COVID-19 PANDEMIC

ETHICAL CONSIDERATIONS IN RESPONSE TO THE COVID-19 PANDEMIC

http://www.lebanesemedicaljournal.org/articles/68(1-2)/pandemic15.pdf

Michel DAHER[1], Georges ROUHANA[2], Nagi SOUAIBY[3], Kamal KALLAB[4], Fadi ABOU-MRAD[5], Sami RICHA[6]

Daher M, Rouhana G, Souaiby N, Kallab K, Abou-Mrad F, Richa S. Ethical considerations in response to the COVID-19 pandemic. J Med Liban 2020; 68 (1-2) : 99-104.

INTRODUCTION

We are facing an unprecedented and devastating situation caused by the coronavirus spreading rapidly around the world, changing the way we work and live. In one way or another, we are all involved in confronting the COVID-19 pandemic.

The COVID-19 pandemic poses grave challenges for societies all around the world. Many lives have already been lost, and many more people fear for their own health and that of their loved ones.

Moreover, the economic impact of the pandemic has cost people their jobs and livelihoods, and started to impact people's wellbeing and mental health. The effects of this public health emergency will affect an entire generation.

On an another hand, the present situation should induce reflection. During this challenging pandemic, we are confronted with many ethical issues which need acceptable solutions. Human Rights (as stated in the Universal Declaration of the United Nations in 1948), are an important reference when elaborating these solutions.

It is important to ensure that the political strategy be founded on an interdisciplinary consensus between science, ethics, law, and society at large.

The key good solidarity and compliance from the society is to deliver clear and transparent information, based not only on scientific knowledge, but also rooted in the Human Rights.

We will be reviewing in this article the most prominent ethical considerations that can be met during the development of the COVID-19 pandemic.

AUTONOMY VERSUS SOLIDARITY IN THE CORONAVIRUS PANDEMIC

The current pandemic is an unprecedented challenge to our society and leads to serious ethical conflicts. While health policy makers work on securing an efficient health system during this pandemic, the major ethical issue is to engage the society in a process of responsibility and solidarity.

There is a conflict between two essential values: the respect of "Individual Rights" and the "Protection of society and the community". The physician's role here is essential. He must ensure that society is protected against epidemic spread, while insuring the protection of personal rights.

Whatever decisions will be taken, whatever their nature, human dignity has to be respected.

Some constraints on population and particular restrictions on individuals have to be taken; they should be decided and applied in conformity with a legitimate objective of general interest, without entailing unreasonable or discriminatory measures, and should be defined in the light of data acquired from science, particularly on their effectiveness.

When dealing with coronavirus, the watchword is solidarity more than autonomy. Policymakers must be aware of the severity of the restrictions implemented, how people can cope with them and for how long. Painful decisions, such as restriction of civil liberties, should be made by the organs mandated by the people to govern the healthcare system. For a better compliance from the population, it is necessary to mobilize Orders, Corporates, Syndicates, Political parties and others, to explain the measures applied.

Although the greatest attention must be paid to the goal of slowing considerably the spread of the coronavirus, decision makers should consider how to return orderly to a reasonably "normal" life as well as regular economic activities.

[1]Surgery Department, University of Balamand, El Koura, and Saint George Hospital, Beirut, Lebanon.
[2]Department of Radiology, Lebanese University, Beirut.
[3]Emergency and Forensic Medicine Departments, Faculty of Medicine, Saint-Joseph University, Beirut; Emergency Department, Notre-Dame Maritime Hospital, Byblos, Lebanon.
[4]Neurology Department, Saint-Joseph University, Beirut.
[5]Neurology Department and Division of Medical Ethics, Faculty of Medicine, Lebanese University, Beirut, Lebanon.
[6]Department of Psychiatry, Hôtel-Dieu de France and Faculty of Medicine, Saint-Joseph University, Beirut.
*Corresponding author: *Michel Daher, MD, FACS* e-mail: mndaher@inco.com.lb

In the name of solidarity, the best thing we can do to help each other during this public health emergency is to stay away from each other. Those of us with confirmed COVID-19, need to self-isolate. Those of us who have been exposed to a confirmed case of COVID-19, need to self-quarantine. Those of us who have been travelling, need to self-quarantine. All others, who are not essential workers, need to stay home as much as possible. If we have to venture out, we need to practice social distancing.

