



INTERNATIONAL JOURNAL OF CREATIVE RESEARCH THOUGHTS (IJCRT)

An International Open Access, Peer-reviewed, Refereed Journal

Bioethics And Pandemics: A Case Study Of Public Health Ethics

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Abstract:

The COVID-19 pandemic has raised many ethical challenges, but key among these has been the possibility that healthcare systems might need to ration scarce critical care resources. Rationing policies for pandemics differ by institution, health system, and applicable law. Most seem to agree that a patient's ability to benefit from treatment and to survive is first-order consideration. However, there is debate about what clinical measures should be used to make that determination and other factors that might be ethically appropriate to consider. The covid-19 pandemic has concentrated bioethics attention on the "lifeboat ethics" of rationing and fair allocation of scarce medical resources, such as testing, intensive care unit beds, and ventilators. This focus drives ethics resources away from persistent and systemic problems-in particular, the structural injustices that give rise to health disparities affecting disadvantaged communities of color. Bioethics, long allied with academic medicine and highly attentive to individual decision-making, has largely neglected its responsibility to address these problematic "upstream" issues. It is time to broaden our teaching, research, and practice to match the breadth of these significant societal inequalities and unmet health needs.

Keywords: Bioethics, pandemics, justice, Care, and Health care

Introduction

Ethics is a philosophical discipline pertaining to notions of good and bad, right and wrong- our moral community life. Bioethics is the application of ethics to the field of medicine and healthcare. Bioethics, born out of the rapidly expanding technical environment of the 1900s, is a specific domain of ethics focused on moral issues in health care. Fritz Jahr first coined the term "Bioethics" in 1927 in an article that sought to examine the "Biological imperative" of plants and animals in research. Bioethics has addressed many questions ranging from abortion and euthanasia to health care policy and the individual right to refuse treatment. Philosophers see bioethics as the

practical application of philosophy in today's world as it deals with questions on the morality of actions in the clinical and research fields.

Bioethics, on the other hand, is a more overtly critical and reflective enterprise. Not limited to questioning the ethical dimensions of doctor-patient relationships, it goes well beyond the scope of traditional medical ethics in several ways. First, its goal is not the development of, or adherence to, a code or set of precepts but to better understand the issues. Second, it is prepared to ask deep philosophical questions about the nature of ethics, the value of life, what it is to be a person and the significance of being human. Third, it embraces issues of public policy and the direction and control of science. In all these senses, bioethics is a novel and distinct field of inquiry. Nevertheless, its history must begin with the history of medical ethics.

Ethical Principles

In 1979 Beauchamp and Childress published the first edition of their book "Principles of Biomedical Ethics", which featured four bioethical principles autonomy, nonmaleficence, beneficence, and justice.

1. Autonomy

Autonomy is the freedom and ability to act in a self-determined manner. It represents the right of a rational person to express personal decisions independent of outside interference and to have these decisions honored. In the domain of health care, respecting a patient's autonomy includes obtaining informed consent for treatment, facilitating and supporting the patient's choices regarding treatment options; allowing the patient to refuse treatments; disclosing comprehensive and truthful information, diagnoses, and treatment options to patients, and maintaining privacy and confidentiality. Respecting patient's autonomy is essential, but it is also important for nurses to receive respect for their professional autonomy. Considering how the language nurses choose defines the profession's place in health care.

2. Nonmaleficence

Nonmaleficence is the principle used to communicate the obligation not to harm. Emphasizing the importance of this principle is as old as an organized medical practice. Healthcare professionals have historically been encouraged to do good, but if they cannot do good, they are required to do at least no harm.

3. Beneficence

The principle of beneficence consists of performing deeds of "mercy, kindness, friendship, charity, and the like." Beneficence means people take action to benefit and promote the welfare of other people. At the same time, people are obligated to act nonmaleficence toward all people, not to harm anyone. There are limits to beneficence or the benefits people are expected to bestow on others. Generally, people act more beneficently toward people they know or love rather than toward people not personally known to them, though this is not always the case.

