Ethical Viewpoint Paper

Biomedical Ethics and the COVID-19 Pandemic

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Introduction

The Covid-19 Pandemic has been a game changer. It is literally a showstopper. The first cases of COVID-19 were reported in Wuhan, Hubei Province, China on 31.12.2019. Soon thereafter, the virus engulfed over 185 countries. On 11.03.2020 the WHO declared COVID-19 a pandemic.
Everything the current generations knew and understood about the human condition- its limits and its challenges - have been tested. While the blame has been placed squarely on China's shoulders, the global spread has been perpetuated by ignorance, carelessness and in many cases, political or medical compliance. In this paper we will examine some hard facts and look at possible measures to mitigate these.

What We Are Dealing With

COVID-19 is an infectious disease pandemic that is spreading more rapidly than our healthcare resources can handle. The ethical issues of the pandemic, therefore, represent an intersection of the ethical problems of a contagious and highly morbid disease with the ethical concepts widely used in directing allocation of scarce resources [1].
This perfectly encapsulates the core issue that has been the heart of every economic problem i.e unlimited wants but limited resources. In pandemic terms, it would be understood as a major global health issue with severely limited resources – of knowledge about the virus, of the best possible response and of the material resources to contain, inhibit and eventually eradicate. Given that when the pandemic reared its ugly head around Dec 2019, there was absolutely little knowledge about the virility of this virus and its ability to jump across the globe. However, within a short span and several news reports of largescale deaths due to Covid-19 initially, especially in Italy, US, Brazil, France etc. the world knew it had a severe problem on its hands and no one could quite predict the way it would pan out.
The World Health Organization (WHO) which has been mandated to direct international health within the United Nations' system and to lead partners in global health responses [2], became the torchbearer for the nations in understanding and responding to this crisis. I remember checking the site as my organization quickly put in a Business Continuity Plan to respond to the situation. This was an official and respected node of information that we all referred to as we trudged along, and we still do.
As the Covid-19 crisis was declared a pandemic and nations (including India) went into lockdown the severity and gravity of the situation hit home. Such a direct social, economic, medical, psychological, and political impact was not experienced before by anyone alive today and a general state of fear prevailed at least in the first few months of the lockdown. Ignorance and misinformation also played a huge part and many an erroneous WhatsApp messages added to the confusion. People responded according to their educational levels, religious and superstitions beliefs, social and economic statuses. Job losses, shift to online education, severe social restrictions, lack of availability of food etc. led to increases in mental health issues, rise in domestic violence, sexual abuse especially of the vulnerable and children and such challenges.

Examining the bio-medical issues in the pandemic has to then be viewed, through this lens.

Issues

Unequal's Amongst Equals

As the days rolled on it became amply clear that those above 60 were the most vulnerable to the Covid-19 virus. Along with this age group, also those with existing co-morbidities became victims. Like in any largescale tragedy, whether a natural or man-made calamity, there is a direct correlation between the right to treatment and the availability of resources. Among those infected, who could get treatment, especially when requiring artificial respirators (which were limited) became an issue. Rumours of people being left to die because of non-availability of beds in hospitals or failure to get timely medical intervention due to the huge number of patients started doing the rounds. Those who could afford the expensive ICUs or those with political influence managed to get the much sought-after hospital beds. The poor and those who did not 'know' anyone, were made to go around in a miserable and sick state to hospitals trying to get in. The best solution here would be to re-allocate non-finite scarce resources, (that may be in short supply, but that can be resupplied) to the most medically deserving. However, the recovery process has been very slow and again corruption always remains a hidden push factor in such decisions.

A second medical dilemma was also about the efforts to save an elderly vis-à-vis a younger person. The ethical issue to using severely limited medical equipment in either case also must have been dealt with by many a medical professional.

In such cases the protocol followed in organ transplant could be of help. 'The social worth and the completeness of the recipient's life do not enter the equation because organs are allocated according to a strict protocol. This decision-making process is universally accepted and is regulated by tight oversight [3].

However, given the newness of the pandemic and coupled with the fact that there was no known medication that could help the patient, it was more of a wait and watch game rather than one of treat and heal. Added to this, the rough charges of treating covid patients would run into lakhs as per day charges in ICUs itself is quite high. Many insurance companies did not cover this pandemic and the economic burden on families wiped out the bank balances of many as well.

Though many hospitals started dedicated Covid wards and some even fully converting themselves to dedicated Covid treatment hospitals, this was not enough. The government in India prepared to house covid patients in specially designated areas set up on grounds, schools, and establishments as well.

When Covid-19 Takes Precedence Over Other Illnesses.

In the midst of all the high drama about the Covid-19 virus, with news reports, social discussions, business agenda, political statements etc. all making it their sole focus, the reality of the existence of other critical diseases like cancer, heart ailments, kidney failures, organ transplants, Alzheimer's, Parkinson's, motor neuron diseases, blindness and those undergoing rehabilitation etc. – all suddenly disappeared from conversations. It became as though they ceased to exist.