Social responsibility is a duty. One does not have the right to remain passive when faced to a threat to society and to remain confined to rigid laws far from social requirements.

RESPECT OF CONFIDENTIALITY & PRIVACY RIGHTS OF PATIENTS DURING COVID-19 CRISIS

Confidentiality and privacy are two of the six health universal rights. The four others are: right to access healthcare, right to information, right to nondiscrimination and right to self-decision making.

Confidentiality means protection of the personal information "that a patient reveals to a physician or to a health care provider but also what is heard, understood, seen or concluded by the physician".

Confidentiality has limits and legal derogations on how and when it can be disclosed to health authorities, a judge or a third party. According to the Lebanese Code of Ethics (Law 240 amended in october 2012, initially Law 288 of 1994, Article 7) confidentiality is a public matter. The physician is bound to this confidentiality at all times while taking into consideration some exceptions imposed by the law and public interest.

Privacy is the state of being free from being observed or disturbed by other people. The Lebanese Law 574 (2004) related to the patient's rights and informed consent, chapter 3, art. 12, stipulates that every patient under the care of a physician has the right to privacy on his/her life and all related information.

After the novel coronavirus (COVID-19) was declared a pandemic by the World Health Organization (WHO, March 11, 2020), it was considered as a serious danger to public health. In order to make people aware of this threat, some public health programmes carried information about person identity, affecting in many ways confidentiality and privacy.

To what extend should confidentiality and privacy be respected in COVID-19 pandemic?

According to the *British Council of Bioethics* (Re: Guide to the ethics of surveillance and quarantine for novel coronavirus), "the avoidance of significant harm to others who are at risk from a serious communicable disease may outweigh the consideration of personal privacy or confidentiality, and on this basis it can be ethically justified to collect non-anonymised data about individuals for the purpose of implementing control measures. However, any overriding of privacy or confidentiality must be to the minimum extent possible to achieve the desired aim. Liberty-infringing measures to control disease, such as quarantine and isolation, can be justified if the risk of harm to others can be significantly reduced."

In Lebanon, the declaration of COVID-19 cases is mandatory by decree decision of the Ministry of Public Health (MOPH). In a pandemic situation like the one we are facing with COVID-19 crisis, what is going to prevail: the values and ethical principles that are integral to the "Universal Declaration of Human Rights" or usefulness and efficiency as primary values for the good of the community?

In practice, the key element to consider is the good communication: Alarming statements issued by authorities scaring people to observe confinement as well as media breaking news lead to fear and stigmatization of COVID-19 pushing them to hide their illness. Consequences may be a miscommunication between healthcare providers and patients resulting in a delayed or missed care and treatment.

SHARED DECISION MAKING IN A PANDEMIC DILEMMA OF VENTILATOR ALLOCATION

COVID-19 is attacking the patient's era after the emergence of the notion of personalized medicine that influenced the development of healthcare facilities over the world (Iles, 2004), particularly the North countries. Medical decisions were initially guided by narrative-based medicine (NBM) where the patient narrated his/her symptoms and the healthcare professional (HCP) listened until a common story approved by the patient and understood by the HCP was formulated. The objectives of the consultation, the milieu and the dialog were the focus (Launer, 2002). Progress drove to privilege patients' choices and called upon the Law to protect these options leading to the patient's era, whereby move from NBM to shared decision-making (SDM) was realized over the last two decades. This entitled that HCPs introduce choices, discuss therapeutic options, and explore preferences to be honored by the actors and community (Elwyn et al., 2012). The problematic is whether this can be maintained during a pandemic. To answer we decided to reflect on a clinical complex situation that generated public and professional fears while facing COVID-19, specifically the dilemma raised by the allocation of ventilator.

The pandemic burdened medical resources calling for a rationing in the use of ventilators, particularly for dying patients (Truog et al., 2020). The most problematic was

mechanical ventilator (MV) which is not only rare but used for long periods by the same patient. The media, even in the Arab region, highlighted the issue disseminating confusion regarding access to intensive care unit (ICU) with comments like "first come, first served" or "the youngest will be served while the old rejected".

