An interview with Dr. Arthur Caplan, professor of bioethics at New York University, on the COVID-19 pandemic

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The WSWS had an opportunity to speak earlier this month on the COVID-19 pandemic with Dr. Arthur Caplan, the Drs. William F. and Virginia Connolly Mitty Professor of Bioethics at New York University's (NYU) Langone Medical Center and the founding director of the Division of Medical Ethics. Born and raised in Framingham, Massachusetts, Caplan received his Ph.D. in the history and philosophy of science at Columbia University in 1979.

In 1989, he organized the Center for Bioethics Conference on Medical Ethics and the Holocaust. His work in exposing the Tuskegee Syphilis Study led to securing an apology from Louis Sullivan, then the secretary of the federal Department of Health and Human Services, in 1991.

He received his appointment to NYU in 2012 after nearly two decades at the University of Pennsylvania in Philadelphia. He has worked on initiatives with pharmaceutical companies like Johnson & Johnson for the equitable distribution of experimental drugs outside clinical trials under compassionate use.

Benjamin Mateus: Good afternoon, Dr. Caplan. As a way of an introduction, I was hoping you can tell us what you do at New York University's medical school. Most people are not acquainted with the field of bioethics.

Arthur Caplan: Good afternoon. Sure. I run a program that I founded at NYU. It has been around about seven years and basically its mission is to address ethical issues with medical students. We also have a masters degree program in bioethics.

The field has been around for about 50 years. We review consensus about things to do or things that should not be done, whether it is consent to research or privacy and confidentiality issues. For instance, protections for patients with brain death definitions—when someone is brain dead, even if you can maintain their heart and lungs, should you?

We teach these to the students. We debate areas where there are not laws or regulations like cloning, stem cell research, and eugenics. Also, issues like transgender surgeries, especially in minors.

We also get involved in advising governments and companies and patient groups about who goes first for vaccination, or how do you get a drug for your kid that is not yet approved by the Food and Drug Administration.

BM: Regarding the pandemic, which is probably on everybody's mind in your department and specifically the vaccines that have come out, how do you explain the vaccine hesitancy that we are seeing among health care workers? What is driving that issue?

AC: It is a big issue. I recently heard from a friend of mine in the Cleveland area that refusal rates among nursing home staff might be as high as 60 percent. It is just off the chart and nobody thought things were going to be that big. So, refusal is causing real problems because if you do not get the staff vaccinated at a hospital, or teachers vaccinated, then they can miss work, not be available to care for patients or teach the kids and you must close the school.

We hope that the vaccines prevent transmission. We do not really know that yet. But the bet is that it does, so that you also want to get vaccinated so that you do not make others sick, particularly those who are older and who are poor because they tend to be more vulnerable to the virus.

In surveying people who refusing to take the vaccine, it seems people are worried that the vaccines were rushed, and that Trump pushed them through for political reasons and that the data on their safety is not very good. I do not think that is true, but I think it is their concern.

Now, I think the data is rather good. I think Trump did try to rush them, but that is not why they got approved. They got approved because the data looked good. But he, in his inimitable fashion, caused more harm because he basically kept saying, you have got to get these things through and arm-twisting the FDA and things like that, which make people nervous.

There is an anti-vaccine movement that just does not like vaccines and they have piled on to COVID-19, saying we do not need it or it is a hoax. One of the people who got arrested for breaking into the Capitol was a doctor who leads one of these anti-vax groups who said the whole thing is a hoax. That is trouble because they are on social media. It makes people nervous.

Some of the people who are not taking the vaccine are pregnant women or women thinking about getting pregnant. And there is always a worry on the part of women that vaccines will be dangerous to the babies. So, you see more resistance and refusal by women and the health care workforce for nursing and teaching that are female—that gives you bigger [vaccine hesitancy] rates.

Doctor rates are not as high. While it is not as male-dominated as it used to be, it is still more male than female. So, that is a difference. Then, I think, there is also some resistance because people are thinking, "I don't want to be first. It's not that I won't take it, but let's see how it goes with the first group of people, and then I'll get in there."

BM: Where does the anti-vaxxer movement, which is different from the COVID-19 vaccine hesitancy, come from? In your surveys and your evaluation of the anti-science behavior, what have you discovered about these movements?

AC: Some of that comes from libertarian thinking, which is, "I don't trust what experts say. I'm my best judge of what's good for me." It is sort of a disrespect of experts and expertise. We started with the mask wearing where people were running around saying, "COVID is a hoax. You do not need a mask. It's all nonsense."

