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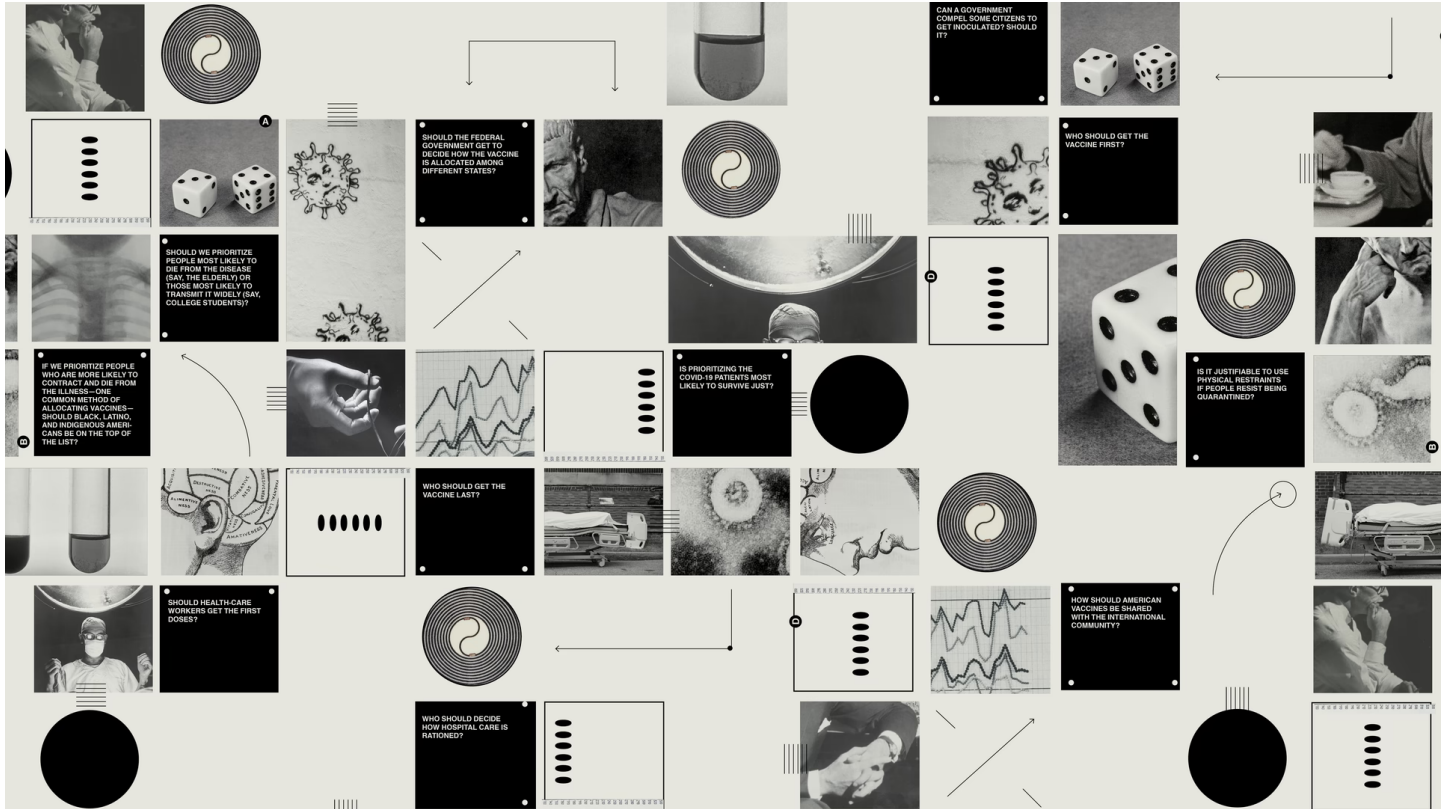


Photo illustration by Arsh Raziuddin\*

HEALTH

# WHAT THE CHAOS IN HOSPITALS IS DOING TO DOCTORS

Politicians' refusal to admit when hospitals are overwhelmed puts a terrible burden on health-care providers.

By Jordan Kisner

JANUARY/FEBRUARY 2021 ISSUE

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THE ORIGINAL “God Committee” had seven members: a surgeon, a minister, a banker, a labor leader, a housewife, a government worker, and a lawyer. They convened in the summer of 1961 in Seattle because a professor of medicine at the University of Washington had invented a new method of dialysis that could indefinitely filter the blood of people whose kidneys were failing. His device, hailed as the first artificial human organ, resided in an unobtrusive annex of Seattle’s Swedish Hospital, and it seemed like a true medical miracle. Suddenly people with less than a month to live could be restored to health, provided they could be dialyzed regularly. But at the time, roughly 100,000 Americans were dying of end-stage kidney disease. There were hundreds, possibly thousands, of viable candidates. The program could take only 10. Who should get the lifesaving care?