4. Justice

Justice, as a principle in healthcare ethics, refers to fairness, treating people equally and without prejudice, and the equitable distribution of benefits and burdens, including assuring fairness in biomedical research.

What Pandemics is:

A pandemic is an outbreak of infectious disease that occurs over a wide geographical area and is highly prevalent. A pandemic generally affects a significant proportion of the world's population, usually over several months. Pandemics arise from epidemics, which are outbreaks of disease confined to one part of the world, such as a single country. In December 2019, an outbreak of pneumonia of unknown origin was reported in Wuhan, Hubei province, China. Pneumonia cases were epidemiologically linked to the Huanan Seafood wholesale market. Severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2), the seventh human corona virus was discovered in Wuhan, Hubei province China, during the recent epidemic of pneumonia in January 2020.

Patients with SARS-CoV-2 infection may present symptoms ranging from mild to severe, with a large portion of the population asymptomatic carriers. The most commonly reported symptoms include fever, cough, and shortness of breath. A chest X-ray usually shows multiple mottling and ground glass opacity in patients with pneumonia.

The COVID-19 epidemic has radically altered how we practice medicine worldwide in recent months. Physicians are traditionally educated to practice medicine with a patient-centered approach, but the whole healthcare system has moved to a public health focus in the wake of the epidemic. Elective surgical treatments that may help people in developing countries have been canceled in several countries. Elective surgical treatments that may help individual patients have been withdrawn in several nations to safeguard healthcare professionals and personal protective equipment (PPE) needed to treat COVID-19 patients. This shift in perspective may cause moral anguish among physicians. Moral distress develops when internal and external barriers prohibit physicians from making ethically sound decisions.

During pandemics, healthcare providers have multiple responsibilities, including the responsibility to care for their patients, the responsibility to protect themselves from becoming infected so that they can remain productive and in action throughout the pandemic, the responsibility to protect their families and neighborhoods, and the responsibility to protect their colleagues, many of whom may become ill and have to go on leave, whose jobs may jeopardize.

Healthcare in general

Healthcare is the treatment, prevention, and management of illness and preservation of physical and mental well-being through the services offered by the medical, nursing, and allied health professions. According to the WHO, healthcare embraces all the goods and services designed to promote health, including "preventive, curative and palliative intervention, whether directed to individuals or population." The organized provision of such services may constitute a healthcare system.

Health is defined as a state of complete physical, mental and social well-being, not the non-existence of disease or ailment. Health is a primary human right and has been accorded due importance by the constitution through article 21. Article 21 stresses upon state governments to safeguard the health and nutritional well-being of the people; the central government also plays an active role in the sector.

The Indian health sector consists of

- Medical healthcare providers like physicians, specialist clinics, nursing homes, and hospitals.
- Diagnostic service centers and pathology laboratories.
- Medical equipment manufacturers.
- Contract research organizations (CRO's), pharmaceutical manufacturers.
- Third-party support service provides (catering, laundry).

History of the Healthcare sector in India before independence, voluntary work was the base of healthcare in India. Traditional healthcare practitioners have contributed to society's medicinal needs since ancient times. Knowledge concerning the medicinal properties of plants and herbs was passed on from generation to generation to be used for treatment. It was only through colonial rule, and the dominance of the British that changed the scenario in Christian missionaries managed hospitals. After independence, the government of India laid stress on primary health care and put sustained efforts to better the healthcare system across the country. The government initiative was not enough to meet the demands of a growing population, be it primary, secondary, or tertiary healthcare. Alternate services of finance were critical for the sustainability of the health sector. In addition, in India, although modern medicines, indigenous or traditional medical practitioners continue to practice throughout the country. In any state, healthcare services are essential not only for human resource development but also for restly the people's faith in the institution of governance. The main threat of these services includes delivering preventive, promotive, and rehabilitative healthcare services at the primary, secondary, and tertiary levels. The primary healthcare system inherited from the independence period has undergone enormous changes in establishing an advanced network of health delivery systems.