Some of it comes from long-standing American skepticism in many circles about science, frequently, people who are religious. In America, as a lot of religious people are, they are not gung-ho or as convinced about science, as you might see in some other cultures and countries. Ironically,

support for vaccines is very high in places like Africa, where they see the benefits of vaccination. Here you do not see the benefits right away of measles or tetanus vaccination because those diseases were tamped down. So, then people started to turn to skepticism, as they say, "you keep telling us we need vaccines, but I don't see any disease around." Whereas in Africa, people say, "thank goodness we vaccinated because three years ago, everybody in the village got measles and now it's gone."

I would say too, that science has its own problem, which is it does not have good communicators. It tends not to do a good job talking to the public. Everybody is always praising Tony Fauci or maybe somebody like Paul Offit, who is a senior researcher at Children's Hospital [in Philadelphia], but I could probably name all the people who show up in the media from the science and medical realms. And it is not a long list. That is a self-inflicted wound.

BM: What are your thoughts about the campaign to roll out the vaccine? In the fall, Pfizer had promised 100 million doses of their vaccine, which quickly dwindled to 50 million. Then Vice President Mike Pence and the White House coronavirus taskforce assured the public they would see 20 million doses administered by New Year's Day. Now we are well into January with around 10 million shots and more than two-thirds of the vaccines still to be administered.

And there is this manic urgency now to get these vaccines into people's arms and talking about bypassing the two-dose regimen, bypassing their emergency use authorization regulations.

AC: Yes, it makes me nervous a little bit. We have some 20, 25 million doses in warehouses now and they do not seem to be going out logistically. It has been a problem. So, adding another 100 million more does not necessarily mean that they are going out either. You need to solve the logistics problem as much as the supply and distribution issues.

They said they were going to get it done, I think by the end of December, around 20 million. So, weeks later, not even close. It is pretty clear that they did not help the states distribute nor set up enough vaccination sites. I am not against trying to push out more vaccine, but unless we open up civic centers, baseball stadiums, building lobbies, dedicated vaccine places, which can go 24-7, even during Christmas and Martin Luther King Day, I do not think it is going to work.

And then I also think that you should relax the eligibility criteria a little bit. They are currently getting in the way. I'm all for saying, "try people over 65 people who might have coexisting conditions that put them at risk. Make sure you remember the prisons and the people with developmental disabilities in the group homes" and then figuring out whether being too tight on the initial criteria was getting in the way of people administering the vaccine.

I am not worried that it is a big gamble because we'll run short and we will not be able to do the second doses. I am worried that we have not solved that logistics problem.

BM: There is the problem of giving away all the vaccines, that if people come back for their second dose, there will not be one there for them. They are being told one shot is safe or that they can wait three months before getting their second dose. Pfizer has said there is no data to support extending their regimen. The World Health Organization said there is limited data that people could wait up to six weeks under extreme situations.

AC: Well, it is never good to just give out one dose and hope. I think what they are believing is that the manufacturers can produce enough. They have talked to them, I have even talked to them a little bit, and I think there will be enough to do the second doses. What they were doing was they were saying, "Art Caplan got dose number one and we have another dose with his name on it to give as dose number two. Now we will just assume there will be some extra doses there that we do not have to hold it for him."

Okay! If the manufacturers are pretty sure about their supplies I might say, "Can we start with 25 million? Let us see how that goes before we do the whole thing. Just to be sure we can roll this stuff out."

BM: In your discussions with these manufacturing groups, have you spoken to the issue of the new variants of the virus?

AC: Yeah. It is just another reason to get the damn vaccination out there with two doses because that is likely to be more effective than one dose. So, move it already! I think these variants are more transmissible but not more lethal. I think it just spreads faster. *[Ed. note: More recent evidence suggests that the B.1.1.7 UK variant may be more lethal.]*

BM: What are your thoughts on a lockdown, especially with more than a quarter million daily infections and over 3,000 deaths each day?

One of the concerns being raised is that with increased transmissibility of these new variants we are going to see the health care systems become totally overwhelmed. The numbers in the UK have shown that rates of hospitalization in London and around England have once again reached dangerous levels. A significant majority of the US population still has not been exposed to the virus. The Centers for Disease Control and Prevention essentially said that the UK variant will be the dominant strain in the US in March.

Dr. Michael Osterholm, who is on Biden's coronavirus taskforce, has called for a lockdown with financial support until we get transmission rates sufficiently down and the public health infrastructure built up and people vaccinated such that there is no further loss of life. Biden has essentially muzzled him.

