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Bioethics in Medical Care Rationing During the Coronavirus Disease-19 Pandemic

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ABSTRACT

Background: Coronavirus (CoV) disease (COVID)-19 poses difficult situations in which the ethical course of action is not clear, or choices are made between equally unacceptable responses. **Methods:** A web search was performed using the terms "bioethics; COVID-19; ethics; severe acute respiratory syndrome CoV-2; emergent care; pandemic; and public health emergencies." **Results:** Protection from COVID-19 has resulted in the cancellation of necessary medical interventions, lengthened suffering, and potential non-COVID-19 deaths. Prolonged lockdown reduced well-being, triggering or aggravating mental illnesses and violence, and escalated medical risks. Collateral damage includes restrictions on visitations to hospitals, alienation from the deceased relative, or lack of warm caring of patients. Finally, in a public health crisis, public health interest overrides individual rights if it results in severe harm to the community. **Conclusion:** Balancing ethical dilemmas are one more challenge in the COVID-19 pandemic. (REV INVEST CLIN. 2021;73(1):1-5)

Key words: Coronavirus disease-19. Ethics. Medical care. Public health.

BACKGROUND

The coronavirus (CoV) disease (COVID)-19 pandemic has strained resources, forcing health-care professionals and society to change paradigms. For example, physicians are forced to diverge even the sickest patients away from hospitals, and society is demanding strict public health measures that may infringe on the fundamental human rights of freedom and autonomy. It may seem like a lose-lose situation, and resolutions take a "lose-least" approach contemplating different ethical principles. However, while medical

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Table 1. Ethical differences between public health and biomedical research

Ethical topics	Emergency or disaster public health	Biomedical research
Scope	Focus on emerging or existing health problems	Focus on research involving human subjects
Intent or purpose	To prevent or control disease or injury and improve health	To generate or contribute to generalizable knowledge
Informed consent	Often considered not necessary	Basic tenant
Ethics guidelines	Standard guidelines are relative to the magnitude of the public hazard	– Ethical guidelines are well-established and are subject to independent ethics reviews – There are numerous resources available for guidance (Nuremberg Code, Declaration of Helsinki, etc.)
Context	The context is disruptive by nature and often in places with limited resources that creates a state of urgency	Most of the times the context is stable with adequate resources
Ethical tenants	– Duty to care – Duty to steward resources – Duty to plan – Distributive justice (allocation protocol that is consistently fair) – Transparency (make the protocol clear to everyone)[2]	– Autonomy – Beneficence – Non-maleficence – Justice[1]

care ethics emphasizes the individual, focusing on the patient's autonomy and the cure and treatment of health conditions, public health ethics emphasizes the greater good of a population or community and the pursuit of collective action. These ethical frameworks contrast with the well-established ethical principles in research of Beauchamp and Childress[1-3], whose goal is to produce evidence to advance the greater good (Table 1). The following paper describes the ethical challenges the medical community, society, and public health systems face under the COVID-19 pandemic and the moral duty to follow (Fig. 1).

CHALLENGES IN HOSPITAL ADMINISTRATION AND MEDICAL CARE

Resuming normal activities during or immediately after the pandemic has been arduous. Hospitals have risks of cross-contamination. There is shortage of beds, personnel, and resources. Patients admitted to the hospitals remain isolated, for fear of viral transmission, either to the visitors or from them. Bacterial resistance is increasing due to the use and abuse of antibiotics. Furthermore, additional medical consultations may not be available.

Ambulatory procedures are also challenging. Clinics need significant adjustments to keep clean spaces and to prevent overcrowding on the waiting rooms. As a result, fewer consultations are given per day, increasing the hurdles to get specialized care.

