

## COVID-19

## Covid-19: A view from New York

RUTH MACKLIN

**Abstract**

*I live in New York City, identified as “the epicenter of the Covid-19 pandemic.” My view differs from that of many of the millions living in this large metropolitan area who are poor. I am not rich, but I am privileged: I have a retirement income for which I have saved all my working life and I have no debts. I am isolated in my apartment having food delivered. But what if I require hospitalization, from Covid-19 or another medical condition? New York State has guidelines for allocation of scarce ventilators in times of scarcity. The guidelines reject advanced age as a criterion for triage because it discriminates against the elderly. Other proposals contend that priority should be given to those who have not yet “lived a full life.” Allocation guidelines set a priority on saving the most lives, but hard choices remain within that broadly defined goal.*

**Key words:** Covid-19 pandemic, New York epicenter, resource allocation, age-based selection, shortage of ventilators, triage committee

New York State has recently been identified as “the epicenter of the world-wide Covid-19 pandemic.” The term is apt in light of the sheer number of current coronavirus infections and the projected number of new infections and predicted deaths. As of April 10, 2020, the state recorded 170,512 cases and 7,844 deaths. I live in New York City, with the largest metropolitan area population in the United States. On April 10, the city had 92,384 known cases of Covid-19 and 5663 deaths. According to the World Atlas, more than 800 languages are spoken in New York City. The city comprises boroughs, administrative subdivisions, of which the best-known internationally is Manhattan—the tourist mecca where the many cultural and financial institutions are located. A densely populated section of another borough—Queens—has emerged as “the epicenter of the epicenter,” with a rising rate of deaths from the coronavirus (1). One section of Queens that has the highest

number of cases and deaths is ironically named “Corona.” Another well-known borough is the Bronx, famous in the past for crime and violence but more recently, for urban renewal. According to some metrics, the Bronx is designated as “the poorest urban county in the United States.” The word “urban” is important here, as it distinguishes the Bronx from even poorer rural counties in regions such as Appalachia. An analysis of New York City by postal zones shows that the areas with the highest positive Covid-19 test rates are the ones with the lowest estimated per capita income.

My home is in the Bronx.

**My view from New York**

I have entitled this reflection A view from New York—rather than *The view*—because my experiential view differs from that of many other residents of this large metropolitan area. I know the same is true also for most of the world’s mega cities and even smaller urban centres and rural areas. Like other urban communities and states in the US, the governments of New York City and New York State have mandated isolation at home except for people employed in essential occupations. Several states and communities in the US have resisted such mandates, to the dismay of public health officials who have urged “social distancing” as a way of life during the current pandemic.

Like many, if not most New Yorkers except for those who work in essential industries, I am maintaining strict isolation in my Bronx apartment. The one exception is my daily exercise walk outdoors, where I am able to keep the requisite distance (6 feet in US measures, slightly less than two meters) from other walkers and joggers. Although my 18-story building is surrounded by other smaller and larger apartment buildings, no commercial establishments are located nearby. The streets are nearly free of automobile traffic, so walkers and joggers (most of whom are now wearing masks) can stay at the recommended distances from one another. This opportunity does not exist in poorer neighborhoods, which tend to be more densely populated and where people must leave their apartments to buy food or other essentials. Still, since the isolation mandates were issued, the first question I confronted was how I would obtain food and other necessities. I had never before ordered grocery deliveries (except for occasional take-out orders from the local pizza or Asian restaurant menus). But I was not going to leave my home to shop. Unlike other residents of the city, I do not need to go to a workplace deemed essential or to an unemployment office to get a

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paycheck or other compensation. I do not have to get on a bus or the New York subway system for any reason. I drive a car, but my car has been in the apartment building garage since before the isolation mandates were issued. Once, soon after the lockdown, I went to the laundry unit in the basement of my building. It was impossible to keep the requisite distance from other people using the washing machines and dryers. Despite my protective gloves and face mask, I felt vulnerable and have since been washing my clothes in my bathtub. I'm also exploring a pickup and delivery laundry service. For years I've had a housekeeper who cleans my apartment once a week. Since the isolation began, I have not used her services but have continued to pay her the same amount I had paid weekly for many years. I plan to continue paying her while she is no longer cleaning my apartment as long as the current situation persists.

