

## Checkmate to Bioethics? The Case of COVID-19

Fabio Alberto Garzón Díaz\*

Bioethics, as the first cousin of philosophy, suffers from what philosopher Hegel told us during his lifetime, “When philosophy paints lights and shadows, an aspect of life has grown old, and cannot be rejuvenated, but only understood. Minerva’s owl takes flight only during sundown” (1, p.36). The problem is how to fight an invisible opponent. What to do when your opponent enters your body and kills you from the inside? This pandemic has taken away our trust in the “Other,” even if they are our parents or children, since it turns a simple act of love — a kiss or a hug— into a deadly weapon. No one, not the richest nor the poorest country, was prepared for this. The COVID-19 pandemic has put the world in check and proposes a new planetary order. Bioethics must take its most reflective streak, understand the phenomenon, and draw lessons from this heartbreaking experience so that we do not make the same mistakes again that are costing us so many bitter tears and deaths.

I will present below some points that may help us to continue the debate and possibly reach agreements on how to advance in a post-COVID-19 world:

- **The controversy between individual liberties and the common good, or in bioethical terms, between citizens’ autonomy and the welfare of society.** This controversy is not new since Kant himself wondered how the idea of authority could be reconciled with the postulate that individuals are free to set their goals and purposes, according to their judgment (2). For philosopher Victoria Camps, “between individual freedom and the common good there should be no contradiction if an attitude of responsibility prevails.” Camps appeals to the commitment of each citizen to a common good, which is, in this scenario, to stop the infection and avoid the collapse of the health care system. Most citizens have shown their commitment and conviction upon understanding that the limitation of freedom imposed by “a mandatory quarantine” had to be accepted as the best alternative to fight this disease. We must also recognize that this imposition has been welcomed based on dread and fear, rather than on a rational act, while a feeling of compassion has elicited a supportive, selfless response from citizens (3).
- **A race to cure the disease.** Does the end justify the means? The ideal would be conducting multinational and public research to, firstly, understand the disease and formulate appropriate management interventions and practices and, secondly, evaluate the safety and efficacy of any proposed diagnostic tests, treatments, vaccines, and management strategies. This ideal has many difficulties: 1) the competition among governments, laboratories, and scientists to produce the first vaccine; 2) patent ownership and exploitation

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\* Editor, Revista Latinoamericana de Bioética. E-mail: [revista.bioetica@unimilitar.edu.co](mailto:revista.bioetica@unimilitar.edu.co).

by whoever makes the best offer, and 3) the relaxation and omission of some phases of clinical research or ethical criteria (e.g., informed consent, review by a Research Ethics Committee, among others).

- **The doubtful safety and effectiveness of a vaccine developed in such a short period.** For example, the experimental mRNA-1273 vaccine was developed by scientists from the U.S. National Institute of Allergy and Infectious Diseases (NIAID) in cooperation with the biotechnology company Moderna. It began to be tested on 45 healthy volunteers between 18 and 55 years of age, even though there is no safety data on the vaccine in preclinical trials (the FDA authorized the performance of animal testing for the vaccine at the same time as phase I trials with healthy volunteers). These trials are critical as they provide evidence that vaccinated animals did not experience severe side effects and developed immunity to the disease concerned. Similarly, consent for the phase I vaccine trial is not publicly available; it is unclear whether healthy individuals were informed of the potential risks of receiving mRNA-1273 doses and from which sources such risk information was obtained (4).

On the other hand, the safety and efficacy of COVID-19 drugs are being tested on humans. For example, we have heard from President Trump himself that chloroquine and hydroxychloroquine—both approved by the FDA to treat malaria and certain autoimmune diseases—could be effective treatments for COVID-19. However, in the few studies where testing was performed, the number of participants was small, and they were not randomized into a treatment group and a control group (placebo). The results of their therapeutic effectiveness are not promising, in addition to the side effects of taking hydroxychloroquine such as nausea, diarrhea, skin rash, skin pigmentation (such as darkening or dark spots), changes in hair, and muscular weakness. Hydroxychloroquine can rarely cause anything from anemia to visual problems or vision loss, and there is also a real danger of shortage for

patients with lupus and other autoimmune diseases who have been using this approved medication for years.

At this rate, it is possible that the agencies in charge of approving drugs, either the FDA or Invima (in Colombia), will approve a COVID-19 vaccine or treatment based on the efficacy data of phase II clinical trials instead of phase III trials with more participants and/or studies other than randomized clinical trials, with questionable evidence and little safety and efficacy. We would not want to repeat past mistakes such as thalidomide or recently Avastin (whose generic name is bevacizumab), which was approved by the FDA for use in combination with Taxol (paclitaxel) in February 2008 to treat patients diagnosed with metastatic HER2-negative breast cancer (not having received chemotherapy yet). However, such approval was revoked shortly after because subsequent data established that its harm to patients outweighed its benefits.

- **Distribution of resources.** Who lives and who dies? The question brought about by the COVID-19 pandemic reminds me of German philosopher and psychiatrist K. Jaspers and his concept of limit situation (Grenzsituation), “We are always in situations. Situations change, opportunities arise. If they are lost they never return. I myself can work to change the situation. But there are situations which remain essentially the same even if their momentary aspect changes and their shattering force is obscured: I must die, I must suffer, I must struggle, I am subject to chance, I involve myself inexorably in guilt. We call these fundamental situations of our existence limit situations. That is to say, they are situations which we cannot evade or change. Along with wonder and doubt, awareness of these ultimate situations is the most profound source of philosophy” (5). The pandemic is leading us into making decisions in extreme situations.

