustice.[12]

Infectious diseases, with their potential for local impacts and global scope, were also overlooked in the formative period of bioethics, leaving bioethicists without the tools for their conceptual consideration.[13] HIV/AIDS offered opportunities to expand the remit of bioethics. But, surprisingly, few bioethicists engaged with HIV/AIDS or with its numerous social dimensions. With a few exceptions, the ethics of infectious diseases such as HIV/AIDS were initially shaped as domestic discussions and focused on confidentiality and professional obligations in a clinical context or on the ethics of HIV research in the developing world.[14] Later on, discussions about HIV/AIDS addressed research exploitation and the exportation of risk in LMICs.[15] Instead, the real ethical work around HIV/AIDS took place among activists and on the global stage. HIV/AIDS activists transformed the methodology of drug trials so that the drugs would reach patients faster, protested against governments that were unresponsive, and sought to ensure access to drugs by patients in LMICs. A global turning point was in 2001 when the United Nations General Assembly held a special session on HIV/AIDS, the first time for a health issue. It is here that HIV/AIDS became narrowly and politically framed as a global security threat, and so even at this level and opportunity, the first modern pandemic was not perceived as a bioethics issue.[16]

With some exceptions,[17] bioethics discussions about health as global and social justice issues were situated in public health schools and predominantly within the small field of public health ethics.[18] The focus of that work tended to be on domestic public health policy rather than global health. The few notable voices calling for global health ethics to be a focus of bioethics were received as identifying issues outside the mainstream and went largely unheeded.[19]

The field of bioethics was in large part disconnected from ongoing discussions, both domestically and on the world stage, of health policy issues such as rights to health care and certainly about rights to *health*. Those parallel discussions were happening, however, in political philosophy, human rights, law, and global development.[20] Reorienting bioethics—to attend more to health, not health care; to health equity, not allocation of scarce resources; to social justice, not distributive justice; to the effects of the pandemic, its emergence at a time of increasing nationalism, and its disparate racial impacts in the context of the Black Lives Matter movement—is required for a bioethics that is ready to address the challenges of a post-COVID world.

Global Health Ethics—a Bioethics for the Post-COVID World

It became clear by mid-March 2020 that the COVID-19 pandemic was going to be of a scale and nature very different from recent pandemics such as SARS, MERS, and H1N1. National responses to the pandemic in the form of shutting down most international trade and travel as well as many social activities through national "lockdowns" would be devastating to many countries in the short term and for years to come. As weeks progressed, it also began to be clear that diverse global and domestic dynamics could also have destabilizing impacts on the existing world order. That both Henry Kissinger and Mikhail Gorbachev, along with other senior statesmen and stateswomen around the world, published public statements about the need for giving attention to the global order signaled that responding to this phenomenon required more than science, money, and, even, pandemic ethics.[21] So, does the discipline of bioethics, and ethics more broadly, have something to contribute to analyzing and stabilizing the world order, or even to making it better? And, more specifically, can ethical resources and reasoning help address the role that health could or should have in stabilizing or reforming the world order?

Some international relations scholars may understand and integrate the pandemic as a new kind of global threat that requires mitigating and managing. That is, the pandemic is background music to the dominant issues of US-China relations or waning American influence in the global arena. There is another view that has more room for ethics, particularly related to human health and well-being. Gorbachev, as well as others, has come to recognize that world order needs to be reformed and centered on human well-being. He writes, "The overriding goal must be human security: providing food, water and a clean environment and caring for people's health."[22] And Dani Rodrik argues that "hyper-globalization" was too focused on trade and investment to the neglect of public health, and it was coming to an end even before the pandemic. A new, well-crafted globalization is needed that is centered on human rights, climate change, and public health.[23]

This focus on human well-being as the foundation of world order, or at least as a prominent part of global cooperation, is not novel. Emphasizing human well-being as the right target of global institutions and cooperation has motivated various efforts such as the United Nations' human security agenda advocated by the Japanese government.[24] And recent efforts to identify and promote cooperation around global public goods have been led by international agencies such as the United Nations Development Program, World Bank, and International Monetary Fund.[25] There have also been efforts to motivate national governments to go beyond aggregate macroeconomic indicators and focus on human well-being. These have included high-profile international commissions and the creation of new measures to assess the state and progress of countries, such as the Better Life Index of the Organisation for Economic Co-operation and Development.[26] While these efforts have aimed to put human well-being at the center of the work of international organizations, global cooperation agendas, and even national programs, they have not taken root. Growth in gross domestic product, international trade and investment, financial globalization, and, of course, national security have been hard to dislodge as primary concerns in the relations among countries.