Clinical ethics challenges arising in the care of Covid-19 patients

A number of ethical issues occur during the treatment of patients with Covid-19 of, which. Some of are as follows:

- 1. Treatment of Covid-19 patients as a means to an end:** clinical medicine cares for individuals after the onset of illness and therefore emphasizes alleviating suffering, pain, and psychological and emotional distress. On the other hand, public health works with health populations to prevent disease or the spread of infection. In pandemics like Covid-19, there is a very fluid distinction between these two approaches. Public health and population protection take priority, and all state interventions are directed towards the containment of infection and reduction of morbidity and mortality. Most decisions are driven by statistics and mathematical modeling based on the numbers of susceptible, exposed, infected, or cured people. Testing, detection, isolation, and treatment of individuals become a means to keep the number of infected persons low.

The foundational tents of clinical ethics, including respect for the individual patients' rights, values, preferences, care for individual needs, and avoiding unnecessary harm to and discrimination against

infected persons, all take a back seat during such emergencies. Clinicians, whose primary training is in caring for individual patients, are forced to adopt public health strategies during the pandemic, leading to moral distress.

- 2. Duty to care versus the right to protection:** One of the most contentious issues globally during this pandemic has been the scarcity of personal protective equipment for healthcare personnel working with Covid-19 patients. The emerging consensus across international ethical guidance seems to be that duty to care during pandemics and emergencies must be voluntary. They must be associated with reciprocity from the health system, the government, and society to protect providers. This can be in the form of providing PPE, duty hours that offer adequate time for rest and recuperation, comfortable rooms to stay in a while separated from family and loved ones, and adequate incentives in the form of monetary or non-monetary compensations. However, the fear, anxiety, and guilt of transmitting the illness from patients to their loved ones will likely cause substantial distress among healthcare providers and impact their care.
- 3. Rationing of Scarce resources in pandemics:** Though rationing of scarce resources is a public health concern, it has important implications for clinical care provision and clinical ethics. Hospital beds, ventilators, medications, and personal protective equipment for healthcare providers, are all becoming scarce resources. Clinicians are pushed into making morally contentious decisions on allocating beds, ventilators, and medicines. Making such decisions takes a heavy toll on the psyche of healthcare providers etc. These decision algorithms select a few patients in preference to others based on criteria such as age, presence of comorbidities, contribution to society, etc., and having to make these decisions causes the clinician severe moral stress. Since these decisions significantly impact the community, active community engagement is essential to understand community perspective, values, and priorities. Local guidelines must be developed to support healthcare providers in making rationing decisions that are relevant and acceptable to the community.
- 4. Dignity and death:** Families of patients who died due to covid-19 face severe emotional stress. Firstly the patients die alone in the hospital isolation ward or the critical care unit. Their family and loved ones do not get a chance to say goodbye. The formalities of body disposal without contamination of the environment further place severe restrictions on certain vital traditions and rituals performed as part of funeral rites. All of these are also significant causes of moral distress for providers.

Clinical ethics considerations in the care of non- covid 19 patients

Clinical ethics challenges arise during a pandemic in relation to "Non-Covid-19" patients, such as denial of clinical care for non-emergency conditions and lack of clinical support for mental illness.

Moral distress of healthcare providers: The healthcare providers, namely doctors, nurses, technicians, and others, cannot address these significant ethical issues described above. Some of these emerge from the conflict between their responsibility to the individual patient and their responsibility to the public during a public health crisis. Such ethical issues are a cause for severe moral distress among healthcare providers.

It is essential to understand that when you need medical care, you should seek treatment; delaying care may create more significant risks to your health. And as we see that if we fall ill, we quickly move toward the hospital, but in Covid, we have seen that all the hospital beds, wards, and staff were fully occupied with Covid-19 patients. This also affects other patients (other than covid) because the prime focus of doctors was on Covid patients, and most of the time, other patients were negligent.