Spain, one of the COVID-19 hardest-hit countries, has 235,777 cases and 28,700 deaths as of today (05/24). One of the reasons why there have

been so many deaths is the collapse of their health care system, especially intensive care units (icus). According to data from the 2018 Spanish Ministry of Health, there are 4,267 ICU beds in public and private hospitals, although the total number of beds has tripled in some communities during the epidemic. Since April 28, the accumulated percentage of coronavirus patients admitted to ICUs has been reported to be 9.2 % (11,472) of the 124,757 people hospitalized. How are resources to be distributed in the face of this panorama? How can ethics or bioethics stand this reality? In many hospitals, patients died without receiving any treatment. Latin America had a small advantage in that the pandemic came a few weeks later, which enabled some (not all) countries to take some far-reaching measures, along with hygiene and social distancing protocols, and make every effort to avoid maxing out hospitals and clinics. In addition to curbing the exponential level of contagion, quarantine prevents patients from using the emergency services at the same time and distributes them over time.

This situation allowed implementing some recommendations made by multiple agencies, including the World Health Organization (WHO), about decision-making with scarce resources (such as ventilators or ICU beds) to meet all the needs of the population during the COVID-19 pandemic. Given that we cannot do everything that must be done, what is the most ethical way to proceed? Acting responsibly requires the establishment of prioritization criteria when making decisions. The WHO made four recommendations: 1) establish transparent prioritization criteria: the existence of transparent and publicly accessible criteria strengthens the people's trust in health authorities, which is key to their support, and takes this weight off of intensivists; 2) save the highest number of lives: this involves prioritizing those who are in the best clinical condition to survive treatment over those who will hardly recover even with treatment. The latter does not imply abandoning patients; they should always be given the necessary palliative care in the absence of treatment;

3) prioritize health workers: doctors, nurses, therapists, and others risk their lives to save the lives of others. Therefore, prioritizing their care satisfies a criterion of justice and allows saving the highest number of lives due to their central role in the care of others, and 4) treat everyone fairly: every patient (with COVID-19 or another illness) should be treated equally. Following the principles of justice and equity, it is essential to ensure that there is neither differentiated treatment according to privilege nor discrimination due to age, ethnicity, religion, sexual orientation, socioeconomic status, ideology, or other criteria unrelated to these recommendations (6).

■ **Our health professionals are heroes, but not martyrs.** According to the Royal Spanish Academy, the word martyr has three meanings: 1) a person who is killed because of their religion; 2) a person who is killed or suffers significantly because of their beliefs or convictions, and 3) a person who makes sacrifices to fulfill their obligations. Let us not turn our health professionals into martyrs. In several interviews, health professionals state that, besides being applauded from balconies, they urgently require personal protection equipment and supplies to treat those in need efficiently. Moreover, this claim is neither false nor unfounded fear because many health workers at a considerable number of hospitals in the country barely have essential resources, which contrasts with the growing demand for medical services created by the pandemic (7).

Despite everything, the novel coronavirus has left us in check, but not mate yet. Although the king is threatened, this situation can be changed using a legal move because the human being has an extraordinary capacity called resilience to overcome critical moments and adapt after experiencing some unusual and unexpected circumstances. It also means returning to normal. Right now, we are already thinking in post-coronavirus terms: we are capable of healing the deep scars left by the pandemic to think about and plan a better future. We are about to take the crown away from the king.

In the name of the editorial board of *Revista Latinoamericana de Bioética* and my own, we dedicate this issue to the heroes of this pandemic, the health professionals (doctors, nurses, paramedics, to name just a few) who have risked their lives for the most vulnerable and feeble, those who have suffered the agony of this utterly heartless coronavirus disease.

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**Note:** We inform our readers and collaborators that *Revista Latinoamericana de Bioética* will adopt a different numbering system from now on. Until last year, the journal used a three-factor numbering system containing a volume indicator that coincided with the last two numbers of the current year, a serial indicator of the total number of issues published by the journal, and, finally, a frequency indicator of whether the number was published in January–June (1) or July–December (2). Therefore, the last two issues were designated 19-36-1, indicating that it was the 36<sup>th</sup> issue of the journal published in the first half of 2019, and 19-37-2, indicating that it was the 37<sup>th</sup> issue of the journal published in the second half of 2019. However, this numbering was hard to follow as it is contrary to most journals’ usual systems and it did not match the one assigned to our issues by international indexation databases. Besides, the fact that the serial indicator followed the total number of issues made it seem as if the first referred to the volume, which led some readers and contributors to believe that, for example, the second number of volume 36 and the first number of volume 37 in 2019 were lost or forgotten in our publication history.

From now on, *Revista Latinoamericana de Bioética* will adopt a much more consistent and standardized numbering system, consisting only of a volume indicator referring to the current publishing year and a frequency indicator that determines whether the number was published in January–June (1) or July–December (2). This numbering system not only matches the one that has historically been assigned to us by indexation databases, but also makes our publication frequency clearer and more familiar to our very dear community of readers and contributors.