Perhaps it is the depth of the near-universal shock to all governments and societies as well as to most international organizations that has created an opening to consider fundamental questions about the world order post-COVID. The lack of a robust, coordinated effort among nation-states and other global actors, and the continued neglect of public health in some of the weakest countries in the world, would mean more waves of the pandemic or would mean that the virus keeps circulating in the world, indefinitely threatening all countries. Epidemics and pandemics are also unpredictable. Depending on how the pandemic continues to evolve in the world, and how various countries respond domestically and abroad, this pandemic or worse pandemics to come could further destabilize geographic regions and world order.

The fast progression of the COVID pandemic is bewildering to bioethicists and global justice philosophers as much as it is to academics studying the world order. What is, or should be, apparent to all is that the spread of deadly infections makes patently visible the current state of interconnectedness of all human beings on this planet. Despite long-standing debates about globalization, it was largely understood as a phenomenon of trade and finance or, perhaps, of the clash of cultures. A virus being passed from person to person across borders makes global interconnectedness tangible, and personal vulnerability from being interconnected is immediately palpable. At the same time, it is a significant observation in itself that global interconnectedness helps transmit direct harms alongside many of the good things such as faster travel, exchange of ideas, greater economic prosperity, and alleviation of poverty.

A second related but distinct aspect that has become more visible is the interdependency of societies. Many Anglo-American global ethics and justice philosophers have up to now viewed the world as a group of distinct, self-contained entities. This is perhaps an understandable extension of theorizing about social justice in terms of self-contained individuals. As such, global ethics and justice have focused largely on possible rights and obligations across national borders, particularly between rich and poor countries. To state it simplistically, many global ethics and justice philosophers have focused on the question, What do we owe to distant strangers, particularly the poorest?[27] This pandemic challenges such a framing of the main problem in global ethics in a few ways. The pandemic has explicitly shown that all persons on this planet are interconnected across borders. And through those interconnections, we are made vulnerable to grievous harms and death. Moreover, it is likely that we have also passed on harms to other people in other countries. For example, by hosting one or more major international airports, wealthy countries—which previously were the benevolent actors in global ethics—have likely enabled the spread of the virus to other countries, particularly low-income countries that will suffer enormously.

And beyond receiving and transmitting harms, it is fairly well evident from the basic epidemiology of the pandemic that no single country or group of countries can contain the pandemic by themselves. No country can control the pandemic within its own borders and remain protected without all other countries also controlling the spread in their own countries. Interconnectedness, and interdependency, makes coordinated global action necessary to contain the pandemic everywhere. And not just the cooperation of a few countries but of all countries is needed to protect every country for as long as necessary. Benevolence or even humanitarian ethics is not the appropriate ethical resource to draw on in this situation. The necessity for and benefits of cooperative action at a global level have previously been identified regarding many other global issues such as climate change, nuclear proliferation, and illicit drug trafficking. But the distinctiveness of this pandemic is that it makes more prominent the interconnectedness and interdependency of all human beings, while producing a sense of urgency that is due to the imminent threat to bodily health, possibly leading to the deaths of untold thousands. And importantly, social interactions within and across borders will, in fact, be more necessary for societies to recover from the economic and social devastation.

