COVID-19 and global bioethics

COVID-19 y bioética global

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Abstract

The global phenomenon of a pandemic has reactivated the notion of global bioethics, arguing that mainstream bioethics insufficiently addresses the pandemic experience. This experience highlights connectedness, differential vulnerability, unexpectedness and unpreparedness. During the pandemic, ethical concerns are framed in a specific way. This article examines three ways of framing: with the notions of exceptionality, controllability, and binarity. It then discusses the framework of global bioethics providing a broader and inclusive perspective on the pandemic experience. A fundamental notion in this framework is relationality. It also accentuates that individual and common interests are not opposed. A third consideration in this perspective is solidarity. A global bioethics framework is an incentive to rethink globalization, global governance, public health, and healthcare. If bioethics as a social and global endeavor mobilizes the moral imagination in order to expand the scope of moral concern by applying the human capacity to empathize, it crucially contributes to enhancing social life and civilization.

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1. COVID-19 and ethics

The COVID-19 pandemic is associated with an increase of ethics publications and an upsurge of interest in global bioethics. A PubMed search (in early July 2021) shows that the pandemic inspired a large number of publications on related ethical issues. These publication cover a range of issues: crisis standards of care, expedited research, duty to care, triage in intensive treatment, prioritization of vaccination. The majority of studies is concerned with moral dimensions of treatment (Table 1).

Table 1: Number of publications.

Search terms	2019	2020	2021 (First half)
Ethics & COVID-19	3	2,2525	1,729
Ethics, COVID-19 & treatment		1,419	802
Ethics, COVID-19 & standards of care		236	150
Ethics, COVID-19 & triage		188	100
Ethics, COVID-19 & prioritization		131	103
Ethics, COVID-19 & duty to care		41	32

A significant number of these publications explicitly addresses global bioethics. If we look at the development of global bioethics publications in general, it is noticeable that for a long time the number is rather low, but since 2014 it started to rise (Table 2).

Source: Own elaboration.

In 2020, a search with the keywords «COVID-19 & global bioethics» produces 63 publications while in the first half of 2021 60 journal articles are published. That means that in 2020 23% of all global

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Table 2: Growth of global bioethics publications.

– since 1982	1-2 / year
– since 1999	28 / year
– since 2014	166 / year

Source: Own elaboration.

bioethics publications are related to the COVID-19 pandemic (63 out of 236), and in the first half of 2021 this has increased to 39% (60 out of 152). Looking at the total number of publications with the keyword «ethics», the contribution of publications on COVID-19 and ethics increased from 13% in 2020 (2,525 out of 19,850) to 16% in the first half of 2021 (1,729 out of 10,569).

A tentative conclusion is that the COVID-19 pandemic has stimulated research and publishing activities focused on the ethical dimensions of the pandemic experience. It is interesting, however, that a number of publications engages in bioethical self-reflection, arguing that bioethics is insufficiently addressing issues of community, the common good, solidarity and fairness. While the new viral threat highlights common vulnerability and interdependency, nationalistic policies only focus on the needs of specific countries, often diverting resources away from low and middle-income countries (1). While the pandemic exacerbates the health disparities within countries and across the world, in mainstream bioethics disparities and inequities have not played a major role (2). Bioethical analyses and recommendations are often based on utilitarian calculations, assuming that the major conflict is between individual interests and the common good (3). Another frequently mentioned dilemma is that between public health and individual freedom (4). These self-reflective analyses conclude that the dominant approach of bioethics is inadequate in the face of the pandemic because it does not provide consistent normative policy guidance (5) or its

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overemphasis on personal autonomy and individualism (6, 7). The pandemic has exposed shortcoming and misconceptions in bioethics (8). Others argue forcefully that post-COVID bioethics should have a global perspective (9). More attention should be given to embeddedness and connectedness, thus not only to the broader context of healthcare but also to the social and cultural networks in which individuals are included. That means articulating the importance of the common good, and the perspectives of justice, vulnerability and solidarity. In the age of COVID-19 global bioethics should be reimagined in order to address global phenomena, so that a new global health governance landscape will emerge (10), the conditions for global solidarity and cooperation examined (11), and the voices of marginalized and disadvantages populations included in ethical discourse (12). If a global disease threat such as COVID-19 demands global responses, a broader and more encompassing ethical framework is needed than that provided by the dominant model of bioethics (13).

2. The pandemic experience

One reason why the phenomenon of the pandemic reactivates the notion of global bioethics is related to the characteristics of the pandemic experience. For many people, especially in high-income countries, globalization has been a rather abstract and external process resulting in useful and less expensive products such as smart phones, computers, and clothes, ordered online through Amazon, Google and Apple as well as the ability to travel and have holidays everywhere on the globe. The threat of COVID-19 has lifted global phenomena out of beneficial abstractness. Globalization now has become an internal experience, impacting human life itself. It becomes a source of tension between countries and regions, and an impediment to public health measures, manifesting dependencies and inequalities. The pandemic experience thus highlights *connected-*