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The committee set out to make this choice “with no moral or ethical guidelines save their own individual consciences,” as *Life* magazine reported. The physicians briefing the group had already narrowed the field by eliminating people older than 45 (because they were more likely to develop complications that would hinder their recovery) and children (on the theory that they weren’t mature enough to handle two 12-hour dialysis sessions a week, and were possibly vulnerable to unpredictable side effects). Beyond that, the committee was on its own.

Its members weighed, among other things, whether the person could afford to live near enough to the hospital to get regular treatment; whether residents of other states should be eligible, considering that Washington taxpayers had partially funded the development of the treatment; whether a chemist or an accountant had the greater “potential of service to society”; whether a candidate was “active in church work”; and,

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for the married men under consideration, which of their wives could best cope with losing her husband. “A woman with three children has a better chance to find a new husband than a very young widow with six children,” the labor leader remarked. The results of the deliberations were unsurprising, to an extent: The 10 patients chosen from among the first 17 who came before the committee lived; the others died. To this day, we know the seven committee members only by their professions, a Chaucerian feature that makes this story feel more like a fable than a piece of science history.

It was eerie to stumble across the God Committee—also known as the “Life or Death Committee”—last spring, when I was following the story of a different artificial organ. In New York, the nightmare scenario being discussed on the radio, in the bodegas, on TV was that the hospitals, overwhelmed with COVID-19 patients in respiratory failure, would run out of ventilators. Reports from northern Italy [gave a grim preview](#): angst-ridden medical teams arbitrating which patients would get to breathe and which would be consigned to die. Governor Andrew Cuomo was on national television begging the federal government for more ventilators and personal protective equipment. Article after article outlined a series of awful questions: If and when New York hospitals ran out of ventilators, should the machines be allotted on a first-come, first-served basis? Based on who was sickest? Based on who was most likely to survive? Based on who, if they survived, had the most years left to live? Based on some randomized lottery system?

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As it happens, the job of answering these questions is still frequently left to committees. But today, “the lawyer, the housewife, the banker, the minister” have been supplemented by bioethicists. “New York’s Bioethics Experts Prepare for a Wave of Difficult Decisions,” read the headline of a March 28 *Washington Post* article. “Who Should Be Saved First?” *The New York Times* asked, pointing out that “well before rationing caused by coronavirus, protocols were established about ‘who lives and who dies.’”

The article was right—there were protocols, written by committees of ethicists, physicians, lawyers, clergy, philosophers, community activists, and political scientists. In New York, guidelines for allocating ventilators in a pandemic had been designed by the New York State Task Force on Life and the Law, which used the 1918 flu as a model. These guidelines were part of a plan for “crisis standards of care,” or protocols for handling a public-health emergency that outstrips the medical system’s capacity. Published in 2015, the task force’s plan envisioned the transfer of equipment, personnel, and patients among hospitals to ensure that one institution wasn’t overrun while others had empty beds.

Last March, as the coronavirus took hold, the committee met with the state’s health commissioner to brainstorm ideas for COVID-specific protocols. Despite that meeting, its key recommendations were never taken; no crisis standards of care were implemented in New York. These standards can be initiated only by the government—a process that, in most states, including New York, requires a declaration from the governor. This left the clinical ethicists staffing New York’s hospitals—along with the doctors and nurses and administrators—to figure out rationing themselves.

“At a certain point, I realized the ambulance is the score of this movie,” Joseph J. Fins, the chief of medical ethics at the Weill Cornell Medical Center in Manhattan and one of the leading figures in the field, told me in October. He lives down the street from his hospital, and by late March the wail of sirens had become an unending drone, day and night. He and his team of ethicists were on call 24/7, trying to support physicians, nurses, and administrators through the initial COVID-19 surge. “Our world became 69th Street,” Fins said.

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The doctor had five patients, two intubation teams, and not very much time. *What do I do?* the physician pleaded.

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Fins is an affable 61-year-old with an easy smile and a calm, teacherly aspect. He wore a crisp white shirt and a tie for both of our video interviews, despite being home in his apartment. More than once in our conversations, he referenced Thucydides. An internist as well as a bioethicist, Fins serves on the task force that in 2015 came up with ventilator-allocation guidelines for New York. “Our analysis was anticipatory and a tabletop exercise,” he wrote in an academic journal in June. “It was not the real deal.”