The COVID-19 epidemic has thrown the healthcare industry into sharper light than it has ever been before. On the one side, healthcare workers are being praised as "Corona Warriors." Yet, there have been instances of patients being denied medical aid and non-compliance with safety standards, jeopardizing the lives of healthcare workers and patients.

Many additional questions and concerns remain, especially in high-risk sites and clinical settings. One problem is in the emergency department, where crowding is identified as a significant concern because emergency departments were also fully occupied with covid patients. Furthermore, other than covid, patients with unbearable pain and illness were pushed out of the department. This may have two reasons; firstly, according to doctors, those patients with symptoms of suspected COVID-19 should be rapidly triaged and separated from the general population, ideally in a well-ventilated space with a distance of at least six feet from others until they can be placed in an isolation room. Because of these patients, others may also get affected. Secondly, hospital personnel, including caregivers, support staff, administration, and preparedness teams, will be stressed by the challenges of a prolonged response to COVID-19, the crowd of patients causes headaches in medical staff, and they can't see the patients then properly.

Standard Ethical Theories and the Isolation of a Province

Although all standard ethical theories appeared in the discussion, they were not exhaustively analyzed, such as the 'Act and Rule utilitarian theories' by Jerry Bentham and John Stuart Mill, Deontological theory of Immanuel Kant.

Act utilitarianism demands that all our individual choices must aim at maximizing measurable good. By setting up the restrictions (prima facie bad), the government tried to slow down the spread of the pandemic (good?), promote public health (good), and save lives (good), maybe at the expense of losing other lives (bad). Whether applying the brakes at the time when it was done will turn out to be good or bad can be reliably assessed only when the pandemic is over. Empirical calculations might retroactively support the isolation, but the possible sacrifice of some innocent lives will still leave some moral residue.

Rule utilitarianism instructs us to devise principles to act in particular cases. One such code could be using Quality Adjusted Life Years (QALY) in decision-making. If those who die are very old, they will not dent the national QALY aggregate as much as the young and healthy. Sweden seems to be following this policy. Another option would be to devise some utilitarianism with side constraints. Basic human rights, for instance, could set the limits of seeking health and economic utility. Due to international treaties, Finland and Sweden swear by this rule, but lawyers and philosophers have questioned whether it was applied during the pandemic.

Moral legalism is not an ethical theory, but it informs citizens' thinking in some parts of the world, including Finland. According to it, we must only obey prevailing laws to be moral. This is compatible with the jurisprudential creed of legal positivism, which states that the law is the law because it is the law. No further justification is possible or desirable. On the other hand, the idea is incompatible with natural law theory, which teaches that morality is above existing law and that some rules are wrong and need not or should not be followed. Human rights lawyers criticized the Finnish government's restrictions by arguing that they defied international human rights legislation. Some philosophers objected and appealed to higher moral grounds.

Kantian ethics requires us to respect humanity in ourselves and others. We must act so that we never use humanity as a mere means but always as an end. Did the government abide by this rule? Both sides quickly argued. Yes, because the possible loss of life in the isolated province was not the cause of health benefits elsewhere. No, because the vulnerable were put in harm's way to benefit others. The magic and challenge of the Kantian formula is in the expressions "mere means" and "also as an end," which can be interpreted in more ways than one.

Natural law ethics forbids us to violate or disregard our essential human goods, which are, in the traditional formulation, survival, health, shelter, having and raising offspring and seeking knowledge, especially concerning God. Insofar as the government's decision was about protecting lives and health, this approach readily supports them. Since the same family of theories has also produced the doctrine of double effect for exceptions, it is not always clear how the principles should be applied.

In its Aristotelian formulation, Virtue ethics advises us to seek a Golden Mean between the extremes of doing too much or feeling too strongly and doing too little or weakly. This idea works relatively well in threatening situations: we should have moral courage instead of being rash (too much action, too little fear) or timid (too little action, too much fear). It does not, however, provide a straightforward guide for political choices. A care-ethical interpretation might be more promising. This insists that we identify and recognize vulnerable groups and cherish special relationships. Taking these into account in public as well as in private decision-making would prompt us to protect groups that are in particular danger. Since older people and people with disabilities are under specific threat, care ethicists could join forces with human rights lawyers to criticize Uusimaa province's isolation.