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ness as a basic feature of globalization. One dimension of global bioethics is its worldwide or planetary scope. This meaning is by the image of Earth on the cover of Potter's first book on bioethics (14). The planet is visualized as a lonely globe in outer space, articulating the experience that it is the common home of human beings within the universe. This image of the globe, powerful as it is, posits the Earth as an external object. It does not provoke the sense that it is in fact the habitat of human beings so that our relationship to «environing» conditions is internal rather to external; we cannot disengage ourselves from our habitat; our lifeworld cannot be disconnected from the planet. The image of «globe» risks therefore to separate humans from the context within which they dwell. A more appropriate metaphor to express the characteristic of connectedness is «sphere» (15). Using this metaphor evokes interconnectedness, relatedness, and interdependency. This is also expressed in notions such as «atmosphere», «biosphere», «ecosphere», and «virosphere». The planet is not just the dwelling location but the world within which humans live, in which they feel at home. For human beings, as embedded in spheres, the environment is not an external setting but part of their lifeworld. The notion of sphere presents the world as lived experience, perceived and understood from within. The human world begins in the local rather than the global because the spherical view accentuates embeddedness, and thus locality. Globalization therefore is not an external process that impacts our common globe; it concerns the human world, the *mundus*, expanding the life world through global interaction and cultural diffusion. This is why *mundalization* is sometimes proposed as a better term for global processes (16). Mundialization (as expressed in the French «mondialisation» and «bioéthique mondiale») underlines the interchange and integration of ideas and values of people and cultures around the globe, rather than the spatial and geographic dimensions of the world as our home.

The second characteristic of the pandemic experience is *differential vulnerability*. In principle, all humans can be infected but SARS-

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CoV-2 is not affecting everybody in the same manner and with the same severity. Older citizens, people with underlying health conditions, and racial and ethnic minority groups have increased risk of getting sick, being hospitalized and dying from COVID-19 (17). People in poor neighborhoods are more vulnerable to the disease, while recurrent COVID outbreaks are described in nursing homes, slaughterhouses, and prisons (18). Disadvantaged populations often have more health problems as the result of lack of access to healthcare, poor and unsafe living conditions, lack of employment, and environmental degradation. People with disabilities, chronic illnesses, and older people all have conditions that reduce long-term life expectancy. These populations and people risk to be doubly affected, not only by the virus but also by utilitarian triage criteria that aim to maximize the number of life-years saved so that priority in treatment is denied because of their poor long-term prognosis (19). One of the most harmed areas of numerous societies are elderly and nursing homes while policy-making for a rather long time is focused on acute hospital care and little protection is available for the older, frail and vulnerable residents of these homes. Public health measures furthermore have unequal effects. These measures such as lockdowns and widescale testing are implemented in wealthier parts of the world and advocated for other countries, while the different context of less-resourced countries is not taken in to account. A substantial number of people, particularly in developing countries, are not be able to comply because they live together with many others in crowded housing, or lack adequate housing, with limited sanitary facilities, poor access to healthcare and to internet, do not have formal jobs, and have to go out for making a living, when government efforts to provide economic relief, secure income and health insurance are absent. Low-income countries are supposed to implement the same public health measures as more affluent countries, but they are not able to acquire sufficient protective equipment, and are not prioritized in the distribution of global resources such as test kits, medicines and

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vaccines. But even in well-resourced countries people in low paid service jobs (such as retail, food services, childcare, and hospitality) must continue to work. The same is true for people with lower socio-economic status have to work in crowded conditions (e.g. in slaughterhouses), have to use public transportation, and often live in multigenerational households. Lockdowns, distancing, and self-isolation are measures that can be best carried out by wealthier citizens and those with better accommodation. But even in these circumstances, the burdens are not equally distributed: women are often more impacted than men when schools and day care centers are closed, and since they have more part-time employment which is more likely disrupted. The evidence that COVID-19 is worsening the existing inequalities in health and society points to the need to pay special attention to notions of vulnerability, solidarity and equality to address disparities from a more encompassing ethical framework (20). The pandemic has also made some people vulnerable due to xenophobia, scapegoating, stigmatization, and discrimination. That experiences are not the same everywhere and that COVID-19 reinforces existing inequities is evident in the global vaccine gap. While in many countries in the Global North almost 50% of the populations have received at least one dose of a COVID-19 vaccine, in low-income countries this is only the case for 1.1% of the people (as of July 21, 2021). The relatively worst affected continent is Latin America. With 8% of the world population, it has 20% of all global coronavirus cases, and 32% of global deaths. Only 10% of the population is fully vaccinated, but in some countries (e.g. Honduras and Guatemala) it is close to nil. In July, almost all new infections are caused by the Lambda variant. Cases rapidly rise, even in Chile where more than 61% of the population is fully vaccinated. The Continent has limited capacity for genome surveillance, so the variant was detected late, and it is difficult to estimate the full prevalence of the Lambda variant. The large reservoir of unvaccinated people, makes it easier for the virus to mutate, becoming more infectious and making vaccines less

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effective. In most Latin American countries the most commonly used vaccine is China's CoronaVac which has poor efficacy. One study found that a single dose is only 3% effective, rising to 56.5 percent after both doses (21).