This aggravated social concerns affecting the preparedness to cope and inviting ethicists to explore the option of ventilating patients by Ambu bag when there is no ventilator. Ideas were raised just to empower communal solidarity without considering the dangers to the HCP bagging the patient, nor positive end-expiratory pressure (PEEP) that is mandatory in acute respiratory distress syndrome (ARDS) (synapse.aan.com/ethics).

Worldwide number of patients needing MV rose from 1.4 to 31 patients per devise. This worsened with restricted availability in respiratory therapists and trained critical care personnel leading to rationing (Emanuel et al., 2020).

Most of the rationing protocols encouraged saving most lives and maximizing improvements, thereby giving priority to patients having better chances to respond if treated. The idea "first come, first served" proposed for patients having similar prognosis is not acceptable in a pandemic because it affects the principle of justice and might lead to violent behavior. Therefore, random allocation should be encouraged.

Ceasing MV from one patient and making it available to another is possible through advanced patient's wishes and/or the person of trust or when treatment is judged futile by the physician under certain jurisdiction. This is socially accepted when the concept of futility is introduced in Biolaws. It is not the case in the Arab world where futility is not only legally prohibited but an additional parameter that weakens the social bond in the public health domain. A social cohesion is therefore a must (Abou-Mrad et al., 2014).

Good clinical practice guidelines highlighted the principles that should be honored by every physician, namely, beneficence, justice and embracing the vulnerable that is a quality determinant in healthcare (Abou-Mrad et al., 2014). The burden of MV withdrawal should not be left to the clinical physician because of its debilitating distress. Hence, a triage committee should be established to handle the decision, neutralize paternalism, and alleviate the clinician's emotional suffering.

This committee is invited to ration the decision, act as an independent body, and involve collectivity defined by those people who are concerned with the life and death of the patient but are confined and not able physically to assist their beloved. The benefits of such a committee that would act as an advisory body are tremendous in gaining public trust and confidence that is crucial to every health care system for the post pandemic period.

Two structures in hospitals could serve here: (i) the Institutional Review Boards and (ii) the palliative care groups.

The first, because of their independence and highest representativeness and the second offer support for cases where a prolonged time to death is expected. Advice from the two groups along clearly written protocols will provide a holistic approach to the enormous emotional, spiritual and ontological burden facing carers.

Returning to the initial hypothesis of whether SDM is maintained in a pandemic, we must keep in mind that it took decades for medicine to move from NBM to SDM. Pandemic has replaced SDM with community decision making (CDM) involving more actors and emphasizing the wellbeing of the population shifting more towards utilitarian ethics overcoming, in the depth of the western countries, the anglo-saxon approach in the patient's care.

What is reassuring with the elaboration of this triage independent committee, is that both models (utilitarian & anglo-saxon) and approaches (SDM & CDM) banned the clinician to decide solely on withholding or withdrawing, therefore rejecting the physician's paternalistic attitude,even in a pandemic, to continue honoring the principle of autonomy.

ADVOCACY FOR A GLOBAL ETHICS DURING THE PANDEMIC

Almost a hundred days after the start of the epidemic, it is a right and duty to ask ourselves if our actions and attitudes were compliant with ethical principles, knowing that previous experiences led to many recommendations. WHO (2007, Ethical considerations in the development of public health measures in the face of an influenza pandemic), the CCNE in France (Avis N° 106, Ethical questions raised by a possible influenza pandemic, February 2009), and World Medical Association (Notice N° 106, Ethical questions raised by a possible influenza pandemic, April 2019) are the most relevant.

Recently, on March 26, 2020, UNESCO and COMEST published a statement on COVID-19: "Ethical considerations from a global perspective", in order to learn lessons and enhance international cooperation.

The origin of the virus is still unclear. The alert made by a Chinese doctor was ignored for a while.

Some countries lacked transparency, others vigilance; football matches and election rounds were held despite the announced gravity, leading to a shortage of health resources and the painful sorting of patients to resuscitate. At the same time, barriers appeared between countries, and communities to stop the spread of the disease.

The lack of cooperation between countries for both either information sharing or resources is evident. Means of struggle are unequal to the disadvantage of the poor countries. The absence of a concerted international action has resulted in a "*chacun pour soi*" attitude (every man for himself). The behavior of European countries is an example. The specter of overpriced future treatments and vaccines haunts poor countries.