The real deal was almost beyond imagining. During the eight weeks of the surge, Fins’s team members at Weill Cornell worked around the clock, providing 2,500 ethics consultations and addressing a range of horrific questions they’d never previously encountered. Fins likened the influx of critical-care patients to what you’d expect if there had been “a major plane crash at LaGuardia Airport”—only the influx never stopped. Patients just kept coming. Hospital staff needed to know how to triage. “We were approaching the hinterland of chaos.”

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Physicians in the emergency department were begging Fins for the authority to withhold CPR when they felt it was futile; they wanted to be able to focus their care on patients with better odds of surviving, and to avoid the viral transmission that CPR can cause. But since 1987, New York State law has generally held that physicians must try to resuscitate a patient, unless the patient has a “do not resuscitate” order. Hospitals could have, in theory, made an argument for suspending doctors’ obligation to follow that law given the crisis circumstances. (The prosecution of health-care workers after Hurricane Katrina is seen as a disastrous example of what happens when doctors work without legal clarity regarding their end-of-life decision making during a

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crisis.) Fins's team quickly wrote 12 different versions of a triage protocol, hoping to anticipate whatever guidelines might come from the New York State Department of Health—but no guidelines ever came.

Photo illustration by Arsh Raziuddin; images from  
Bettmann / BSIP / Cornell Capa / *The Denver Post* /  
Myron Davis / Getty

“This was a stress test for medical ethics, for distributive justice and the allocation of scarce resources,” he wrote. “Simply put, there were more patients to be resuscitated than available personnel, much less equipment.” As far as we know, New York hospitals never ran out of ventilators, but the state did experience terrible shortages of PPE, of staff, of crucial equipment and supplies. In March, PPE was so scarce on the ground in New York City that pictures surfaced of nurses wrapping themselves in trash bags. At hospitals across the city and state, the shortage contributed to the policy of prohibiting all visitors. It wasn't acceptable to, say, risk depriving a nurse of PPE in

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order to provide the gear to visitors, whom the hospitals were ethically obliged to protect from exposure, for their own sake and to limit community spread.

Hospitals faced other urgent and difficult questions. Physicians needed to know: What do we do when we have a COVID-19 patient who wants to be discharged against medical advice but who would be returning to a home where she cannot isolate from others? Can we sequester patients over their objections? Is using physical restraints justifiable if people resist being quarantined? Comparable questions and shortages now confront hospital systems around the country, as COVID-19 cases spike all over. Questions of rationing have emerged again, in Utah and elsewhere, reprising the grisly experience of last spring.

In New York, staff ethicists became lifelines for frightened colleagues who were “surrounded by 10 to 15 critically ill intubated patients in the emergency department, while the patients’ panicked relatives sat nervously in a (virtual) waiting room, anxiously expecting news of their loved one,” Fins later wrote in *The Journal of Clinical Ethics*.

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One call in particular sticks out in Fins's memory: a frantic consult request from an ER doctor with three patients who needed to be put on ventilators right away. Within 15 minutes, two more arrived. The department had enough ventilators, but only two teams of practitioners that could work them.

COVID-19, when it triggers acute respiratory distress syndrome, causes the body to essentially drown itself: The lungs stiffen and fill with blood and fluid until the person suffocates. A ventilator can force pure oxygen into the lungs with enough pressure to overcome some of the fluid and stiffening, but putting someone on a ventilator is a tricky, risky procedure that requires expert training. Fluids and secretions spray into the air, exposing everyone in the room to infection; patients usually have to be sedated and even paralyzed for the procedure.

This doctor had five drowning people, two intubation teams, and not very much time.

*What do I do?* the physician pleaded.

BIOETHICS AS A FIELD developed in response to concerns about the doctor's power: Someone who is uniquely equipped to heal is also uniquely equipped to harm. Writings about the moral obligations of medical practice date back thousands of years, but until the 20th century there was, generally speaking, trust that doctors were reliable moral actors—besides which, the doctor's might was naturally restrained by the limitations of medical technology. But the rash of scientific advancements in the 20th century presented physicians and scientists with awesome new capabilities: cultivating human life in a laboratory; artificially sustaining life after brain death; manipulating genetics. That century also witnessed a number of human-rights atrocities committed by physicians and scientists: the torturous medical experiments that German doctors subjected prisoners to during the Holocaust; the radiation

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experiments done on pregnant women and schoolchildren after World War II; the Tuskegee syphilis experiments.

The upshot was a steep erosion of public trust in medicine concurrent with a dramatic increase in the ability doctors had to “play at God,” a temptation that the Hippocratic oath warns against. By the 1970s a new field, bioethics, had emerged, whose experts were supposed to advise and check the power of scientists and physicians.