So how does my view from New York, in this pandemic, differ from that of many of the millions living in this large metropolitan area? I am privileged. I am not rich, but I am privileged. I am living on a retirement income for which I have saved all my working life. I have no debts. I have no dependents (my grown children are self-sufficient) and no elderly parents. My home mortgage is fully paid off and I can afford the monthly maintenance fees, my phone and internet costs, and other necessities of daily life. Yet this is certainly not the case for many other New Yorkers—as well as residents of Mumbai, New Delhi, London, Milan, Barcelona, and other cities throughout the world. Many urban residents live in crowded conditions they cannot avoid. Many rural residents are far from urban centres where they can purchase necessities—if they can afford them. Large numbers of people who have already lost their jobs and have few resources do not have enough money even for the basics of food and shelter. Soup kitchens and food pantries have sprouted all over the city. And people who still have jobs in essential industries and retail establishments are at greater risk of acquiring infection than those who can shelter at home.

I am privileged, yet given the sheer number of infected people in the city, I am susceptible to the coronavirus if I venture outside my self-confined environment. Even though I am healthy, because of my advanced age (I turned 82 last month) I have a weakened immune system and therefore, I'm more susceptible to a worse infection than large numbers of younger people. But unlike very many of those who are younger but at risk because of their home or neighbourhood environment, I am able to shelter and have necessities delivered. As one who adheres to the recommendations of the public health specialists, I feel relatively safe.

But what if I need medical treatment, for infection with Covid-19 or something else? What if I have to be hospitalised for an urgent medical condition? What if I need ventilator assistance when there is a shortage of the equipment (which is already occurring)? Should my age disqualify me, regardless of my otherwise relatively healthy condition? Will such rationing decisions be left to physicians in charge of ICUs? If so, on what basis will they decide? Are there guidelines for such rationing

in times of pandemics such as this, and if so, what do the guidelines say?

### Resource allocation in the time of Covid-19

As it happens, New York State has guidelines for allocating scarce medical facilities in times such as this (2). These guidelines were issued in November 2015 by a long-standing bioethics commission, the New York State Task Force on Life and the Law, in anticipation of a shortage of ventilators in an influenza pandemic. The guidelines comprise four chapters: Adult Guidelines, Pediatric Guidelines, Neonatal Guidelines, and Legal Considerations for implementing the guidelines. The document unequivocally states that the primary goal is to save the most lives. The ethical framework includes five components: duty to care, duty to steward resources, duty to plan, distributive justice, and transparency. The individuals charged with making decisions about the allocation of ventilators are not the individual physicians in charge of their patients' care. Rather, it is a triage officer or triage committee that examines the relevant information and determines the patient's level of access to a ventilator.

As noted, the guidelines state that the primary goal is to save the most lives: "Using clinical criteria, patients deemed most likely to survive with ventilator therapy have the highest level of access to this treatment" (2: p 6). Interestingly, unlike other ideas that have circulated about criteria for rationing medical resources in time of pandemics, the New York State Guidelines reject advanced age as a triage criterion "because it discriminates against the elderly." In addition, "there are many instances where an older person could have a better clinical outlook than a younger person" (2: p 5). Nevertheless, the guidelines address circumstances in which the age of a patient may be a factor in allocation. "[I]n limited circumstances, if: (1) the pool of patients eligible for ventilator therapy includes *both adults and children*, and (2) all available clinical data suggest that the probability of mortality among the pool of patients have been found equivalent..., then young age (i.e., 17 years old and younger) may be utilized as a tie-breaker to select a patient for ventilator therapy" (2: p 7). Although these guidelines were never implemented at the time they were issued because shortages from the anticipated influenza pandemic did not materialise, the current situation in New York has brought the guidelines into prominence once again.