Pertinently, these major illnesses requiring medical intervention were postponed or called off because of again, non-availability of medical staff and resources or simply due to the high risk for co-morbid patients to the Covid-19 virus.

In any case, the untold misery, pain, and suffering that these patients have had to undergo is also a big ethical concern. Further several patients who did get admitted for their treatments also apparently contracted covid during their stay. As one could not really verify the authenticity of the reports, families would have no option but to rely on the hospital and believe them. This also added to aggravated medical costs.

Unverified rumours of organ harvesting as family members were not allowed to view the body of the deceased due to Covid-19 protocols also made the rounds. The severe lack of transparency along with the previous deficit of faith in hospitals who inflated medical costs added to the deepening of the fear factor.

The only solution in such cases is to provide authentic medical reports and transparency in dealings between the patient/ deceased's families and the hospitals.

Now, the government has encouraged health insurance companies to extend their medical cover to covid cases in a bid to stem this problem. Renewal premiums have also escalated.

Front Line and Health Care Workers

Lack of protection and care. While a health care worker cannot shirk away from the responsibility to providing health care to a patient who had contracted the virus, the question that needs to be asked is can he/she also refuse to assist? There were reports that those doctors who resigned to avert treating Covid-19 patients were threatened with legal action. The sheer numbers that inundated the hospitals and covid centers far outnumbered the medical professionals available. Most of them worked round the clock severely compromising their immunity due to long working hours, stress and exposure to the disease.

There were also several instances where medical workers were threatened by family members when they got patients to be compulsorily quarantined to avert the spread of infection. Some health care workers were also being evicted from the residences by their neighbors on account of the fear that they would spread the disease, apart from being subject to ostracization and discrimination [4].

There was also a severe shortage of PPE gear as well, which meant double exposure both to the medical staff as well as the patients. Governmental authorities were caught on a back foot with respect to protecting the medical front line staff. Most did not have appropriate PPE and were using alternatives like rainwear, helmets etc. A newspaper reports that as on April 9, 2020, nearly one-third of those infected in India were health care workers. It required the intervention of the Supreme Court to direct all State governments to provide proper PPE to the hospital staff. 'The order came to be passed with the following directions to provide all health care workers, amongst other things, with Personal Protection Equipment (PPE) to protect against Corona Virus, COVID-19, to provide them necessary police security to protect them from any violence, register offences against those who had perpetrated acts of violence against health care workers and to explore alternate local arrangements to augment domestic production for the production of the PPE' [5].

There are also many NGOs operating in the health care sector, SENHA being one of them in Mumbai. My organization recognized their need for PPE kits and as part of the CSR donated the same.

Several independent organizations working in this field receive little or no governmental assistance and must rely on Corporate and Private donations to fund their Covid-19 outreaches – which has a major impact in containing the virus spread.

Interestingly, even though the Supreme Court did pass the order, provision of the PPEs remains a challenge and relies largely on private charitable donations. The Centre in May 2020 ordered for 2.22 crore personal protective equipment (PPE), of which around 1.42 crore was to be bought from domestic manufacturers and the rest imported [6].

While on the PPE, the same applied to ventilators and other medical equipment and medicines such as Hydroxychloroquine and availability remains a core issue.

The important aspect of medical insurance for medical workers too is a taboo topic.

The scheme rolled out under the Pradhan Mantri Garib Kalyan Package covers loss of life due to COVID-19 and accidental death on account of COVID-19. No expenses on their treatment such as hospitalization and doctor consultation would get reimbursed if they were to recover after treatment [7].

While the medical workers are expected to put their lives at risk to treat Covid-19 patients, little is done to secure their own health.

A definitive bill by an Act of Parliament needs to be passed offering front line medical workers better packages, comprehensive insurance and suitable assistance as required if we are to encourage and support their service.

Further counselling, mental health services for these warriors should also be offered free of cost as they could face trauma, anxiety and stress related diseases resulting out of this situation.

Countries like Germany, Romania, Lithuania provided mental health, childcare, financial and other assistance to their medical workers during the pandemic. India needs to take a leaf from their book!

Reporting of Positive Cases

Patient confidentiality became a critical issue during the pandemic with the need to protect others at risk by association. Given that anyone can contract the covid-19 virus and it is class, status, gender, or age neutral, it has been easier to break the news. However, especially during the earlier days of the pandemic, social ostracization in several residential areas were reported leading to severe distress to the patients and their families.

As mentioned earlier, health care workers were also viewed with suspicion and access to their homes was also denied by neighbours largely out of fear and misinformation.

While it is not mandatory to declare one's covid status, it is still beneficial to the society around and also a good way to seek assistance especially if the family is in quarantine and needs supplies. In several areas though the societal stigma causes this declaration to become a more distressing situation and is also a reason many prefer not to declare the same.