The field has evolved to meet demand. Today, bioethicists work on the moral dimensions of a broad range of medical issues: genetic engineering, artificial intelligence, organ donation, assisted suicide, surrogacy, data privacy, reproductive rights and technology, alternative medicine, disability studies, pain management. Their primary role is consultative—tackling the question *What should I do?*, whether the querent is a pharmaceutical company asking about the best way to test a new drug on children, a state government wondering whether it’s okay to mandate mask wearing, or a federal government sorting out whether to relax guidelines to speed up a vaccine trial. Their task often isn’t to offer a verdict or directive but to help the decision maker tease out the options, clarify the aims of various stakeholders, and note any obvious ethical pitfalls.

A wide spectrum of approaches and values exists within the bioethicist community, many of them traceable to various branches of ethical thought. To dramatically compress several centuries of isms: An ethicist might favor deontology, which suggests that you should judge an action based on whether it follows moral and ethical rules, such as honesty or duty to others. (Kantians, named after the most famous deontologist, make up the school’s most prominent sect.) She might be a consequentialist, who worries about the impact of a decision, as opposed to its motives. (Utilitarianism is the most familiar version of this school, prioritizing the greatest good for the greatest number.) She could be a virtue ethicist, whose highest priority is striving to fulfill ideals such as justice and kindness; a pragmatist, who holds that any ethic can really be judged only by evaluating its practical application; a Deweyan pragmatist, who believes that ethical choice evolves over time, requiring constant reevaluation; and so on.

Especially when it comes to life-and-death questions, ethicists fiercely debate the right path—not only the path itself, but the correct basis for it. “The reality is these decisions are really controversial,” says Matthew Wynia, the director of the Center for Bioethics and Humanities at the University of Colorado. “You could go in several different directions, and all of them have some ethical justification, but not a justification that 100 percent of people are going to buy.”

A self-identified “pragmatist with some deontological leanings,” Wynia has spent the past 20 years working on standards of care in public-health emergencies. “It’s very common to look at catastrophic disasters and say, ‘Just try to save the most lives,’” he told me. As reasonable as “save the most lives” sounds, taken too literally it would require that hospitals prioritize the patients they deem most likely to survive—the ethical dangers of which are obvious when applied to COVID-19. In the U.S., the disease disproportionately kills people of color, those with preexisting conditions (sometimes linked to poverty), the elderly, and people with disabilities, so a system of care that privileges *only* survival odds reinforces existing injustices. “Equity still matters,” even in a crisis situation, Wynia said. “Justice matters. Fairness still matters. You’re not just trying to optimize a number.”

Tia Powell, who served as executive director of the New York State Task Force on Life and the Law in 2007, when it released a preliminary version of the ventilator-allocation guidelines, and who today is director of the Montefiore Einstein Center for Bioethics in the Bronx, told me that the guidelines were motivated by the desire to even out the quality and availability of care. The goal was to keep New Yorkers’ fates from depending on which hospital they landed in, or what team of doctors they happened to encounter. She sighed. “You don’t want people making complex decisions and policies while tired and frightened, or at the last minute and behind closed doors.”

But this is exactly what happened in New York last spring, and in other parts of the country this fall, as coronavirus cases climbed exponentially. As of this writing, only a few states have enacted crisis standards of care, despite how resource-strapped their hospitals have become. (Texas’s governor has not instituted crisis standards of care even though at various points multiple counties in the state have run out of room in their hospitals, which had to turn people away.) “What we learned is that no matter

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how good the ethical guidance, governors are incredibly reluctant to actually implement explicit triage,” Wynia told me. “Why do you think that is? Because it would mean admitting that we are not able to provide top-quality medical care in the United States of America in 2020.” When asked in late March how the state would decide who got ventilators if it ran out, New York’s Governor Cuomo said, “I don’t even want to think about that consequence.” (State administration officials told me that their focus had been increasing the system’s capacity, and that they never seriously considered rationing or crisis standards, despite pleas to do so from medical professionals and organizations like the New York State Bar Association and the New York Chapter of the American College of Physicians. “The last resort was never an option,” said Gary Holmes, a spokesperson for the department of health.)

“I understand it, by the way,” Wynia said. “No one would want to be accountable for making these decisions. They’re tragic decisions, which is why they roll downhill. Right? From powerful person to less powerful person to the person who can’t say *I refuse to make that decision*. That’s how they end up in the lap of the bedside doctor.”

NORMALLY, IF FIVE PATIENTS arrived in the ER with the same condition and roughly the same level of urgency, they would be treated in order of arrival. If they arrived at roughly the same time and with the same condition, they would be treated in order of urgency. But the panicked phone call about the five patients who all needed ventilators presented a vanishingly rare predicament: five patients, same arrival time, same problem, all critically ill.