The third characteristic of the pandemic experience is *unexpectedness and unpreparedness*. It is not the first time that humanity is confronted with pandemic diseases. Human life has always been marked by infections, since humans, animals and microbes cohabitate in the same world. But the advances of medical science have promoted the belief that these diseases can be managed and controlled, and sometimes eradicated through vaccinations and medications (especially early in life). Infectious diseases as lethal threats have become less frightening for many people. However, this is a cultural prejudice since populations in less developed countries are continuously threatened by infectious diseases. In 2019, just before the COVID-19 outbreak, 409,000 people have died from malaria, and 1.4 million from tuberculosis (22, 23). In fact, especially in Africa and Asia, more people are infected by malaria (in 2019, 229 million cases) and dengue (390 million people) than by COVID-19 thus far (24). Previous lethal pandemics such as the Black Death in the 14th century, cholera in the 19th century, and Spanish flu in the 20th century have had a major impact on society and culture, but they were mostly regarded as history. Diseases such as Avian flu, Ebola, and Zika have been an early warning for the current pandemic but the lessons have not been taken seriously in most countries. For most countries and authorities the viral threat of COVID-19 came as a surprise. An example is the list of ten threats to global health requiring attention for the next decade, published by the World Health Organization in early 2019 (25). Air pollution and climate change are on the top of the list. It also includes infectious diseases such as global influenza, Ebola and other high-threat pathogens, dengue and HIV. The list has been the basis for the new 5-year strategic plan of the Organization (the 13th General Programme of Work), allocating three billion US dollars to transform the

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future of public health to ensure more access to health care, better protection from health emergencies, and to make more people experience improved health and well-being. The 2019 list differs from the one published one year earlier. The number one on this 2018 list is pandemic influenza. In fact, the majority of threats on this list are infectious diseases, including cholera, diphtheria, malaria, meningitis, and yellow fever. Many of these infections are no longer regarded as global threats one year later. Just before the outbreak of COVID-19 there obviously is no expectation of an imminent pandemic threat, although since 1992 experts have warned against the dangers of emerging infectious diseases. The experience with the coronavirus pandemic brought humanity back to its condition of connectedness. Although there are numerous differences between the past and the present, there are two basic realities that are still the same. One is the reality of microorganisms, reminding us that human beings are embedded in nature. Human beings cannot survive without viruses. They constitute a virosphere that not merely surrounds humans but that is within them (26). The other reality are human beings themselves. It is not clear how much their nature and behavior have fundamentally changed over time. It seems that in view of a lethal challenge, humans continue to show the same behavior as in previous times. Even if we have now more medical knowledge as ever before, it needs to be used by human beings. Policy recommendations only work if they are followed and implemented. Healthcare information is never completely certain so that there are always doubts and uncertainties. It also is applied within a social and cultural context which can be authoritarian or liberal, so determining limits and constraints on how stringent measures such as quarantine, isolation or testing can be applied or enforced. As a form of drama, a pandemic is not just a medical event but a social phenomenon with a particular evolvement in time, depending on how humans behave and interact. Knowledge of the pathogen and the etiology of the disease is not sufficient to control an epidemic disease (27).

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3. Framing ethical concerns

How ethical concerns are conceived and forumated is the result of a specific manner of framing. For instance, caring for infectious patients is interpreted as professional duty leaving aside considerations of personal risk or risk to family members and relatives but also the responsibilities of healthcare facilities to provide a safe environment. Another example are policy measures such as physical distancing and masking that often move from appeals to voluntary responsibility to mandatory requirements with the argument that the collective interest overrides the interests of individuals, emphasizing compliance with the measures rather than adherence to them on the basis of persuasion and motivation. A third example is the argument that in emergency circumstances priority should be given to treatment of COVID patients since that will save most lives while treatment of patients with other conditions is scaled down or cancelled as «collateral damage». The framing of ethical concerns is performed with three fundamental notions: exceptionality, controllability, and binarity.

a) Exceptionality

Ethical concerns during the pandemic are frequently pre-structured and formatted with the discourse of exceptionality. It can take two forms. Intrinsic exceptionality refers to the claim to be outside the general pattern, and thus especially privileged. Before COVID-19 some countries thought to be exceptional because they assumed to be well prepared for a global epidemic. After the outbreak of COVID-19, specific countries presume that they are less vulnerable and more resilient than others. During the pandemic, countries try to profile themselves as exceptional in their policy approaches, scientific contributions, or vaccination strategies. Special claims are made by the healthcare profession demanding priority in triage and vaccination because of the higher risks undertaken and their ins-

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trumental value for the healthcare system. From an ethical perspective, arguments in favor of intrinsic exceptionality may be true or false but what they do is to assign such value to a country or profession that it becomes difficult to criticize policy-makers, scientists or healthcare workers because they are special. The second form is extrinsic exceptionality; i.e., the argument that an emergency situation creates special conditions in which the usual standards and practices no longer apply. In this form, the ethical perspective itself is affected. It is argued that special circumstances justify actions that normally would not be acceptable, for example confining citizens to their homes, testing mandates, crisis standards of care, expediting of scientific research, or deprioritizing older patients for ventilatory interventions. Allegedly, as these examples illustrate, the ethical considerations that apply in normal circumstances can no longer be used but should be either bypassed or reversed into a utilitarian framework so that the individual interest of patients will be subordinated to the common interest of all. In the context of public health, extrinsic exceptionality shows itself for example in the safety standards that are used. The need for early release of new vaccines and their emergency use approval is associated with less rigorous surveillance of safety and effectiveness than usual. Another example is the debate on re-opening society and the economy. While in normal circumstances, all possibilities will be used to minimize potential risks, this has not been the case in the public health policies of most countries, as evidenced in decisions to relax stringent measures and re-open the economy, not because the viral threat has diminished but because safety and health security are balanced against other values such as economic recovery. This is also evident in early policy recommendations by the WHO and several governments not to use face masks. Even if the evidence for their effectiveness is not clear-cut, in ordinary conditions the precautionary principle would have led to the policy to advice their use. In ordinary life, safety first is a basic principle that has instigated many regulations for human traffic, industrial