At the time of this writing, I had signed up for a webinar entitled "Ethical Framework to Guide Scarce Resources." Prior to the webinar, registrants received a questionnaire designed to anchor the discussion. Among the questions were the following: "Should a priority score be based on saving the most life-years (i.e., prognosis of long-term survival - living more than one year)?" and "Should age be a factor in determining the allocation of scarce resources?" These questions, among others, were discussed during the webinar. The result demonstrated that preference for saving the young before the old was the predominant view. In stark contrast to the results of this informal poll, a 72-year-old, self-professed "liberal

bioethicist" wrote a letter to the *New York Daily News* objecting to "the prevalent pressure on old people to bow out gracefully." She wrote: "why can't we ever hear from an old person who wouldn't 'forgo [his] own life to save the life of [his] grandchild' any more than he would expect his grandchild to make the reverse sacrifice? And if his grandchild would welcome the sacrifice of her grandparent's life, how could she possibly be worth it? Aren't we all equally valuable regardless of age?" (3)

How to answer the question, "aren't we all equally valuable regardless of age?" As a matter of the intrinsic worth of every human being, it's easy to say "yes" to that question. But extrinsic factors come into play. The old person who wouldn't forgo his own life to save the life of his grandchild has that grandchild's parents to contend with. One of those parents is the old person's son or daughter. We consider it sad and we grieve when a grandparent dies. But we expect our children to outlive us, which is why we consider it a tragedy when parents lose a child—even when that child is an adult outlived by her parents. So the old person who wouldn't forgo his own life to save the life of his grandchild may alienate his own son or daughter, thereby losing both a grandchild and a child.

The debate over age-based rationing in a pandemic is simplistic. It takes into account only one factor that could be used (ethically or unethically) in deciding who should get limited life-saving resources. A more nuanced account takes multiple factors into account, illustrated in a recent article in the *New England Journal of Medicine* (4). The article delineates four fundamental values: "maximizing the benefits produced by scarce resources, treating people equally, promoting and rewarding instrumental value, and giving priority to the worst off" (p. 3). These ethical values are used to make six specific recommendations. These are: maximise benefits; prioritise health workers; do not allocate on a first-come, first-served basis; be responsive to evidence; recognise research participation; and apply the same principles to all Covid-19 and non-Covid-19 patients. Although few would quarrel with the list of ethical values described in the article, how those values should be used in making specific decisions is open to debate.

Here is one example: "Operationalizing the value of maximizing benefits means that people who are sick but could recover if treated are given priority over those who are unlikely to recover even if treated and those who are likely to recover without treatment" (p 4). This is the standard "triage" method developed in wartime: divide the wounded into three groups in order to maximise the number of lives saved. But even that rule requires interpretation and justification for specific groups—in particular, young versus old. "Because young, severely ill patients will often comprise many of those who are sick but could recover with treatment, this operationalization also has the effect of giving priority to those who are worst off in the sense of being at risk of dying young and not having a full life" (p 4). I find this interpretation of what it means to be "worst off" rather odd. It prioritises the young over the old with the same prognosis in a way that appears to avoid "ageism" as a selection criterion. But what is the basis for claiming that a

six-year old is worst off by "not having a full life" when a child of that age has no conception of what it means to have a full life? The six-year old has not formulated any life plans. Moreover, what is the basis for an ethical presumption that every person born deserves a "full life"? A 50-year old single mother with two teenaged children and a younger child at home has achieved more of the proverbial "full life" but she also can anticipate another 25-30 years to complete that life, with important family obligations to fulfill before reaching that point. Of course, taking such individual factors into consideration in allocating scarce medical resources would be impossible. However, if an allocation scheme seeks to prioritise the young over the old, it would be more honest to use a straightforward utilitarian criterion. That is, for any society to flourish it must continue to produce younger generations that are healthy and productive. It is already evident in a number of countries today (Japan and Italy are examples) that a population distribution skewed toward older members faces problems of diminished productivity and insufficient governmental resources to care for the elderly and infirm.

