

## **Nuffield Council on Bioethics – Written evidence (COV0032)**

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The Nuffield Council on Bioethics welcomes this opportunity to respond to your inquiry into the science of COVID-19, and strongly supports the aim of ensuring that lessons learned in this outbreak can help inform future emergency preparedness.

We note your inquiry seeks to identify research opportunities in epidemiology, medical care and basic science and does not cover the social and ethical implications of the crisis and our response to it. However, we believe you cannot separate these – science and medicine necessarily engage social and ethical dimensions

A key theme in our report *Research in global health emergencies: ethical issues* (published in January this year) was that of the interconnected nature of biological and medical sciences, social science and ethics. Similar arguments were made in the report of a major international workshop, [Interdisciplinary research in epidemic preparedness and response](#), held in October 2019 by the Academy of Medical Sciences, Medical Research Council and InterAcademy Partnership. In these areas interdisciplinary work is crucial.

In order to understand transmission of a novel virus, for example, basic science research is clearly essential to gain understanding of how the virus is spreading – whether through touch or airborne, if airborne over what distance etc. However, patterns of virus transmission are also directly influenced by social factors, such as patterns of social mixing, cultural traditions in greeting (such as handshakes and kissing), and cultural traditions in care. Moreover, in order to achieve any necessary change in those behaviours, policy-makers need to rely not only on the understanding gained through, for example, the behavioural sciences, but also fundamentally on the values that underly our social activity and **trust** on the part of those being asked to change deeply embedded behaviours. This requires those responsible for the outbreak response to demonstrate their **trustworthiness**.

A key part of demonstrating trustworthiness is through respectful and meaningful engagement, on the part of both researchers and policy-makers, with communities affected by the epidemic (in this context, all of us). Such engagement needs to be two-way – so that policy-makers understand (and act on) the values and concerns of those affected. This has been well-recognised in the context of the Ebola outbreak, as described in the quote below from an African Union spokesperson reflecting on the challenges of COVID-19:

*"Ebola thrived on touch, an important aspect of how many Africans conduct social relationships in life and death. Only when the social contract of trust was formed, and the response was community-owned and led, did we learn the important lessons of how to care for loved ones and give dignified burials that acknowledged the human values of social connection, in times that necessitated traumatic but necessary physical distancing."*

Similar challenges face us in the UK in response to COVID-19 as we work through the ramifications of physical distancing on our day-to-day lives and in our relationships. These social and ethical aspects are an integral part of the role that scientific research can play in effective emergency response.

COVID-19's disproportionate impact on the UK's black, Asian and minority ethnic (BAME) population shows huge disparities in infection and mortality rates, with two-to-four times increased risk of death for members of these groups. Public Health England's rapid review and stakeholder consultation into the differential effects of COVID-19 highlighted comorbidities, social and economic inequalities, as well as structural racism as contributing factors to these outcomes.

Further research investigating the impact of COVID-19 on BAME communities should focus on the role of health inequalities by considering the social determinants of health, which are racially (or ethnically) patterned. The role of structural racism highlights the need to further explore the interactions of race and health, and the impact of this on access to and experiences of healthcare.

Ethical issues of trust and respectful engagement also arise in the context of vaccine trials. In particular, once a promising candidate vaccine has been developed, it is crucial that recruitment processes are seen to be fair, transparent and trustworthy, likewise in the prioritisation of certain groups in vaccine delivery. Trust in the scientific process, and in the need to obtain reliable data on the efficacy of the vaccine, needs to be earned through respectful communication, and listening to wider public concerns. Similarly, if an effective vaccine is to achieve aims of herd immunity, policy-makers will need to engage seriously with those who are resistant to the general use of vaccines.

*29 June 2020*