

Is coronavirus treatment fair? Not in an unequal society

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An important notion underlying most clinical and ethical pandemic guidance worldwide is the concept of fairness; whether this is the question of how to make decisions to [allocate limited health resources](#) or

the need for ethical guidance on how healthcare staff should make [difficult decisions about care](#) to ensure that regulations are standardized around the country.

But when it comes to [health](#), "fair" is a misnomer. This is because the principle of fairness relies on the premise that good health is available to everyone equally, when we know it is not.

The factors that contribute to our wellbeing are known as the "[social determinants of health](#)". These include the conditions in which you were born, where you live and work, how much money you have, your education, and how accessible health care services are to you. All of these things contribute to our ability to be healthy, but they are not fairly distributed amongst the population. This is the source of the health inequalities that exist in our society.

The inherent unfairness of health is a problem when much of the guidance for doctors, hospitals and healthcare facilities argues that, in the name of fairness, the [criteria for providing care](#) should be based on how healthy a person was before they contracted COVID-19.

And here is where it gets tricky, because COVID-19 has not affected the population fairly.

For example, COVID-19 has hit people from ethnic minority backgrounds hardest for [several important reasons](#). This population was already disadvantaged by poorer health due in large part to [systemic racism and inequalities in our society](#), for example, the fact that people from an ethnic minority background often live and work in areas of deprivation. They are also more likely to work in public-facing roles such as healthcare, retail, transport and the food industry.

Bad guidance?

As governments develop guidance to tackle COVID-19, the inherent health inequalities that plague our nation have been largely forgotten. But as I and my colleagues have [argued in parliament](#), they are as deadly as COVID-19, if not more so. This has resulted in the development of inadvertently discriminatory guidance, as COVID-19 lays bare what happens when policy ignores the social determinants of health and the inequalities they create.

Take, for example, the guidance that is used to determine the priority of care for treatment during pandemics. [Research from previous pandemics](#) has found that when decisions are made using only the likelihood of long-term survival and co-morbidity (meaning the other illnesses a patient has), people from ethnic minority backgrounds are disproportionately disadvantaged. This is because these groups are more likely to have a [higher incidence](#) of many of the health conditions used to decide whether critical care is appropriate.

For example, people of South Asian background are at a [higher risk of heart problems](#) if they come from a deprived background, while richer people in this demographic have a [significantly lower incidence](#) of heart disease. This is problematic given that in their "Information to support decision making" during the pandemic, the National Institute for Health and Care Excellence [names heart disease](#) as a condition that could be used to determine that a patient should not be escalated for further care, for example being admitted to ICU.

The example of heart disease highlights how ethnic minority groups may not receive the same care as white British patients and shows how existing guidance neglects the relationship between ethnicity and health.

Ethics in the abstract

We can see that advocating "fairness" as a guiding ethical principle is hardly fair at all in practice. In fact, it could be lethal. So why does fairness continue to dominate the [medical ethics](#) that influences the clinical guidance?

This is perhaps because, in ethics, the idea of being fair and that of being universally applicable are often conflated. Ethics has a bit of a fetish when it comes to creating principles, concepts and theories that can be applied universally to every person equally. The assumption here is that doing so is fair because everyone is treated equally.

Patient autonomy is one such concept. Autonomy is still understood as an individualistic ideal, where all patients make decisions on their own, with no outside influences. This way of understanding autonomy persists in large part because it allows the concept of autonomy to be generally applicable. This is despite [several years of research](#) showing patients make decisions in different and nuanced ways, largely influenced by culture, gender, socio-economic status and ethnic background.

In medical ethics, the focus on generalities ignores the many important ways that our society is not fair, and how health is unequally distributed across the population.

As [my research](#) has shown, ethical theory developed without reference to the context in which it is used, meaning existing societal norms, is seldom helpful in achieving its stated goal of supporting ethical medicine. For guidance to be relevant it must consider the context in which that medicine will be practiced.

As we face another year battling the COVID-19 pandemic, we must take what we have learned since March 2020 and implement it in both ethical and clinical guidance, including how we are rolling out the COVID-19 immunization program. Any guidance that informs decision-making

during the pandemic must account for the relationship between ethnicity, health and COVID-19 to ensure that it does not promote or exacerbate existing structural disadvantages.

It is not OK, and certainly not ethical, to come out of the pandemic with more people from ethnic minority backgrounds dead, bereaved or suffering from long-term complications than their white counterparts, simply because the [guidance](#) doctors use was supposed to be "fair."

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