A pathology lab worker who collects home samples for the RT PCR test also mentioned that when they visit societies, they are asked several questions by the security staff as to the covid status of the family they are visiting. Today however, with RT PCR tests becoming mandatory for travel etc., this line of questioning may reduce considerably.

Another emerging issue with regards to the RT PCR tests are the reported corrupt practices that are also on the rise. Several cases of using old negative reports by simply editing the date of testing are being reported. This is again putting the person as well as his/ her co-travellers at risk as in the event of being a covid-19 asymptomatic (and worse symptomatic) carrier, it will only cause more issues. This situation unfortunately can only be mitigated once the vaccination drive is towards completion, or a majority of the citizens get vaccinated.

Celebrities also play a big part in encouraging a collaborative mindset when they post their covid positive status over social media. It often makes the situation more acceptable to the general public. Government awareness drives in local languages, through educational and public institutions, public transport etc. are excellent ways to gain social acceptability of covid positive situations.

Clinical Trials, Vaccinations, And the Race to Commercial Profits

As there was no known cure when the pandemic hit, several pharmaceutical companies got into the race for clinical trials to bring out a vaccine. While it was still unclear, in the research processes, there were reports of deliberately infecting humans with the corona virus as part of the clinical trials in some parts of the globe with a view to accelerating these trials. Such reports however remain unverified.

Two vaccines that have been granted emergency use authorization by the Central Drugs Standard Control Organization (CDSCO) in India are Covishield® (AstraZeneca's vaccine manufactured by Serum Institute of India) and Covaxin® (manufactured by Bharat Biotech Limited). Both the Indian COVID-19 vaccines have completed their Phase I & II trials. Covishield® has completed its Phase III trials in UK and the bridging trial in India [8].

Second major issue lies with the equitable distribution of these vaccines. While most countries have affirmed their commitment to fair access for all the citizens and residents to the vaccine, it is only possible if the vaccines are mass produced and made available. The economic power of countries to purchase the vaccines for all their people will severely limit the scale and use of these vaccines in their lands, pushing up the economically forward in the hierarchy to receive the doses much before the poorer sections.

Fair distribution of a pandemic vaccine is unlikely without a solid ethical framework for allocation. This ultimately depends on 4 factors: the ability to develop or purchase; reciprocity; ability to implement; and distributive justice.

Further, especially in a huge country like India, misinformation is a chief cause of ignorant responses to the acceptance of the vaccines which have eventually rolled out.

Fear feeds on ignorance. Social media has played a huge part in this. However, with the government giving a push, creating awareness campaigns, and organizing the vaccination drives in an orderly fashion it is becoming more acceptable. Not to mention the requirement for vaccination certificates for renewal of all health insurances, further encouraging the acceptance.

The cause for concern is the continued availability of the vaccines through legal channels to avoid black marketeering, which usually occurs in such situations.
Not just availability but affordability is also an important criterion that needs to be looked at. Thankfully the covid vaccines offered by the government are in the Rs. 200/- range. The COVID-19 vaccine was launched on 16th January 2021. The first group included healthcare and frontline workers. The second group to receive COVID-19 vaccine are persons over 60 years of age as of January 1st, 2022, and persons between 45 and 59 years with comorbid conditions. This group started receiving vaccinations from March 1st, 2021. Those who are above 45 years of age will be able to take the vaccination from April 1st, 2021.
The vaccine roll outs are also predominantly in the urban areas with online registration being the mode of securing the spot. If anyone does not have access to the online mode, it will be a long wait to get vaccinated. India stands second in the world in terms of the number of vaccine doses administered (as on 25th March 2021 with 8 states having administered highest number of Covid-19 vaccine doses - source Hindustan Times).

SOPS And Requirements

Another common challenge especially at the onset of the pandemic was the clear standard operating procedures to stem the spread. It took some time and learning from the infected countries after the virus had claimed thousands of lives to understand the basic procedures of sanitizing, washing hands with water and soap, wearing masks and the most commonly used measure of a lockdown.
However, there were quite some challenges with these.
Access to clean water and sanitary conditions for a country like India itself is a non-reality. Soap and sanitizers and proper masks were still beyond the reach of many. To expect adherence without provisioning on the part of the government is fallacious. We are still a country where spitting, defecating in the open and living in slums is acceptable. In such a scenario, the spread of the virus is a given.
Further, declaring a lockdown with no reaction time hit millions of citizens very badly. The most vulnerable of the lot were the very young, elderly, single and the sick. Each was left to his own with fear and anxiety playing havoc on many.

Conclusion

I have attempted to capture some of the challenges and ethical issues that we have encountered over 2020. Needless to say, there is hope on the horizon but the danger is still not over. As the vaccines roll out, at least in India, witnessing the process it is heartening to note that the exercise has a method. However, we have a really long way to go to normalize life and recover in every way – emotionally, economically, psychologically, socially and mentally from this event.
Meanwhile, we live another day, grateful to be alive and hopeful of a bright future.

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