The decision was “based on who was most likely to survive,” Fins told me. Drawing on a modified version of the save-the-most-lives method to which Wynia referred, the ethicist on call (one of Fins’s colleagues) advised the physician to prioritize the five patients using the sequential organ-failure assessment (SOFA), which predicts the likelihood of short-term survival. (Not all ethicists think SOFA is an adequate prognostic system for COVID-19—Wynia has pointed out that it hasn’t been an

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accurate outcome predictor for pandemic flus.) The ethicist also reminded the physician to be vigilant for any implicit bias in the assessment (ageism, ableism, racism). This wasn't rationing; it was prioritization: In what order would these patients get put on ventilators?

This distinction between prioritization and rationing may seem technical, or like doublespeak. What's the difference when "deprioritizing" someone might mean he doesn't survive long enough to get the care that could have saved him? But in this case, the prioritization seems to have made sense. The medical team was able to give the third, fourth, and fifth patients in line other kinds of mechanical respiratory support to bridge the gap. The fifth patient had end-stage dementia and multiple organ failure.

Fins said that situations like this, in which all of the options are bad but you have to make a decision, create "a kind of a moral scar for the clinician." The clinical ethicist's job is to help the scar fade, essentially by assuring health-care workers that they did the best they could given the circumstances. "The moral explication is a balm for the clinicians, who have to go back and do it again." In this case, they avoided the absolute worst: All five people were eventually placed on a ventilator.

The full-scale ventilator shortage people feared never came to pass in New York last spring. But the wave of relief at dodging that particular catastrophe has obscured the fact that other kinds of rationing did occur amid the chaos—and is still occurring as the coronavirus continues to rampage around the country. For instance, in a challenge that harkens back to the God Committee, last spring dialysis was in critically short supply. As COVID-19 patients developed renal failure in large numbers, hospitals began to run out of dialysis liquid. As the stock of the liquid shrank to nearly nothing, Fins's team, alongside other ethics teams across the city, considered the questions at play: "Is it better to dialyze three people really well or six people not as well but enough to try to maintain their viability?" What about if you have 12 people who need it? Once again, a committee was sitting around a table (or around their various dining tables on Zoom) trying to come up with a protocol for who would receive dialysis and who would die.

"I kept feeling gobsmailed," Tia Powell told me, describing what it was like heading Montefiore's bioethics team during the surge. "Like, *What now?! It's going up to the*

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*kidney? We need dialysis?* No one saw that coming!”

Powell, who is a psychiatrist, chairs the bioethics committee of a hospital system that’s very different from Fins’s Upper East Side institution. In the Bronx, Montefiore serves the patients who are most vulnerable to COVID-19: people of color, the uninsured, and Medicaid recipients. Terrified of running out of beds, clinicians, and equipment, the hospital drafted doctors from other specialties into critical care, turned conference rooms into intensive-care units, built tents outside to test and triage patients, reused PPE when possible, and retrained staff on alternative ventilation equipment. Powell described the situation as “staying just one step ahead of the wolf.”

Photo illustration by Arsh Raziuddin; images from BSIP /  
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It was terrifying not only because people were dying in droves, Powell said, or because running out of ventilators would mean more death, or because the dearth of PPE could put doctors and nurses in mortal danger—it was terrifying because clinicians were facing a quality and scale of uncertainty and moral trauma that they’d never seen before, in ways that affected their clinical decision making. Suddenly, performing

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CPR posed agonizing ethical questions. Chest compressions spewed virus into the air, putting the medical team at extra risk of getting the disease. Normally, this is a risk medical staff take without hesitation. But doctors and nurses quickly realized that in most COVID-19 cases, CPR was useless—the patients died anyway, skewing the risk-benefit balance for the procedure.

Kristine Torres-Lockhart is an internist specializing in addiction medicine who was called to provide care for COVID-19 patients at Montefiore's Wakefield campus. She told me about a day when she was assigned to the “code team,” the group that rapidly responds to anyone who loses a heartbeat or whose vital signs become unstable. “I think that was honestly one of the most physically and emotionally draining days of my career to date,” she said. She and her colleagues worried that being on the code team would expose them to the virus, which they'd then take home to their families. The resuscitation measures themselves were athletic and exhausting. The code bell went off over and over again during her 12-hour shift—maybe 10 times, she said. Of the “code blues”—patients who lost a heartbeat—no one survived. “That amount of loss in a day ...” She trailed off. Data now indicate that this is the pattern in hospitals across the country and around the world. When COVID-19 patients go into cardiac arrest, it's often because their lungs are failing, which can't be solved by restarting their heart. Mortality data suggest that only a small percentage—as low as 3 percent or less—of COVID-19 patients who receive CPR survive.