The great consequence is injustice. Who will pay the heavy price in human life and cost?

We are still not safe from a recrudescence of COVID-19, let alone subsequent epidemics. We must manage successive waves, sanction false news on social networks and address the root of the problem, including the relationship of humans to animals and or laboratory manipulations.

Strategy for global ethics is mandatory for the present and future. Any action on a planetary scale will have to respect human dignity, justice between countries and between individuals, solidarity, swift measures and efficiency; this is an ethical requirement, the choice of health and people's lives must take precedence over economy or politics. Context, whatever it is, cannot change ethical values, emergency only forces them to prioritize them provisionally.

Any plan should take advantage of the multiplicity and complementarity of resources across countries. The multilateral action advocated by WHO in 2007 must lead to a strong international treaty.

A sufficiently coercive treaty must include sanctions for countries and leaders who conceal information regarding the evolution and the treatment of the pandemic, sanctions for large companies breaching the main principles of ethics, notably justice, beneficence and non-maleficence. A treaty, which would allow access to research results to everyone and prevent states or commercial harmful exclusiveness.

This treaty must built structures of global governance, which, among other things, should ensure the necessary prioritization of needs on a global scale and coordination between member countries and ensure that governments respect ethical principles with regard to their citizens. Instead of narrow national interest, let us call for international cooperation and solidarity at all levels between international organizations, governments, and civil society. This should include an engagement from rich countries to provide significant help and assistance (technical and medical supplies) to poor nations confronted to this pandemic. It is never too late.

This is how, during such challenges, humankind can rediscover its solidarity, its values and reshape a culture worthy of the human person.

PSYCHOLOGICAL SUPPORT FOR PATIENTS & CAREGIVERS DURING COVID-19 PANDEMIC

The coronavirus crisis has highlighted a major anxiety generalized to the whole population, affected and not reached, and affecting even caregivers.

This irrational anxiety has generated the stigmatization of those affected and even of those caring for them. The health professionals' activity in a context of high and continuous demand has considerable impacts at different levels (physical, psychological and social). Thus, the risks these professionals are subjected to go far beyond the potential infection, and therefore they must be taken into consideration in the planning and implementation of specific strategies as a condition to ensure the safety of professionals, the full functioning of health institutions and the permanent care of patients at different stages of the disease. By fighting stress during this period, we significantly reduce stigmatization, which is one of the major ethical issues of this phase.

Coping with stress during the COVID-19 pandemic

It is normal to feel stressed, sad, confused, angry, or scared during a crisis. This can be completely normal. Time spent watching, reading or listening to news, which is a source of anxiety and distress, should be minimized and information sought only from reliable sources (such as the WHO), which could minimize anxiety. It is imperative not to use tobacco, alcohol or other drugs to manage negative emotions.

In the case of massive anxiety, it is important to benefit from the skills that anxious people have already used in the past and which helped them to manage life's difficulties.

It is also important to look for the positive and hopeful stories of people who have suffered from COVID-19. For example, stories of people who have recovered or knowing that the infection rarely affects children and young people. During isolation, it is important to participate in healthy activities as relaxation, such as mindfulness, meditation, prayer or physical activity.

Tips for better mental health for healthcare workers

Health professionals are key elements in any planning process to respond to a pandemic situation, fulfilling their different assistance tasks. We expect them to respond without restrictions, assuming those tasks as agents on the different fronts in which they are qualified and competent, within the limits of their technical and human capabilities. Among these tasks, caring for sick people severely affected by the disease is even more demanding.

It is normal to feel stressed and under pressure. This does not mean that a caregiver cannot do his job or that

he is weak, but that he must manage his own mental health and psychosocial well-being. He also needs to have enough rest between work periods, eating healthy food, practicing physical activity, setting aside time for relaxation, and staying in virtual contact with family and friends.

Being kept at a distance by one's own family or community due to stigmatization or fear could make the situation more difficult. It is imperative to get rid of the guilt of being able to infect your own family from the moment you take the necessary precautions. When you reach a state of emotional, physical, or mental fatigue, you need to know how to turn to others for help, reframe the way you see work, and seek the advice of a mental health professional.

Intervention strategies should be designed to reduce burnout and compassionate fatigue, as well as supporting patients' families to reduce the impact on their personal and family lives.