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production, and occupational activities. That more risks are deemed acceptable in emergency conditions is illustrated in the discussion of adverse effects of some vaccines. When in March 2021 serious side effects of the AstraZeneca vaccine are identified, many countries paused the deployment of this vaccine. Experts respond critically to the pause and argue that vaccination should continue because the risks are extraordinary low (1 in 100,000). But these reassurances that side effects are rare, and much lower than the risk of serious illness due to infection are not convincing since a simple benefit-harm calculation at the population level will not suffice at the individual level. Vaccines are given to healthy people and protect against a disease that might affect them but not necessarily. Individuals do not compare the risk of side effects with the probability to die from COVID but with the probability to get infected. This last probability is in their own hands, and if they meticulously follow public health measures they assume that the risk of infection is extremely low. The argument of exceptionality that more safety risks are acceptable during a pandemic applies to populations but does not work at the individual level where side effects are associated with the personal situation of people. The argument itself may have negative effects since it enhances the experience that individuals may be sacrificed for the greater good, and that the interests of individuals are disregarded since in war speed is more important than caution. The debate on vaccine safety is an example of the downsides of exceptionality. It illustrates the impact of utilitarian thinking promoting a calculating, impersonal, abstract, and decontextualized approach, only focused on consequences, weighing benefits and harms, not for individuals but populations, and disregarding other ethical principles. It also is associated with a technocratic and paternalistic approach, giving experts (epidemiologists, virologist, and intensive care specialists) the first and last word in policy decision-making. This is highlighted in the development and application of triage systems, as well as in vaccination strategies. Exceptionality is furthermore applied inconsis-

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tently. It is primarily used for individuals, not for more powerful agents such as pharmaceutical companies refusing to share data, patents, and property rights for the benefit of all. These agents may even take advantage of exceptional measures by arguing that expedited review of new medicines and vaccines should be maintained now that shorter review procedures have not impacted the reliability and safety of new products, assuming that the emergency conditions may be prolonged when the pandemic is over. The argument of exceptionality is likewise not applied to vulnerable people in nursing homes, prisons, and disadvantaged conditions who need special protection because they are exceptionally affected by COVID-19.

In mainstream bioethics, the basic principles of ethical discourse are respect for autonomy, beneficence, nonmaleficence, and justice. The principle of respect for autonomy is usually dominant, focusing on concrete individuals and interpreting vulnerability in an individualistic way. In the pandemic, the balance between principles changed. Public health and utilitarian ethics give priority to benefit and harm, focusing on abstract individuals as specimens of a collective, and ignoring issues of vulnerability. The ethical debate then shifts from individual to public interests but in both frameworks minor attention if given to the principle of justice and to respect for human dignity. The notion of exceptionality defines the fundamental challenge as a conflict between individual and common good. Rather than bypassing, reversing or shifting moral principles, the ethical framework guiding public health, clinical medicine and research should be broadened, so that more principles are taken into account.

b) Controllability

One of the striking features of the pandemic is the predominance of the war metaphor. Since the virus is an omnipresent threat to everyone, a massive common effort is needed to fight it. There are

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only two options: victory or defeat. The entire society must be mobilized. All hopes are established on a technical solution to the COVID crisis, an ultimate weapon overcoming the vagaries of human behavior by simply injecting a vaccine. In the meantime, the emphasis should be on hospital care and the best possible treatment. In this context, there are only heroes, victims and villains, and dissent cannot be tolerated. After this world war is over, strenuous efforts should be undertaken to prevent future outbreaks. The arms race between viruses and humans demands the building of a critical defense system at the global level, taking the war against viruses seriously with surveillance and public health capabilities as well as international regulations than can be verified to ensure global security, concluded in a pandemic treaty (28, p. 233 and ff.).