Meanwhile, at Montefiore, dozens of critical-care staff members were out sick themselves with COVID-19, and some were dying. While efforts to restart the heart of virtually any patient without a DNR order are normal practice, there were serious questions about whether they were ethical now, considering that they seemed futile. “It is unconscionable to create risk to providers without benefit to the patient,” Powell wrote in *The American Journal of Bioethics* in May, “and indeed to create the likelihood of a painful death if the patient retains any consciousness.” Fins wrestled with the question as well after clinicians entreated him to sanction withholding CPR in certain cases. He recognized the abundant ethical reasons for unilateral DNR orders, but something about the idea sat poorly with him—it robbed patients and their families of the right to make that decision.

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To some medical teams, though, attempting resuscitation felt not only fruitless but also like a charade or a lie, like they were giving families false hope. Beyond that, because resuscitation is a somewhat violent process—ribs are broken, bruises inflicted—some doctors and nurses felt demoralized by the sense that they were abusing people’s dying bodies to no positive end. At Montefiore, the doctors responsible for running the codes—officially deciding whether to start chest compressions and when to stop them—were usually second- or third-year residents. This was “horrifying” for newly minted physicians, Powell told me.

Conversations with families about advance directives and DNR orders were wrenching. One of the great tragedies of the pandemic was the way that patients had to be isolated and denied visitors—a decision made out of an ethical imperative to reduce the spread of the disease and save lives, but with the horrible effect of trapping patients alone in hospital rooms, and stranding their frightened loved ones at home, unable to see what was going on or to provide comfort. Torres-Lockhart would call a family to discuss switching a patient to palliative care and the family would balk, unprepared to make end-of-life decisions after a swift decline they hadn’t seen. “It would be like, *What are you talking about? You know, I just dropped off my grandfather/ my mother, like, two days ago. She was here in the house doing totally great.* I think it was just really hard for folks to wrap their minds around that, because they couldn’t physically see it.”

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Fins likened the influx of critical-care patients to what you’d expect if there had been “a major plane crash at LaGuardia Airport”—only the influx never stopped. Patients just kept coming.

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Powell blamed this situation, in large part, on the state’s punting the decision making regarding clinical guidelines. “Under these conditions, placing the burden of a medical decision about CPR onto these traumatized families is also unacceptable,” she

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wrote. “NY’s failure to issue guidance is responsible for creating additional risk to staff and additional pain to dying patients and their families. This was a way to make a tragedy worse.”

The mistrust that sometimes arose was heartbreaking for the doctors, who were working as hard as they’d ever worked in their life. “I think the public perceived it as if we withheld care,” Michael P. Jones, the residency-program director for emergency medicine at Montefiore, told me. “Like we didn’t do everything possible. But we actually did.” He said that of his 84 residents, 35 got COVID-19. Burned into his memory, he said, is the day he had to take one resident by the shoulder, walk him down to the emergency department, and then bring him on a stretcher to the ICU. Their collective sacrifices and efforts, he felt, had been immense. “Many of us had greater ethical dilemmas with regards to doing too much and saying, ‘What are we doing here? We’re not going to be able to help this person ... and how does that interplay with the person in the room next door that maybe we could have done more for?’”

Hospital personnel had to act as family for their dying patients, breaking down emotional barriers they normally maintain to avoid going to pieces every time a patient dies. This was, in its way, the moral response the situation demanded—doing whatever it took to offer the dying some measure of human connection. CBS News [made a documentary about health-care workers](#) at Montefiore during the surge, which features one young nurse recalling the team’s first COVID-19 death. “The family kept saying, ‘They’re gonna die alone.’ And we told them, ‘No, they’re not.’ And the entire unit sat in front of the room and waited for them to pull the tube and allow them to go on their own.” As she tells the story for the camera, the nurse is both smiling and crying. “We said a prayer, we said goodbye, and we told the family, ‘No. They didn’t die alone. They died with us.’”

The moral and emotional weight of treating dying patients like family while also having to decide whom to admit and whom to turn away—and how much care was enough and how much was too much, and which treatments should be deployed when—was too overwhelming for some, especially amid the trauma of witnessing so much death. There has been a rash of suicides among critical-care providers around

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the world, and studies suggest high levels of psychological trauma among frontline personnel. Many are leaving the field or retiring early, citing exhaustion.

To Fins, the system's reliance on already overburdened critical-care workers—rather than on government-enacted protocols—to bear the moral burden of the care decision making was a failure and a tragedy. He cringed at the sound of the 7 p.m. “clap” every night, when New Yorkers came outside to cheer medical workers. “That applause,” Fins said, visibly squirming. “It was, in a sense, mortifying. Nobody liked it. None of us felt we deserved it.” Torres-Lockhart felt hollow leaving the hospital at the end of a long, horrible day of failed resuscitation attempts, and walking out into the 7 p.m. clap. “I didn’t feel worthy of a round of applause after a day like that,” she said miserably.