It is this perspective of joint living on this planet, and of having intertwined destinies, that compels us to ask, So how should we live together? This is the mainstay of the philosophy of social and global justice and of particular theories of social contract and distributive justice. In the social contract tradition, a theory aims to identify the rules of social cooperation that fairly distribute benefits and burdens across all involved parties. The most famous modern Anglo-American proponent of the social contract approach to social justice was, of course, John Rawls.[28] Rawls identified a set of "primary goods," certain socially produced goods that serve as all-purpose means for every person to pursue their diverse life plans. Rawls also identified some rules for how these valuable goods should be distributed across individuals. But there are two significant weaknesses to Rawls's seminal theory. He had trouble with a global social contract, and he had trouble with health, even at the domestic level.[29] He pursued a methodology in which he theorized about social justice in a world where there is only one society. After he presented a theory of one ideal society, he then theorized the rules that might govern a world of many societies, each with diverse domestic arrangements, values, and cultures. As a result, he produced a set of minimal rules, and they were far from a global social contract. And regarding health, despite health being so valued by human beings and instrumental on a daily basis to their life plans, Rawls did not place health on the list of valuable goods. This is because he believed that health was a "natural good," something that one is born with or that is affected by personal behavior and luck. The possibility that health or disease and death could be produced or destroyed by social interactions, through the very rules he was seeking to devise, was not part of his reasoning. Such an understanding of health is not a failing unique to Rawls, nor is this social dimension of health just related to infectious diseases.

While a potentially fatal virus being passed from person to person across borders and within borders shows our interconnectedness and interdependency, the same also holds true for the spread of noncommunicable diseases. At the global level, along with many kinds of viruses and biological organisms that are passed across borders daily (e.g., flu), other health harms are also created and distributed through social relations, practices, norms, and neglect. International trade regulations that constrain the ability of countries to restrict or regulate things such as tobacco, alcohol, high-caloric low-nutritious foods, and so forth contribute to the causal chain of poor health of people in particular places—as do various kinds of transnational systems and practices that enable illicit financial flows out of LMICs or the emigration of health care workers. This type of interconnectedness, or causal chains, directly affecting health has been recognized and experienced for decades, particularly in LMICs. But this notion of our health as being affected by events in distant countries and by the functioning of global systems, practices, and institutions is being newly recognized by many citizens of industrialized countries, where the long global chain of causes may have been obfuscated.

The role of ethics in health and world order, then, is to provide moral guidance for the political processes and structures that distribute benefits and burdens across societies. It cannot simply be about how to distribute health care or conduct research in other places. And, unlike human rights law, which has also sought to provide guidance but has historically focused on the relationship between governments and their citizens, the scope of ethics can encompass a whole range of diverse actors that now exist and operate at the transnational global level. Nevertheless, while ethics or global ethics may be the right register from which to address issues regarding world order and the place of health, this is also the time to reimagine global health ethics and bioethics. What does a theory of global ethics or justice look like that starts from interconnectedness and interdependency across borders and that puts human health and well-being at the foundation of global relations?

The existing approaches addressing health in foreign nations as a matter of charity and humanitarianism, or for commercial interest, or for national security have been at least inadequate and, arguably, misguided. We would not be here, in the middle of a global health emergency, if these previous approaches were effective. And global justice philosophers have also been waylaid by the issue of national sovereignty. The debates seemed to be polarized, with one pole centered on justice as being applicable only with a domestic political border and shared social institutions. The other pole is centered on the equal treatment of all individuals irrespective of where we find them, with substantial obligations across national borders to support the well-being of all people. While few if any global justice philosophers see national borders and sovereignty as an all-or-nothing issue, there has been little progress in over a decade on where the balance is between associative duties to compatriots versus general duties to foreigners as well as on the ideal system of global governance.[30]

The renewed recognition of the interdependency of all countries means that to protect ourselves we must also raise the level of health of the worst-off people and countries in the world, not for the sake of benevolence or to fulfill our obligations to ensure their minimal well-being. The continuation of their vulnerabilities to this present pandemic and future outbreaks means that they have the potential to become everyone's health threats. The present pandemic did not originate in some poor region in a poor country. It originated in a large city of a major economic power. There have been disease outbreaks in the United States, and with growing anti-vaccination movements, the likelihood of more is increasing. And, with that, there is the potential of spreading disease to other countries. So our interdependency requires good global citizenship, or reciprocity across all countries. Charity, commercial enterprise, or security approaches do not address all the sources of pandemic threats in other countries or other kinds of potential health threats. Rather, a recognition of shared mutual destinies, and fairness in the global distribution of benefits and burdens, has more likelihood of containing this pandemic and creating global resilience against future pandemics and health emergencies. It is also the right way to live together.