The current crisis has highlighted the solidarity that is extremely essential in this period. New human relationships will undoubtedly arise after the passage of the pandemic.

CONCLUSIONS AND RECOMMENDATIONS

The challenges and consequences of the COVID-19 pandemic affect every person and every region differently with their own vulnerability.

One of the major ethical issues during this pandemic is to engage society in a process of responsibility and solidarity. A good information and transparency will help citizens to accept and apply the different measures taken against the pandemic.

There is a place for ethical reflections in the management of severely diseased patients, the availability and distribution of resources, especially when they are limited. The local Ethics Committee can assist and support HCP to define their priorities in their care.

- Promote the triad of health, solidarity, equality: It is necessary to give priority to the respect of confidentiality and human dignity. Otherwise, the patient feels responsible towards the society.
- Ways out of the crisis: Prepare for the post-COVID-19 period by restructuring and reshaping society medically, legally, economically, politically and above all philosophically in order to rebuild society.

In this spirit we recommend that:

- Protection of human health be accorded a much higher priority in the system of values than economic interests.
- Saving lives is the most important and urgent goal. The public health emergency must not be abused to usurp power, or to permanently suspend the protection of rights and liberties.
- Once the crisis is over, countries should work together to implement lessons learned during COVID-19. A common strategy to deal with a pandemic and similar threats should be elaborated and implemented at the global level.
- States with sufficient resources for healthcare should share their resources with those who lack necessary resources in an attitude of solidarity. COVID-19 has shown, once more, that the most socio-economically deprived are most vulnerable to disease and illness.

We must live through this pandemic, and after it. We must face this situation with strength, care and solidarity.

ACKNOWLEDGEMENT

All authors have equally contributed to the manuscript.

CONFLICTS OF INTEREST

The authors declare no conflict of interest.

REFERENCES

SELECTED REFERENCES

- UNESCO Universal Declaration on Bioethics and Human Rights (2005)
- COVID-19 : Contribution du comité consultatif national d'éthique : Enjeux éthiques face à une pandémie - 13 mars 2020
- European Group On Ethics In Science And New Technologies - Statement on European Solidarity and the Protection of Fundamental Rights in the COVID-19 Pandemic
- Deutscher Ethikrat: Solidarity and Responsibility during the Coronavirus Crisis - ad hoc recommendation
- IBC Report on the Bioethical Response to the Situation of Refugees (2017)
- IBC Report on the Principle of Non-Discrimination and Non-Stigmatization (2014)
- IBC Report The Principle of Respect for Human Vulnerability and Personal Integrity (2013)
- National Council of Ethics for the Life Sciences of Portugal - Public Health Emergency Situation Due To The Covid-19 Pandemic Relevant Ethical Aspects.

STATEMENTS BY NATIONAL ETHICS COMMITTEES

Austria: Geschäftsstelle der Bioethikkommission

Recommendation regarding allocation of resources in intensive care unit in times of Covid-19 (German)

France: The French National Ethics Council

La contribution du CCNE à la lutte contre COVID-19: Enjeux éthiques face à une pandémie

Germany: Deutscher Ethikrat

Solidarity and responsibility during the coronavirus crisis

Greece: Hellenic National Bioethics Commission

The bioethical dimension of individual responsibility in response

to COVID-19 (coronavirus)

Luxembourg: Luxembourgish National Ethics Committee

Repères éthiques essentiels lors de l'orientation des patients dans un contexte de limitation des ressources thérapeutiques disponibles due à la crise pandémique du COVID-19

Mexico: National Bioethics Commission of Mexico

Statement: Bioethics in the face of the COVID-19 pandemic

Recommendations regarding the COVID-19 pandemic, from a bioethical approach

Portugal: National Ethics Council for the Life Sciences

CNECV Statement: COVID-19 Key Considerations

Republic of San Marino: National Bioethics Committee

Statement on ethical issues regarding the use of invasive assisted ventilation in patients all age with serious disabilities in relation to the COVID-19 pandemic

Switzerland: Nationale Ethikkommission im Bereich der Humanmedizin

Corona-Pandemie: Schutz des Lebens und Solidarität stehen aus ethischer Sicht im Zentrum