“It was a bread-and-circus kind of thing,” Fins said. “They needed to believe we were superheroes. But why do we value heroes? Because heroes assume a disproportionate share of the burden.” He shook his head. “We had to do more than we should. A pandemic response based on heroism is a thin reed.”

I asked if he had regrets—things he would have done differently had he known in March what he knows now. Broadly, he said, he thinks COVID-19 has offered a wake-up call to the bioethics field. It hasn’t focused nearly enough on health-care inequity, which COVID-19 has revealed and exacerbated in ways no clinical ethicist or individual physician could fix on the spot: The Bronx and Queens were much harder hit than Manhattan, a fact driven by inequities wrapped up in race, class, and access to insurance. Patients at underfunded public hospitals fared far worse than those at private ones—*The New York Times* reported that at the height of the surge, patients at some community hospitals were three times as likely to die as patients at private hospitals in wealthy areas of the city, such as Weill Cornell. Historically, the bioethicist’s attention has been on the individual patient, but Fins, Wynia, and Powell all suggested that the field should move toward what Fins called “an ecosystemic approach,” one that anticipates and corrects the injustices and resource rationing “baked into the system.”

Yolonda Wilson, a Howard University philosopher who specializes in bioethics, shares this view, and says that COVID-19 has exposed the way the field has marginalized ethicists who argue that racial and other structural inequities merit serious attention.

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“What we’re seeing is that institutions and structures, including bioethics, have been caught with their pants down,” Wilson told me. “Because most folks aren’t trained to talk about this and to think in these ways. So they’re scrambling.”

In September, Fins lamented that Cuomo’s decision to effectively deny that rationing would ever happen (even as it was actively happening) and his refusal to enact crisis standards of care (even as hospitals were having to enact those standards themselves) might have kept other states from taking COVID-19 as seriously as they should. “If New York State had truly acknowledged the need for crisis standards of care, and they were transparent, maybe people in other parts of the country would wear a mask.” He looked tremendously sad. “Maybe people elsewhere would have understood how serious this was.”

MY CONVERSATIONS WITH bioethicists over the past six months produced the eerie sensation of talking to a chorus of Cassandras. Fins’s fear that what happened in New York’s ICUs would replicate elsewhere has come to pass: As of this writing, in mid-November, caseloads are at record highs all over the country, and health-care systems in multiple states are facing rationing. Need far outstripped resources in the Rio Grande Valley for months over the summer, and El Paso, Texas, began bracing itself to exceed hospital capacity in October. The Utah Hospital Association is preparing to ask the governor to enact crisis standards of care as its system becomes overwhelmed. Hospitals in Wisconsin are nearing capacity. The Dakotas, Idaho, Nebraska, and New Mexico are facing similar challenges.

The other big bioethical hurdle facing the field, the United States, and the world is the COVID-19 vaccine—how to create and manufacture it quickly but safely, and, just as daunting, how to allocate it. With successful and safe vaccines now emerging from clinical trials, the supply chain will need months to catch up. Stéphane Bancel, the chief executive of Moderna—a biotech company whose vaccine has, as of this writing, shown strong preliminary signs of effectiveness—predicted in late summer that the

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U.S. and every other country will be “massively supply-constrained” until mid-to-late 2021. Robert Redfield, the director of the Centers for Disease Control and Prevention, has said the same.

Given this, who should get the vaccine first? If we prioritize people who are more likely to contract and die from the illness—which is one common method of allocating vaccines—should Black, Latino, and Indigenous Americans be on the top of the list, given their documented vulnerability? Should the risks associated with being among the first to receive the vaccine be distributed more broadly? Should health-care workers get the first doses? What about schoolchildren, or teachers? Should we prioritize people most likely to die from the disease (say, the elderly) or those most likely to transmit it widely (say, college students)? Can a government compel some citizens to get inoculated? Should it? If the U.S. is the first country to develop the vaccine, should it share its limited early doses with the international community? Should the federal government get to decide how the vaccine is allocated among different states? What if multiple vaccines arrive on the market with different levels of effectiveness, or different side effects? Who gets which one?

The debate about these questions is intense. Take whether the United States should share some of its limited vaccine supply with the international community. Some bioethicists, like Wynia, say yes: The spirit of collaboration and common humanity should rule the day. Others, like Ezekiel Emanuel, the chair of the department of medical ethics and health policy at the University of Pennsylvania and a member of President-elect Joe Biden’s COVID-19 task force, argue that countries are justified in attending to the vital needs of their own citizens, and perhaps even morally obligated to do so, before looking elsewhere. Only once a country achieves herd immunity, Emanuel says, does it become obliged to share.