A shortsighted approach to our current global emergency and consideration of the effects on world order would be to understand it as a waiting game until a vaccine is found. At present, there is a global race under way to develop an effective vaccine against the coronavirus. Billions of dollars have been pledged for the research and development of a vaccine. And there is much rhetoric that the eventual vaccine(s) will be made available to all countries, in some way or another. A vaccine is indeed an urgent goal that must be pursued for the sake of preventing as many deaths and as much suffering as possible. But this is only one type of many deadly viruses that could either emerge or reemerge in the world. And this coronavirus is not the deadliest that is possible.[31] Even after containing this particular pandemic, national and global vulnerabilities to epidemics and pandemics will continue and perhaps increase even more. The economic and social devastation caused by the responses to this pandemic are erasing many hard-earned health gains in many LMICs, and many other infectious disease epidemics are ongoing. Low health and health resilience in any country, particularly as a result of this first wave of the pandemic, makes all countries vulnerable. And beyond vulnerability to another pandemic, it is now common knowledge around the world that the global relations among nation-states, the limited capacities of global institutions, and the lack of good global citizenship enable health harms to spread around the world. The current global order, in essence, is not good for the health of people. Indeed, as it stands, it is bad for certain countries and certain groups within countries.

It is because the pandemic has made evident both the structural inequities and inadequacies within countries and at the global level that we must reimagine global ethics. To avoid the error that Rawls made by starting with one society and then moving on to a world of societies, we must start with the global. The interconnectedness and interdependency across countries shape the health contexts within countries. That is, not only can health harms travel across countries; the world order, as it stands, creates and distributes harms within societies. Macroeconomists studying globalization and “economic contagion” have understood how economic harms travel from the global to the local for a while. And some epidemiologists, particularly social epidemiologists who study the global determinants of disease and death, also understand this. But global ethics and justice philosophers and bioethicists have been late to this realization. And even macroeconomists now recognize that they did not appreciate the public health dimension, assuming that investments in health meant health care. There is a profound role here for global political philosophy and ethics as a field to help build a better world order through reasoning about what the society of nations should be and how people in them should act toward each other, in light of their interconnectedness and shared destinies.

What can we do to fill the gaps and missing links and to enable people to do better global ethics and to put state-of-the-art knowledge about health at the center of the world order? There is an urgent need to build links at least among philosophical fields such as bioethics, public health ethics, and political philosophy. There also must be much stronger links between public health sciences and ethics. And importantly, there must be much better integration between public health schools and international relations departments, programs, and schools. As this pandemic has made clear, how disease spreads within countries is significantly affected by global institutions as well as by how various countries are willing or unwilling to cooperate across borders. Beyond the classroom, there need to be greater opportunities for internships and fellowships in professional settings across disciplines. For example, a bioethicist considers the research lab or hospital as a field site of training. Similarly, a public health ethicist or global ethics philosopher should have opportunities to spend time in settings where global policies are being shaped and implemented. This could be the US State Department or, indeed, the Global Fund or World Health Organization. And international relations practitioners should be able to spend time among bioethics and global health ethics scholars.

Conclusion

We have provided a brief description of the work that bioethics has been asked to take on in responding to the COVID-19 pandemic and the shortcomings in approaches to bioethics and political philosophy that the pandemic has exposed. The history and evolution of the field offer an explanation of the challenges that bioethics has faced in coming to grips with the global ethics issues that surfaced in the pandemic, and this explanation helps point the way toward an expanded scope for bioethics that includes global health ethics.

When the pandemic is under control, societies will be left with the knowledge that social structural inequities produce inequities in health, along with the understanding that global pandemic responses and resilience require governments and societies to be more just. Unfair global and social orders are not just bad for health. Health inequalities, and social responses necessary to sufficiently address pandemic threats, can devastate countries for years, affecting generations, and they threaten the global order. Health equity and human well-being must, therefore, be more of a central concern of global transformations under way and likely will need to be so for the foreseeable future.

NOTES

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