The driving force of these efforts to fight the virus is the belief in controllability. Nowadays, viruses can be quickly identified, their genomes sequenced, diagnostic tests produced and vaccines developed. The viral spread can be controlled with rigorous public health measures, first of all physical distancing. Controllability, according to German philosopher Hartmut Rosa is a characteristic of modernity. Modern social existence is characterized by an *incessant desire to make the world engineerable, predictable, available, accessible, disposable (i.e.,* verfügbar*) in all its aspects* (29, p. viii). But the drive to control separates humans from the world in which they are situated, and regards the world as a resource to be exploited, a collection of objects to master, a treasury of facts and data to discover and to make useful, and an assemblage of obstacles to overcome in order to advance human flourishing. Everything is seen as a challenge. Against this backdrop, we encounter the world, in the words of Rosa, as a «point of aggression» (30, p. 5 and ff). This is exactly the perspective of the military metaphor in the pandemic. The virus is an outside enemy that needs to be controlled, and ultimately destroyed. The four dimensions of controllability are reflected in the approach of the viral threat. First it is made visible, using science to identify the virus and mathematics to quantify the im-

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pact; second it is made accessible through the development of a diagnostic test so that it can be followed how the virus spreads; third it is made manageable with the help of public health measures but most of all through vaccines; finally the threatened world is made controllable by making it useful and more efficient through digital surveillance, remote work and education, and economic restructuring.

The difficulty according to Rosa is that the desire for control is intimately connected to uncontrollability. The more the world is controlled, the more it eludes us. For example, processes of globalization and neoliberal policies promoted the idea that the world is a global market which is self-regulating and will solve problems such as poverty and underdevelopment. At the same time, these processes and policies have produced environmental degradation and increasing inequality which are now threatening global security and nearly impossible to control. The paradoxical connection between control and uncontrollability is observable in the pandemic. There is a strong conviction that science and technology are the optimal means for control that will bring relief. The tools of medical science provide the best way to eliminate the viral threat; all other approaches (simply labelled as «non-pharmaceutical interventions») are of secondary use. But time and again, the virus becomes uncontrollable since humans spreads the pathogen. The sciences of virology and epidemiology are useful but no guarantee that viruses can be controlled since human behavior is not fully predictable and manageable. Even when effective tools such as vaccines are available, problems with production, distribution and deployment impede getting hold of the pandemic. Health security as the ultimately aim of control is therefore always precarious. The two options of the war metaphor (defeat or victory) do not allow for a third; i.e., that the virus will stay with us and that we have to find ways to live with it.

The quest for control and the discourse of war are difficult to criticize since they seem the most rational and efficient way to

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bring the pandemic under control. Efforts to control, manage, predict and calculate the spread of SARS-CoV-2 perfectly reflect the rationalization, bureaucratization and intellectualization of modern societies and cultures but they simultaneously demonstrate the uncontrollability, uncertainty and unpredictability of the modern lifeworld. When the pandemic lasts longer than expected, and policy measures begin to oscillate and are less consistent, this uncontrollability becomes more apparent, and makes people aware what is lost when the focus is only on efforts to make the world controllable. This awareness calls for a broader and deeper ethical discourse.

c) Binarity

COVID-19 has highlighted and aggravated existing dichotomies and contradictions within and between societies. While SARS-CoV-2 is a threat to everyone, not all people are «in the same boat» since some are more heavily affected than others. This is especially true, as discussed earlier, for persons who are already vulnerable and disadvantaged before the pandemic emerged. COVID-19 exposes and exacerbates the existing health inequities and accentuates the significance of socio-economic determinants of health. Another disparity intensified in the pandemic is intergenerational tension, putting the old against the young. Older people are the most vulnerable to serious consequences of infection. Younger persons are least affected but asked to stay at home, keep physical distance, while schools are closed. They experience the prevention paradox: they can disseminate the virus without being ill and at risk of serious effects but have to change behavior in order to protect more vulnerable citizens. Seniors may complain that the curve of the pandemic is not flattening due to irresponsible conduct of younger persons (who have corona parties, go on holiday, and gather in public parks without masks and physical distancing) while they have to self-isolate and experience increasing loneliness. On the other hand, younger generations grumble that their social life is curtailed

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because of concerns with persons who are in the final stages of their lives, and that they have to wait longer to go back to normal since those persons are prioritized for vaccination. These tensions are magnified through some policies, for example the use of age as a criterion of triage for ventilatory support. Other examples are the lack of attention to nursing and care homes where older residents with multiple comorbidities were often not transferred to hospitals in case of infection, as well as policies of herd immunity advocated in Sweden, and initially in the United Kingdom and the Netherlands. Sometimes public proposals are launched suggesting that that the lives of some people, especially older ones who already had their «fair innings» are expendable for the greater good which is usually interpretated as the free flow of the market and economic productivity (31).

The dichotomies and disparities highlighted by the COVID-19 pandemic reveal the dark side of utilitarian approaches in public health. The utilitarian focus of triage systems for example proposes abstract categories of prioritization and is blind to structural healthcare disparities, not taking into account the social context and the variability of patient's needs and vulnerabilities. Guidelines usually do not include voices from marginalized groups (32). The use of the fair innings argument further articulates trends that already were visible before the coronavirus emerged. It proceeds from the anthropological vision of human beings as *homo economicus*: they are first of all rational self-interested individuals motivated by minimizing costs and maximizing gains for themselves. Human life is like a commodity, a resource that can be divided in parts and shares. The terminology of «innings» assumes that life is a form of producing and collecting benefits. Human life is not considered as a whole, in which all stages have a particular value and meaning. The concept of fair innings is also attractive since it is quantitative. Rather than having an ambiguous debate about ethical principles, it suggest clear rules that can be consistently applied and evaluated because it quantifies benefits (33). This approach re-

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gards «the elderly» as a homogenous and abstract category which is necessarily associated with vulnerability, frailty, dependency, and deterioration, rather than as individual people with distinct personal, clinical, and social characteristics, conveniently ignoring that the majority of people older than 60 are not weak, dependent or frail (34; 35; 36). Finally, the reference to «fair innings» during the pandemic accentuates a problem that existed before. Age discrimination that was often implicit, has now become explicit (37). COVID-19 not only illustrates the divide between young and old but further articulates already prevailing ageism. The idea of fair innings therefore is arbitrary and unfair, and ignores that the utilitarian focus on efficiency should be tempered with concerns for equality, vulnerability and human dignity (38).