## Concluding reflections

In preparing this article, I thought it would be interesting to interview one of the employees in my apartment building who lives in a different area of the Bronx to learn something about how he perceives the situation in his community. With my face mask in place and no one else in the lobby of the building, I stood two meters from the concierge desk where he was seated, wearing his face mask as well. I asked his permission to ask a few informal questions (and in case you're wondering, I didn't ask for a formal declaration of informed consent but I promised to preserve confidentiality). The employee, Miguel (not his real name), agreed. My first question was about his experience regarding the pandemic where he lives in the Bronx. He replied that his father had just died from the coronavirus infection. I knew that Miguel had been absent from his position at the concierge desk for the past two weeks. I didn't know the reason for his absence but hoped it was not because he was infected. As I now learned, he was isolated in the 14-day quarantine period. He told me that his father—age 72—had delivered newspapers in the area. Miguel has a side job driving people to NY city airports and I have benefited from his excellent service numerous times in recent years. In those long rides, we talk—about family, about life. So on this occasion I asked him about the situation now with his children, who are in middle school and high school here in the Bronx. His answer: his kids have three or four hours of online lessons every day. They are unhappy that they're not in school and can't wait to go back. It is a tribute to Miguel that he has provided the online resources that benefit his children in this way. Many less fortunate parents in the Bronx lack access to the internet and the means for their children to continue their education during the lockdown.

Miguel's story is more upbeat than that of many others with the same background—a person of Puerto Rican origin in New York City. He has a steady job (and his driving gig as a

“side hustle”). He has a strong commitment to his children’s education. But I suspect that many other residents in this low-income borough of the Bronx may share Miguel’s values but are unable to realize their hopes. In that respect, Miguel is privileged—but surely not as privileged as those of us, like me, who are able to sequester at home and avoid placing ourselves at risk of illness and death.

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# Death in the time of coronavirus

GEORGE THOMAS

## Abstract

*The lockdown of the country, imposed by the government of India, has resulted in additional suffering for the poor without any tangible benefit. The germ theory of disease is an important contribution to human welfare. However, disease has social determinants. Responses to infectious epidemics should be based on social conditions, not only from considerations of equity, but also because they are important for success. Advice from the World Health Organisation has to be tailored to the social realities in India. Current response by the government of India has confined the poor to ghettos. They have lost the means of livelihood without a proper social security net. It is not possible for them to practise social distancing or proper hygiene. The lockdown has the effect of making conditions worse for the poor.*

**Keywords:** Covid-19 pandemic, resource allocation, social origins of disease, unplanned lockdown, diversion of resources, lack of social security

The response of the government of India to the potential threat from the new coronavirus, emphasised once again the deep fault lines in Indian society. On January 30, the World Health Organisation declared the virus a public health emergency of international concern. It was late March before the government decided to act.

In these two months it was business as usual in India. Riots took place in Delhi under the unwatchful eyes of the security apparatus. A mega political show was put on for the President of the United States of America who claimed that he had been promised that millions of people would greet him (1).

These events underline the callousness with which a lockdown of the entire country was announced suddenly at 8 pm on March 24. It boggles the imagination to believe that the Prime Minister and his advisors were unaware of the terrible consequences this decision would impose on the vast majority of the population. According to the World Bank, 659 million people or half the country’s population are poor, and 176 million live in extreme poverty (2). No measures were announced to take care of them. It comes as no surprise that several lakhs of people, who migrate in search of work, crammed into every available means of transport to return to their homes. Thousands trekked long distances (3).

All this demonstrated, in the starkest terms imaginable, that social distancing was not for them. This was yet another luxury item that they could only gaze at.

## Models of disease

The germ theory of disease was a remarkable intellectual contribution. It established that infections are due to micro-organisms and laid the foundation for developing treatments aimed at targeting these micro-organisms. Long before the development of effective vaccines, antibiotics and anti-virals which are tools to treat the infected person, techniques of disinfection and quarantine were used to prevent the spread of disease. The great success of antibiotics and antivirals initially overshadowed the social origins of disease and its spread. The re-emergence of epidemics and pandemics in the modern world brought to the fore an insistent and persistent body of opinion that has maintained that disease has to be understood in a social context (4). Treatment of the individual patient is important, but it is no less important to understand the environmental and social conditions in which an individual becomes ill (5).

## Policy implications

How the knowledge of the interplay between the social and the individual is used to determine policy emphasises the fault lines between nations and closer to home, within

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