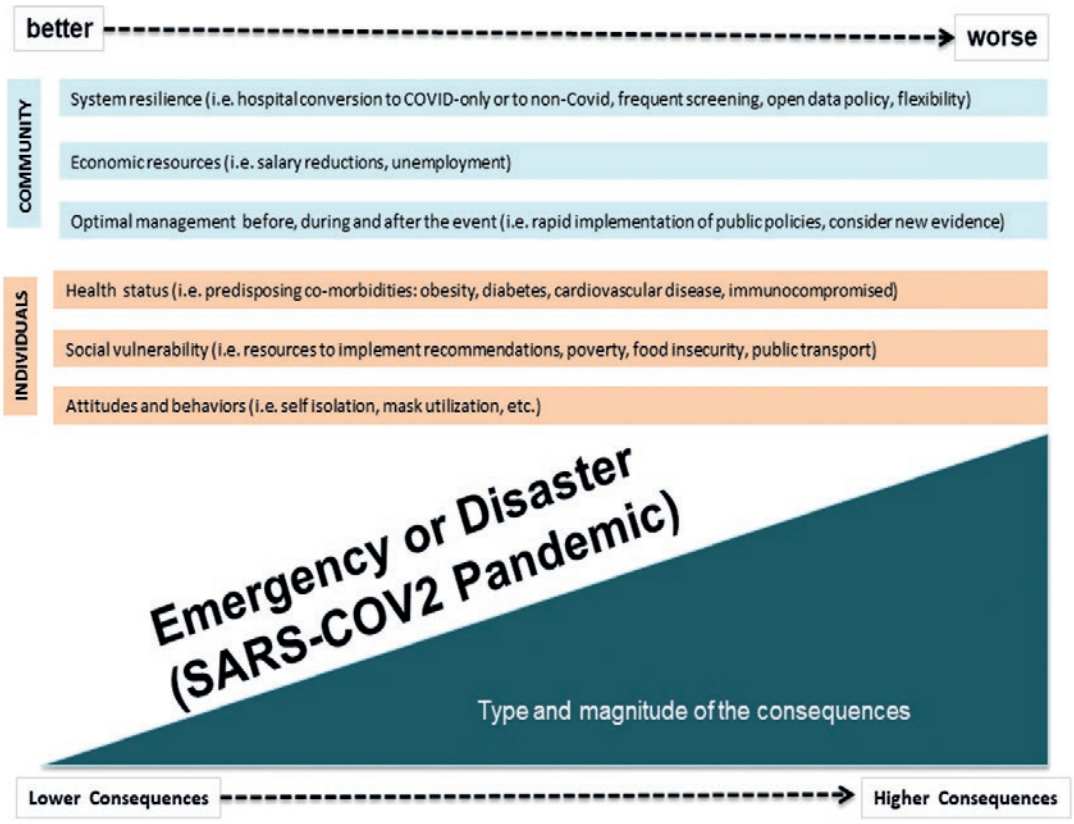
There is also the question of how to maintain underutilized staff during the ongoing pandemic surge[4]. There have been some reports of health systems cutting their salaries or repurposing them to other activities. Finally, if medical and health staff becomes infected, there is an ethical dilemma if the person should be treated differently (i.e., given preference for treatment or resources) or if the institution should cover medical attention or funeral costs.

Possible measures to lessen risks

– The physical and psychosocial harm posed by lockdown must be balanced against the potential benefits of the standard of care in a case-by-case basis

– Before harm and benefits can be balanced, they must first be identified. A relative weight must be given to each harm and gain depending on the context and resource availability

Figure 1. Strategies to cope with SARS-CoV-2 pandemic are depicted. The type of response (better vs. worse) at the individual and community levels is associated with the magnitude of the consequences.



– The stay of patients in medical units should be minimized without altering the quality of care

– Safe communication between hospitalized patients and family members must be priority

– Several institutions like the Cleveland Clinic have published ethical guidelines, treatment priorities, and procedure manuals to prevent discrimination and avoid delays in medical care[5].

CHALLENGES IN THE POLICIES TO REDUCE SEVERE ACUTE RESPIRATORY SYNDROME-COV (SARS-CoV-2) TRANSMISSION

Ideally, during the pandemic, non-COVID-19 patients should attend the hospital only if they need urgent care. However, on the one hand, many of these patients are also the most vulnerable to develop severe COVID-19. On the other hand, this has generated an enormous delay in treating other serious urgent conditions. Health-care providers should keep in mind that the pandemic is responsible for non-COVID-19 lives as well[6]. Now, non-COVID-19 "gray" areas are becoming available in some institutions. Still, it is difficult to decide which patients should receive priority for proceedings with regard to medical attention or surgery within a slowly, staged fashion return to "normal" activities. At present, most institutions are not prepared to establish a new model of care for the "new normality."

Disclosure of positive cases can also be an ethical dilemma. Privacy issues may limit efforts to stop the spread of the pandemic. Patients may claim their right to keep their health information confidential, exposing health care workers to acquire the disease, and limiting information to find potentially infected contacts. Some governments have developed phone applications that trace potential contacts with COVID-19

cases and inform possible contacts. However, concerns about collecting sensitive information without specific permission may cause ethical dilemmas[7]. Furthermore, access to information (i.e., areas with the most significant number of cases or hospital outbreaks) may cause anxiety or fear.