4. The framework of global bioethics

Having examined how ethical reflection has been conceived and framed during the public health emergency, the challenge is how to envision a bioethics after Covid-19 which is global, not merely in the sense that it worldwide but also that is encompassing, inclusive and broad, able to go beyond the disparities and dichotomies and the narrow ethical imagination which has been prevalent. A global perspective proceeds from the significance of relationality for bioethical discourse.

a) Relationality

Global bioethics articulates that human persons are essentially characterized by relationality. As integrated wholes of body and soul they are embedded within communities and they exist in a web of relationships with other beings and the environing world. This is why the notion of «sphere» is more appropriate than «globe», Rela-

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tionality is a more fundamental characteristic than relatedness and connectedness. A person is continuously engaging in relations but this is often conceived from the viewpoint of the individual. The notion of relationality expresses that individuals not merely connect and interact with each other but belong together and are mutually dependent, taking responsibility and shaping their lives together. The first experience of humans is that the world is shared with others. From this perspective, individual autonomy is redefined as «relational autonomy». A human person is constituted through encounters and dialogues with other beings. Authentic human being is being-together; in the words of Gabriel Marcel: being present and available to others (39). Relationality and being situated in the world implies vulnerability since it exposes humans to other persons and the environing world. Relationality is not an option and we cannot make ourselves immune to the world.

It is evident that relationships and relatedness have become problematic in the pandemic. Other people are presented as a threat, and relations may have lethal outcomes since humans are the principal vectors of the virus. The main objective of public health measures is to prevent connections and interactions. Distancing, masking, prohibition of visits, working remotely, and sheltering at home obstruct being too close together with other persons. COVID-19 therefore seems to affect the anthropological condition of human beings. They risks to have their presence and availability reduced, and thus to lose what is specific for humanity. All people face the same dilemma between being secluded or being open to the world since relationships are disrupted but their fundamental relationality is not annulled. For many people public health measures create significant problems, physical ones because they have difficulties in providing for their basic needs, and mental ones because they are lonely and depressed. This renders the continuation of isolation policies increasingly problematic. It also explains why the term «social' distancing is considered inappropriate, «bubbles» ap-

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peared in which closeness and intimacy with at least some others was allowed, and many other ways of interaction and communication emerged (40).

b) Individual versus common interests

The opposition between individual and common interests that often dominates in pandemic discourses ignores the fundamental relationality of human beings. Individuals are not isolated, abstract entities but social beings. This point of view is not accepted in the ideology of individualism, prevailing especially in the West, according to which human beings are independent and self-reliant, the masters of their own life, and choosing their own values, and thus as unique individuals separated and demarcated from other beings. The normative implication of this view is that respect for individual autonomy means non-interference: individual decisions and actions should be respected as long as they do not harm other human beings. In this perspective, public health measures should first appeal to individual responsibility; any interference with personal liberty is problematic, and lockdowns and curfews are unacceptable. In the perspective of global bioethics, however, the opposition between individual and common interests is false because the first type of interests must be reinterpreted, while the last type should be taken seriously. One argument is that personal autonomy is a relational notion. Not only has it originated and been nurtured within a context of dependency but it is also always exercised in interaction with other people, dependent on social and cultural conditions (41). Another argument is that preferences, values, and beliefs are not merely individual but conditioned by the social context. Societies transmit values across generations because norms are internalized. The human capacity to internalize norms means that human preferences are socially «programmable» and human behavior is guided by the moral values of social life. Because human agents are socially entangled and networked, their conduct

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cannot be explained by self-regarding rationality directed at maximizing self-interests but by social rationality, that is taking into account the well-being of other people and the needs of larger society (42). A further argument, especially expressed in global bioethics documents is that autonomy is intrinsically connected to responsibility. Individual actions and decisions have social consequences, so individual autonomy and social responsibility cannot be opposed. Personal autonomy is not abstract and decontextualized but has impacts on concrete other people (43).