Spain: el Comité de Bioética de España

Informe del Comité de Bioética de España sobre los aspectos bioéticos de la priorización de recursos sanitarios en el contexto de la crisis del coronavirus

The United Kingdom: The Nuffield Council on Bioethics

Ethical considerations in responding to the COVID-19 pandemic

Guide to the ethics of surveillance and quarantine for novel coronavirus

Statements by International Organizations

UNESCO International Bioethics Committee (IBC) and the UNESCO World Commission on the Ethics of Scientific Knowledge and Technology (COMEST)

Statement on COVID-19 Ethical Considerations from a Global Perspective

European Group on Ethics in Science & New Technologies (EGE)

Statement on European Solidarity and the Protection of Fundamental Rights in the COVID-19 Pandemic

Coronavirus Resources

- World Health Organization
- European Centre for Disease Prevention and Control
- United States Center for Disease Control
- United States Center for Disease Control: Travel Health Notices
- US Department of State: Travel Advisories
- National Institutes of Health
- City of Philadelphia Coronavirus Disease 2019 (COVID-19)
- Pennsylvania Department of Health Coronavirus Resources
- European Centre for Disease Prevention and Control Available at: https://www.ecdc.europa.eu/en/novel-coronavirus/event-background-2019
- Johns Hopkins Coronavirus Resource Center https://coronavirus.jhu.edu/map.html
- WHO Situation Reports: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports
- US Department of Homeland Security, Homeland Infrastructure Foundation-Level Data: https://hifld-geoplatform.opendata.arcgis.com/datasets/hospitals

Bibliography - Additional Reading Materials

- Berlinger N, Wynia M, Powell T et al. (2020). Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic - *The Hastings Center*. Retrieved 30 March 2020. https://www.thehastingscenter.org/ethicalframeworkcovid1
- Emanuel EJ, Persad G, Upshur R et al (2020). Fair allocation of scarce medical resources in the time of Covid-19. *New England Journal Of Medicine*. Retrieved 30 March 2020. https://www.nejm.org/doi/full/10.1056/NEJMsb2005114
- Vergano M, Bertolini G, Giannini A et al (2020). Clinical Ethics Recommendations for the allocation of intensive care treatments in exceptional resource-limited circumstances. *SocietàItaliana di Anestesia Analgesia Rianimazione e TerapiaIntensiva (SIAARTI)*. Retrieved 30 March 2020. http://www.siaarti.it/SiteAssets/News/COVID19%20-%20documenti%20SIAARTI/SIAARTI%20-%20Covid-19%20-%20Clinical%20Ethics%20Reccomendations.pdf
- De Maeseneer J et al. (2020). Saving lives by European solidarity and cooperation in response to COVID-19. BMJ Global Health blog. Available at: https://blogs.bmj.com/bmjgh/2020/03/27/saving-lives-by-european-solidarity-and-cooperation-in-response-to-covid-19/
- Government, T., Council, N., & Council, N. (2020). Rapid policy briefing - Ethical considerations in responding to the COVID-19 pandemic. (March), 1-11. Available at: https://www.nuffieldbioethics.org/news/responding-to-the-covid-19-pandemic-ethical-considerations
- Meyfroidt G, Vlieghe E, Biston P et al. (2020). Ethical principles concerning proportionality of critical care during the 2020 COVID-19 pandemic in Belgium: advice by the Belgian Society of Intensive care medicine – update 20-03-2020. 1-4. https://doi.org/http://www.siz.be/wp-content/uploads/SIZ_ethical_update20_03_E.pdf
- Nuffield Council on Bioethics. (2020). Health Emergencies: Ethical Issues Short Report. Available at: https://www.nuffieldbioethics.org/publications/research-in-global-health-emergencies
- Rosenbaum L. (2020). Facing Covid-19 in Italy – Ethics, Logistics, and Therapeutics on the Epidemic's Front Line. New England Journal of Medicine. https://doi.org/10.1056/NEJMp2005492
- Delfraissy SD, Delmas-Goyon J, Duée P, Hédon C. (2020). COVID-19 Contribution du Comité Consultatif National d'Éthique : Enjeux éthiques face à une pandémie. 1-10.
- World Health Organization (2016). Guidance for Managing Ethical Issues in Infectious Disease Outbreaks. Geneva: WHO Press.