AC: Personally, I think we should have done more lockdowns already. They have worked to tamp things down in several countries like Israel, South Korea, Taiwan, China, and New Zealand. They seem to have worked. But I think our politicians despair of being able to do it, partly because they do not want to lose jobs. They worry that it will croak the economy and that is not tolerable. And I think if they cannot get somebody to wear a mask, they figure they will not really be able to enforce lockdowns to make people stay home. And we never really enforced them. So, do I think we are going to go into lockdowns? No.

I think there is one other reality, and this is weird to say, but somehow, politically, we have managed to put ourselves in a position where we are not worried about losing lives that amount to 10 jetliner crashes a day. I just watched this Indonesian jet crash. Sixty people died! There was huge press coverage. On the same day, more than 4,000 people dying from COVID-19 received barely a mention in the media—just another day. These deaths are disproportionately impacting the elderly, poor, institutionalized people, prisoners, which accounts for their acceptance.

BM: Clearly, the United States was unprepared for this pandemic, and continues to be unprepared to dealing with it appropriately. What do you see as some of the ethical issues or responsibility of a government to protect its population?

AC: A couple of comments. One, the pandemic revealed something that insiders already knew that the public does not seem to know, which is we destroyed our public health system. We just did not pay for it. We cut it, we ruined it. So, when people say, "Well, let states and counties distribute vaccines, give it to the health department." It is like, who is there? They trimmed all those budgets out. They did not worry about funding them. And now there is no infrastructure, which relates to the second point.

We have spent all our money on treatment. You can treat heart attacks, premature babies, infertility, perform face transplants. My institution, NYU Medical Center, is great. It treats people very well. We spend nothing on prevention. They are in little on what I call basic public health measures. And we do not fund any research on issues like how you get people to change their behavior.

If you asked me, "How do we get people to be more willing to take vaccines or wear masks?" nobody knows. Can we do gene therapy for rare diseases on little babies? Yes. Can we figure out how to get people not to eat too much? No. The whole system is skewed toward lucrative

treatment, not disease prevention. Not public health. And as you probably are aware, a lot of public health does not have to do with medicine but has to do with housing or pollution or climate change or food deserts. I mean, there are things to do, but we do not have them in our health system. We're basically a *fix it* system more than a *health* system.

I think another gripe I have about pandemic bioethics is it relies on people worrying about your neighbor, caring about your community, feeling you have a duty to help and protect others. And we are so individualistic in ethical terms, so oriented toward the individual person and their rights, that morally we are not set up well for pandemics.

It is not just about "you." It is about where you bring the disease and who else is affected. We do not think that way here. Every other country in the world, more or less, has more of a community feel or a community responsibility feel. Britain is a little more like us. They do equally miserably with pandemics.

I think you will see smaller countries like Israel may pull together more. They are set up to protect their community, but partly because of their military and their sense they need to protect themselves, as they see it, from terrorism and military attacks. For that matter, the United Arab Emirates, or a place like that, where they are trying to keep the people happy to prevent their people from killing the rulers. They have big social systems set up. We are not that way.

You know, all I heard about for a long time all summer was my right to do what I want. And governors saying, "I'm not going to force you to wear a mask." But that is not the right philosophy for a pandemic.

BM: Do you think the US will be ready for the next pandemic?

AC: No. I do not see a ton of change. I do not see people saying we need to redeploy the boat. Well, maybe it is too early, but so far, I would say, no. You need to redo the budget. You need to have leaders who emphasize that public health requires different responses. I am not hearing much of that. I am hearing people basically say, "I hope we can vaccinate our way out of this and go back to business as usual."

BM: This brings me to my last point. We have been speaking to many teachers who are in a world of confusion and hurt. Everyone is telling them it is safe to reopen schools. More recent studies corroborate the dangers that reopening schools during the pandemic pose. We would essentially be sending about 100 million people back to these institutions. That can be a disastrous development.

AC: I agree. I think a couple of lessons have been learned. You have to protect the teachers and the staff because they are just not going to come in if you do not protect them. They will not show up. Second, there is a big daycare problem in the country.

Part of the reason the push is on to reopen the schools is for the kids, but part of it is so that the parents can go to work. You need to have better daycare. Then you can have more flexible school hours. You can send them in with bigger shifts, spread them out more, do more remote learning, mixed classroom, and that sort of thing. I think also we need to start testing these vaccines in kids pretty quick.

We have not. We have no idea when we are going to start vaccinating kids. That is bad. If you want to open schools, you better be testing. At least start with adolescents and work your way down. We are not doing that. We have got to really take the school issue more seriously than just yelling, "The kids don't get sick, so open it up."

BM: Thank you for your time Dr. Caplan.

AC: Thank you.