The COVID pandemic clearly illustrates that individual behavior affects the well-being of the community. Widespread use of face masks will protect not only the individual but also other people against possible infection. Testing will identify whether someone is infected, but it is a warning signal that others may be at risk. The aim of vaccination is not just to protect individuals but society as a whole. In a public health emergency, appeals to self-interest cannot be separated from concerns with the interests of others. Individual decisions whether or not to adhere to public health measures have an inherently social dimension. Appeals to individual responsibility will therefore not be sufficient without articulating social responsibility, and without creating the social, political and economic conditions for the exercise of responsible autonomy. That individualistic policies fail without this dimension of social responsibility is evident in debates concerning quarantine, isolation, lockdown and distancing where it is argued that human dignity and human rights are violated. In these debates, dignity and rights are frequently regarded as notions that apply strictly to individuals. Human dignity is considered as a theoretical and abstract construct, an intrinsic quality that applies equally to every human being. It does not depend on human characteristics or conditions such as age, gender, or disease. It cannot be diminished or taken away by any authority or political system, or disregarded in emergency conditions. Dignity does not depend on whether it is recognized or respected since

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it continues to exists even in the most dismal or cruel circumstances. However, this is only part of the story of human dignity. It is also a practical experiential phenomenon, a lived experience. It refers to how humans behave and are treated; human dignity is thus a relational quality. In this perspective, dignity can be disrespected, lost or destroyed. In certain situations and practices, humans experience threats to their dignity and are confronted with undignified conditions (44). Human rights are the focus of similar discussions. Sometimes they are interpreted as rights of individuals, especially emphasizing non-interference to protect individuals against the state, and thus regarding civil and political rights as more important than social and economic rights. In this view, moral individualism is at the core of human rights language as the discourse of individual empowerment. However, all human rights are interdependent. Civil and political rights cannot be exercised if basic conditions for human existence are not provided, as expressed by social and economic rights. Individual persons can only be empowered within a relational context with others. The right to health illustrates that the individual dimension of human rights is connected to a dimension of solidarity and collective good: if appropriate conditions such as access to health care and quality health services do not exists, individuals cannot enjoy their right to health. Like human dignity, human rights are based on the recognition that human beings share fundamental needs and vulnerabilities (45, p. 113 and ff.).

The above arguments apply to another opposition which has intensified during the pandemic: nationalism versus globalism. In emergency conditions, national interests dominate the approach to COVID-19. Countries are first concerned for their own citizens, and try to seize as much protective equipment, masks, and testing materials as possible, often in competition with each other, and without consideration for the needs of other, less powerful and economically weaker nations. Vaccines are pre-ordered and purchased in enormous quantities by high-income countries, leaving other countries at the end of the queue. The World Health Orga-

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nization and international actors have argued multiple times that national policies will not be sufficient to control the pandemic as long as a global approach is missing (46). The arguments are familiar: nationalism will hurt everybody and is self-defeating because all people are connected. The virus does not recognize borders and nations but affects the global population and requires global solutions. Even if the virus can be eliminated in one country, trade and travel will remain affected, economies will not recover, and stability and prosperity will not return as long as the virus is rampaging across the world. It is therefore in the interest of each nation to engage in global efforts to address COVID-19 (47). Nationalist approaches are not only narrow-minded but also self-defeating in the longer run when the virus continues to disseminate and mutate in some parts of the world.

c) Solidarity

In the context of public health, solidarity has since long been endorsed as a key ethical value. Because health systems are interdependent, and disease threats are global, collaboration between healthcare institutions is necessary at national, regional and global levels, requiring open communication, sharing of information, and coordination of policy responses. In the COVID-19 pandemic, international bodies have repeatedly emphasized solidarity as a core concept. The ethical committees of UNESCO call it «an ethical duty to build solidarity and cooperation» (48, p. 4), while the ethics advisors of the European Union refer to solidarity as «a social vaccine» against indifference and exclusion (49, p. 4). Remarkably, the WHO's Working Group on Ethics and COVID-19 lists solidarity as the first ethical principle to apply (50). The Vatican COVID-19 Commission states that the principle of solidarity must be the basis of any specific and concrete intervention in response to the pandemic, which implies that vaccines must be available and accessible to all (51).

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Solidarity is often explained with references to the same grounds as the notion of relationality: it is based on the mutual recognition that human beings share the same needs, that their destiny is interconnected, that vulnerabilities are crucial human features but not equally experienced, and that the well-being of all citizens of the world should be the primary concern of global policies. Yet, what is typical for solidarity are not just these theoretical explanations, but its practical implications. Rather than a feeling of connectedness, and intentions to act, solidarity shows itself in supporting a specific cause and in common action, recognizing that capacities to cope with global threats are unequal. It requires that understanding interdependency and willingness to assist others translates in public action, demonstrating that one's own interests are subordinated to those of others. Such action can be motivated by mutual self-interest, especially in a pandemic where it is everybody's interests to reduce and eliminate infections but the core of solidarity is moral concern for others, selfless commitment to the other rather than the expectation of unilateral benefit. It is not manifested because other people are a threat to our health, but because global health is connected and interdependent. Solidarity differs from charity, aid, and generosity: it signifies mutuality, a symmetrical relation between equals, and implies therefore inclusion and cooperation (52).