The cost that the pandemic is inflicting over the health-care system is also a topic to discuss. Health care workers and individuals with potential professional exposure to acquiring the disease need protection materials and equipment. Still, the budget may not be enough to provide the best protection equipment possible for everybody. Public health officials may confront difficult decisions to distribute resources with fairness when supplies become scarce. In addition, private institutions may be transferring the costs of the equipment to the patients, with a respective profit as well[8].

Possible measures to lessen risks

– Screen COVID-19 asymptomatic infection before any scheduled admission to the hospital by polymerase chain reaction and, in emergency cases, with pulmonary computed tomography scan

– Design strategies to mitigate harm when surgery must be delayed. These include lifestyle or pharmacological measures[6]

– Always respect the principle of autonomy, which gives weight to an individual's freedom to choose between the risks of the circumstances or the need to get individual medical attention

– All health systems should endorse an open data policy to keep everybody informed about the potential risk of acquiring the disease

– All tracing COVID-19 apps should fulfill four principles: they must be necessary, proportional, scientifically valid, and time bound. Information should not be stored centrally after the outbreak is under control[9]

– Implement training for the ethics committee members about the handling of ethical dilemmas during the health crisis.

CHALLENGES IN MEDICAL ATTENTION

Telemedicine, as the available option to adopt, has its drawbacks. Through any electronic media, doctors embrace the challenge to understand the message beyond the words by neglecting the analysis of the voice tone and the facial or corporal expressions[10]. Even when having face-to-face interaction at the hospital, SARS-CoV-2 fabricated barriers between physicians and patients. First, because the time spent with patients must be minimized, and second, because physicians and nurses must wear physical protection making human contact a luxury. The gaps in doctor-patient relationships have widened, mainly, in the most vulnerable patients, precisely because of their fragile condition. Additional efforts need to be made to understand patients fully.

Possible measures to lessen risks

– The very idea of interrupting communication to provide proper care is ethically questionable

– Ensure that sufficient information is provided

– Identify and protect the most vulnerable population

– There is an overpowering need to identify which tools are the most appropriate for each condition.

CHALLENGES IN PUBLIC HEALTH POLICIES

Difficult ethical dilemmas arise when migrating from medical care or biomedical research to the public health arena. Public health measures to protect the greater good for society may interfere with individual rights and liberties. If there is a reasonable scientific probability that an individual is infected and becomes contagious, it might be argued that the state has the attribution (moral and sanitary) to submit him or her to quarantine. If so, hospitals could be obligated to disclose the information of each positive case. But to infringe liberty to prevent individuals from infecting others, even when calls for voluntary quarantine were not obeyed, it is a violation of the patient's autonomy. To grant permission to disclose his or her information violates the principle of privacy.

Other interventions grounded on arguments of the "greater good" are also controversial if weighted against an individual or social harm, that is, the obligation to use masks. If society is coerced for its benefit, it can establish precedents to also demand similar public measures in other controversial health situations, such as mandatory vaccination or sterilization.

Possible measures to lessen risks

– When stakes are high, and the most significant damage is preventable, protection of autonomy must be balanced against public health. To justify such types of violations, several factors must be considered, such as a very high degree of transmission, a short length of quarantine, and extreme risk or public health benefits

– Coercion must also benefit those who are coerced, as much as to society as a whole

– Plans for coercive measures should ensure safe, habitable, and human conditions of confinement, including basic needs

– Vulnerable groups of the society warrant special protection. There must be a clear identification of the most vulnerable population and a plan to minimize the risks

– Liberty should not be infringed to a greater extent than the necessary to achieve the public health goal

– Society should give something back to those at a disadvantage. If society benefits from liberty infringement, compensation should be given to those who suffer the burdens.

CHALLENGES IN BALANCING RESEARCH AND CLINICAL CARE

Although the article deals with ethical problems in patient care during COVID, we are aware that it is also generating bioethical problems in research. "Covidization" of research has increased the number of studies on the pandemic topic[11]. As a consequence, resources, and its potential benefits for other patients, have been diverted. In some instances, this has led to redundancy and wastage of means, and the risk of neglecting optimal care on other important topics, such as highly prevalent or emerging diseases.

Ultimately, lockdown is needed to reduce the risk of contracting COVID-19 but will also result in the cancellation of imperative medical interventions, policy restrictions on visitations to hospitals, and alienation. Public health interest may override individual privileges, raising the question if the basic human rights such as autonomy and liberty are really absolute. Collateral casualties from the suspension of health-care activities may never be fully recovered. The principle of beneficence implies that what is good surpasses the bad. However, beneficence is difficult to estimate when harms, such as death and disease risks, are difficult to estimate. Bioethics grants the underlying principles used to navigate tough decisions, in this case, the COVID-19 pandemic.

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