Different opinions of various thinkers

Alexandra, Dunham, and Casey believe that the Coronavirus disease 2019 pandemic has been an unprecedented challenge to healthcare systems and clinicians around the globe. As the virus has spread, critical questions arose about how to best deliver health care in emergencies where material and personnel resources become scarce. Clinicians who excel at caring for the individual patient at the bedside are now being reoriented into a system where they are asked to see the collective public as their responsibility. As such, the clinical ethics clinicians are used to practicing are being modified by a public health ethics framework defined by the presence of a global pandemic.

Humanitarian crises and emergencies, often marked by high mortality, have until recently excluded palliative care—a specialty focusing on supporting people with severe or terminal illnesses or those nearing death. During the COVID-19 pandemic, palliative care has received unprecedented societal attention. Unfortunately, this has not been enough to prevent patients from dying alone, relatives unable to say goodbye, and palliative care being used instead of intensive care due to resource limitations.

The care framework has shifted from everyday care to pandemic care, prioritizing public health over individual patients and maximizing the good for all in the healthcare system. Orthopedic surgeons must adapt and cope with difficult ethical questions that cause moral distress as systemic restraints prevent us from providing the care that we feel would be optimal. Peter, Randy, and Casey believe that institutions and states develop and enforce guidelines to avoid individual surgeons having to make these tough decisions alone.

Vijayaprasad believes that the SARS-CoV-2 pandemic has exposed the acute vulnerability of countries' health systems worldwide. While countries are scrambling to contain the spread of the infection, the focus is mainly on prevention strategies such as isolation, quarantine, physical distancing, hand hygiene, cough etiquette, and country-wide lockdown. Ethical concerns arise in the context of public health interventions. However, while focusing on the forest, the individuals suffer the illness. The critical argument is for countries to mainstream clinical ethics considerations for the care of patients with Covid-19 as well as "non-Covid-19".

During a pandemic, Paul, Heather, and Anna say that narrowing ethics into silos such as clinical and public health does not help the cause of ethics, which often gets neglected in desperate times. Keeping medical ethics at the center of our response to the Covid-19 pandemic would benefit healthcare systems at all levels. This would also help us be prepared for future pandemics. Strengthening healthcare systems would also provide an opportunity to improve non-covid care.

Amy, Mark, Daniel, and Reshma are of the view that the ethical challenge which covid-19 has also risen is that the healthcare systems might need to ration scarce critical care resources. Rationing policies for pandemics differ by institutions, health systems, and applicable laws.

Julian, Ingmar, and Dominic say no egalitarians are in a pandemic. The scale of the challenge for health systems and public policy means there is an unavoidable need to prioritize the needs of the many. It is impossible to treat all citizens equally, and a failure to carefully consider the consequences of actions could lead to massive preventable loss of life. In a pandemic, there is a solid ethical need to consider how to do the best. Utilitarianism is an effective moral action expected to produce the greatest good.

Conclusion

Individual protective measures during disasters depend on cooperative, synergistic group activity, just as collective existence depends on individual survival. During a pandemic or natural disaster, no one can only defend herself. Every protective or preventative measure requires a collaborative approach, even if it limits individual freedom to some extent, especially if that freedom threatens the group's well-being. While each pandemic has its unique characteristics, recent decades have shown that there are predictable issues regarding the use of public health measures, the scope, and limits of the duty to care for healthcare workers, setting priorities

for the allocation of resources, global governance, and research ethics. So, it may be said that biomedical plays a vital role during the pandemic. The doctors, nurses, and other hospital workers and non-workers also remain far away from their families to care for the general public. Besides that positive factors, it also have drawbacks that can not be neglected.

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