Although there are many examples of solidarity at interpersonal and institutional levels, the absence of solidarity at the global level during the pandemic is striking. This is not surprising since the conditions for solidarity have been eroded in the past few decades. Global policies and international cooperation have primarily focused on economic interests. For example, in the European Union, protection of human health has not received priority since the organization and delivery of health services and medical care is the primary responsibility of individual member states. Global institutions such as the World Health Organization have been systematically weakened by budget cuts and attempts to delegitimize its

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work (53). In most countries, public health infrastructure has been reduced, and health is first of all regarded as an individual rather than collective responsibility. The main driving force for cooperation is the neoliberal ideology of the free market, emphasizing competition, free trade, and commercialization of all aspects of human life. In this ideology, government interference must be reduced as much as possible, and deregulation, privatization, reduction of taxes and public expenditures encouraged. In this philosophy of rational egoism, societies are mere collections of individuals, and solidarity is rejected or regarded as a superfluous value. The same processes have undermined solidarity within societies. The dominance of individualism and the view of the human person as *homo economicus* have diminished the experience of human beings that they are embedded within communities, cultures and environments, and the consciousness that their destiny is connected to distant others as citizens of the world. Since solidarity cannot be imposed unilaterally or top-down, it will not emerge in these conditions (54).

This analysis clarifies that the failure of global solidarity is the result of policies which advance specific values at the expense of others. The COVID-19 pandemic demonstrates the inadequacies of these policies. Public health infrastructures in most countries prove incapable of coping with the virus. Appeals to individual responsibility alone do not manage to control viral transmission. Massive government interventions are necessary to support the healthcare system, the economy, and all sectors of social life. The free market is not able to produce sufficient quantities of protective equipment, medication, and vaccines without substantial public support. At the same time, mainstream bioethics, relying on the language of autonomy, interests, utility, efficiency, and negative rights presents a myopic view of relevant ethical concerns. Starting from the point of view of the autonomous individual, it cannot recognize the connectedness of human beings, and the global dimensions of the pandemic, and thus the need for global responses. After COVID-19,

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bioethics can no longer assume that autonomy is the dominant ethical principle; it must recognize that taking human relationality seriously implies enhancing and embracing social and structural conditions that make solidarity possible.

5. Conclusion

The significance of global health accentuated by COVID-19 underscores the need for a more encompassing discourse of global bioethics. Dominant ethical analyses are often orientated towards disease management, technocratic approaches, and individual treatment rather than attention to conditions in which diseases arise and expand. These tendencies are reinforced during the emergency of the pandemic, emphasizing exceptionality, controllability, and binarity, thus structuring and framing ethical considerations in a specific and narrow way, relegating concerns with vulnerability, human dignity, inequity, cooperation, and solidarity to a lower level of urgency and interest. The COVID-19 pandemic illustrates that another way of thinking and working is helpful to clarify the ethical dimensions of present-day life. The starting point of the argument is the basic relationality of human beings. This is not just the view that human persons are connected to other beings and the environing world, but the philosophical perspective that being human means being-together. Human persons can only exist and flourish because they share the world, belong together, are present and available to each other. This basic relationality has ethical significance. Being situated within relationships and engaging with other beings means vulnerability. Openness to the world and mutual dependency is necessary to make human persons grow, develop and flourish but also exposes them to possible harm and injury. Humans cannot immunize themselves to the world since they would then lose what characterizes them as human beings. Ethical discourse is one way to mitigate and remediate vulnerability. It en-

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courages us to change perspectives, and to imagine ourselves in the position of other people who have the same needs, desires and feelings as we have. It expresses that when we share the world, we must recognize others who have lives to live, and we must treat their interests as equal to our own.

COVID-19 has revived the, mostly forgotten, collective memories of the past, especially of the influenza pandemic of one century ago. Humans now realize that they live in a pandemic era that begun in 1918 and that the idea that infectious diseases can be controlled is false. More than other disasters, COVID-19 has affected all dimensions of everyday life for all people across the globe. The spread of SARS-CoV-2 makes visible and tangible to everyone that human beings are interdependent, illustrating that globalization is a phenomenon of health and disease, and not simply of trade, travel, and finance. Globalization no longer is an abstract set of processes but an experience of mutual and personal vulnerability. Everybody is confronted with the same threat, and scientific knowledge of the virus is the same for everyone and rapidly shared across the globe. Nonetheless, responses to the pandemic are diverse and heterogenous. Some countries have managed the impact of the virus rapidly and efficiently, when in fact numerous others have bungled, delayed, and vacillated in applying public health measures. One reason why global strategies in the face of the pandemic differ has to do with values (for example, individual vs social responsibility; voluntary compliance and self-control vs state enforcement and external control; individual liberties vs solidarity). That COVID-19 has ethical relevancy is furthermore manifested in the social inequities that it has revealed and aggravated. It exposes socio-economic and racial disparities in health and healthcare, as well as the privileges of people who have homes to shelter, and work that can be done remotely. Trends towards discrimination of elderly and disabled people are magnified, and stigmatization and scapegoating are not past. The pandemic also discloses the lack of preparedness of most countries and the insufficiency

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of public health infrastructures. Furthermore it clarifies that the economic order promoted by the neoliberal policies of globalization over the last few decades have led to the moral impoverishment of the social life-world and to multiplication of experiences of injustice, especially of humiliation, disrespect, and inequality.

For these reasons, the pandemic is an opportunity to rethink globalization, global governance, public health, and healthcare with a new appreciation of the common good and the role of governments in protecting citizens, with more emphasis on resilience rather than efficiency. If bioethics as a social and global endeavor mobilizes the moral imagination in order to expand the scope of moral concern by applying the human capacity to empathize, it crucially contributes to enhancing social life and civilization.

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