Rebuttal: Accounting for the Community's Reciprocal Obligations to Healthcare Workers During a Pandemic

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In their thoughtful response to the thesis that healthcare workers (HCWs) should be prioritized for scarce resources during a pandemic,[1] Antommaria and Unaka offer compelling reasons for opposing this position.[2] Common ground can be found in our shared recognition that the community has a reciprocal obligation to HCWs because of their willingness to accept the increased risk of being exposed to serious illness in caring for patients. We disagree on the most appropriate way to honor this obligation and whether HCWs currently have a greater risk of infection than others.

Antommaria and Unaka[2] indicate that "prioritizing HCWs … may have been justified during the initial surge" of coronavirus disease 2019 (COVID-19), when risk was excessive. They suggest that, with universal masking and other measures, infection rates among HCWs now mirror those in the community. However, this assessment is questionable. Personal protective equipment is still inadequate in numerous healthcare settings,[3,4] and many reports, including one by the National Academies, indicate that the threat to HCWs remains higher.[5] In the absence of certainty, I favor erring on the side of continuing to recognize the special obligation to HCWs. Fortunately, COVID-19 vaccines should further reduce the danger of infection, and my article provides justification for prioritizing HCWs to receive them.

Antommaria and Unaka[2] seem to support special obligations to HCWs based on reciprocity, but suggest alternatives to critical care prioritization, such as mental health services and life insurance. In my view, mental health care should be universal and not a means of recognizing the sacrifice of HCWs. Providing life insurance for HCWs reflects a tacit acknowledgment of the increased threat they face. However, given governmental delays approving basic COVID-19 relief, it is unlikely that resources will be appropriated for life insurance, which has not occurred since Antommaria et al made this suggestion in 2011.[6]

Although there may be challenges to identifying and verifying frontline HCWs at risk for exposure to COVID-19, there are always gaps between the principles underlying policies and the way they are implemented. For example, according to guidelines from the Centers for Disease Control and Prevention,[7] the first wave of individuals to receive COVID-19 vaccinations should include "frontline essential workers." Defining and identifying this group of individuals provoke similar concerns to those raised by Antommaria and Unaka[2] about my proposal.

I concur that the narrow category of HCWs fails to include nonclinical and other frontline workers who are at a higher risk of being exposed to COVID-19. My article addresses this issue by suggesting the community has a similar set of obligations to these workers.[1] Nonclinical hospital workers are disproportionately non-White and have substantially lower median incomes than the average US wage earner.[4] Moreover, among HCWs, people of color account for a disproportionate number of COVID-19 cases and deaths.[4] Inclusion of at-risk nonclinical and other frontline workers in treatment prioritization is consistent with concerns about fairness that animate Antommaria and Unaka's article.[2]

The importance of directing attention to the pandemic's exacerbation of racial and ethnic inequalities, as highlighted by Antommaria and Unaka,[2] does not preclude also carefully examining whether special obligations are owed to HCWs and frontline workers. Thoughtful discussions about weighty ethical questions do not represent a zero-sum game, and, as in the current case, the issues raised during such deliberations often have much broader implications. Of note, social justice can be framed in terms of reciprocity, and efforts to confront societal inequities can reflect the special obligations owed Black Americans to address our long history of systemic racism.

In summary, fairness includes accounting for reciprocity and the duties resulting from it. Special obligations are owed HCWs and frontline workers until they are no longer at higher risk for infection. Hypothetical offers of life insurance or mental health benefits are inadequate ways to demonstrate reciprocity. The challenge of identifying HCWs and other frontline workers ought not preclude efforts to do so. HCWs and frontline workers should not automatically move to the head of the line to receive limited critical care resources. However, recognition of their willingness to risk serious infection should be included in the multidimensional calculus for triaging critical care.

Disclosures: The author has nothing to disclose.

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Published online first February 17, 2021.

Received: January 15, 2021; **Accepted:** January 25, 2021

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