Or consider further the question about whether to prioritize vaccine distribution to racial minority groups. Doing so would seem to be a sound choice from a public-health perspective and a just one from a moral perspective, Yolonda Wilson argues, given the higher statistical likelihood that these populations will contract and die from COVID-19, and given the fact that American health care has historically underserved or outright harmed those communities. But according to Dorit Reiss, a legal scholar who specializes in vaccine policy, allocating based on race or ethnicity quickly runs

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into legal questions about discrimination. It would also, Reiss told me, create a new legal precedent for giving certain races medical care first—and America’s track record on the racial allocation of preferential medical care is grim.

In mid-September, the World Health Organization released its preliminary guidance on vaccine allocation, and in October, the National Academies of Sciences, Engineering, and Medicine (NASEM) released its framework, drafted by ethicists, scientists, doctors, and public-health experts. NASEM proposes a rollout that prioritizes, in order, first responders and frontline health-care workers, including people whose job it is to clean and support health-care facilities; anyone with dangerous underlying health conditions and comorbidities; older adults living in group homes or who are unable to self-isolate; teachers, school staff, and child-care workers; and essential workers whose jobs increase their exposure risk, like public-transit workers. No demographic population would have priority, but NASEM suggested making special efforts to attend to “residents of high-vulnerability areas,” which “would incorporate the variables that the committee believes are most linked to the disproportionate impact of COVID-19 on people of color.”

Every ethicist I asked agreed that the NASEM framework was good on the whole, but that the path to its implementation is precarious. (The CDC’s latest “COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations” includes a three-phase plan but remains vague about the logistics and ethics of distribution, stating that “final decisions are being made about use of initially available supplies of COVID-19 vaccines.”) What’s more, while the federal government will distribute vaccines to the states and provide guidelines for who should get inoculated in what order, the CDC announced in late August that states will need to make their own plans for how to allocate the vaccine.

In October, the states submitted their interim plans, which health experts and ethicists say are vague and patchy. Different states prioritize different populations: Arkansas has moved meatpacking workers toward the front of the line; Maryland includes incarcerated people alongside health-care workers and older adults, while Mississippi does not. Some states, like Virginia and Kentucky, say they will give priority to communities of color. ProPublica reviewed 47 of those plans and found that most states aren’t ready for distribution: Georgia’s plan is to relegate distribution

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decisions to local counties and districts; Washington State doesn't have any warehouses ready to store a vaccine, like Pfizer's, that needs ultracold temperatures; North Dakota and Oregon have no clear plan for how to vaccinate migrant workers. Illinois has solicited bids from private companies that could help handle planning and distribution. Meanwhile Native American reservations, and rural areas more generally, are not yet provided for in many states' plans, even as COVID-19 cases have risen sharply there. "Early, when we don't have lots of doses, I frankly do not anticipate that vaccine will be widely available in every rural community," Amanda Cohn, the chief medical officer for the CDC's vaccine task force, told ProPublica in early November.

The chaos and moral confusion that COVID-19 has wreaked in American ICUs—first in New York, and now all over the country—show how a leadership vacuum can generate an atomized and uncoordinated crisis response. Bioethicists fear this is a preview of what will happen with vaccine allocation. (A new presidential administration will likely change the federal response to the pandemic—Biden's announcement of his COVID-19 task force has been met with hope—but whether and how that will affect the course of distribution remains to be seen.) As with the disease itself, the people who stand to suffer most gravely are the ones already neglected or systematically "deprioritized."

One key to a just and effective vaccine plan, all the bioethicists I spoke with pointed out, is the inclusion of affected communities in the making of plans that will determine their access to care—a step that has been almost uniformly overlooked. "In how many spaces are folks who actually are essential workers invited to have conversations about what they understand their needs to be?" Yolonda Wilson asked. She pointed out that Biden's COVID-19 task force, while it does include a bioethicist (Ezekiel Emanuel), has no nurses, no "essential workers" other than physicians on it, and no one who specializes in rural health. "It's good that we have a serious task force and someone who cares about having a real federal response," Wilson said. "At the same time, if all we're going to do is replicate power structures that leave out important voices, then I'm not sure how much work that's doing."

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AS WAS THE CASE last spring in New York, doctors are waiting for guidance from their institutions, which are waiting for guidance from their cities, which are waiting for guidance from their governors. Everyone is girding themselves. How will vaccines be allocated among the states, and once allocated, how should the states distribute them? How much funding will states receive to help with distribution? Who will cover the cost of vaccinating the uninsured? How will tribal sovereignty be respected? What is the state's role in monitoring people after they have been vaccinated? Will states be forced to hand over personally identifiable vaccine data to the federal government?

As of this writing, governors and health-care workers are still waiting for definitive answers.

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