Healthcare workers in an Indian state and their top of the range ethical dilemmas in COVID-19: Perspectives of a practitioner and student of public health

Suganya Barani

Affiliation: India FETP, ICMR-National Institute of Epidemiology

E-mail:suganya.desmart@gmail.com

Abstract:

India, a conglomeration of different states with unique health care systems must deal with the new threat of COVID-19, an emergency which probably no one alive now has a previous experience with. Health care workers who are at the centre of this whirlpool are under tremendous pressure to put on their PPE and mask all their fear, anxiety and uncertainty underneath. In the course of the pandemic, a state in India witnesses threatening attacks on doctors and their dead bodies. Logistics do not go hand in hand with ethics. It is a state’s ultimate priority to protect their health workers and keep them away from worrying about all their dutiful dilemmas especially ethics.

A patient with Acute Respiratory Distress Syndrome require 15-20 days of prolonged intubation and mechanical ventilation, with several hours in prone position and a very patient and prolonged weaning process(1).This is in a common scenario in any hospital with ventilator and ICU setting. The system becomes stretched on receiving ARDS cases due to Covid-19 in gushing numbers with a threatening secondary attack rate, unpredictable clinical course and outcomes. Mathematical models have predicted figures for estimated percentages of hospitalisation among infections and those who will require ventilation support among the infected (2).

In a source constrained setting and increasing reports of hierarchical PPE distribution, the moral and ethical considerations of a health care worker is highly shaken. Among health care workers, airborne transmission is also expected for those working in aerosol settings like mechanical ventilation, nebulisation, providing CPR, Endotracheal intubation and placing a patient in prone position(3).

Ethics takes a beat and bruise when fair allocation of resources is not possible with scarce health goods and services. The government reassures the adequacy of personal protective equipment in repeated press releases with soaring numbers of N95 masks procurement, as a parallel news column reads shipment of masks to Serbia from India. The ground scenario speaks a different story. Junior doctors and nurses are allowed to treat covid-19 patients in isolation wards and senior residents stay away from making even ward rounds. Italy called for and recruited retired doctors to see one by one succumbing to the disease; there will be one less blame on the government of this country when the mortality among senior doctors is not much seen in our setting. It is worrisome to see young soldiers die in a battle as the older ones receive laurels for winning it. In COVID-19 battle, unfortunately, morbidity and mortality is seen even among the younger population including health care workers.

After lessons from the first respondents of COVID-19 pandemic, international discussions revolve around mobilising scarce resources like equipment, personal protective equipment, ventilators etc. to regions where health system’s capacity is strained(4)*.* The scarcity mitigation standards are ridiculed at the outset in our settings as we see government officials of a sub-registrar office in a district wearing protective equipment which is not even a uniform sight as yet in all Covid-19 hospitals of the state. Ethical allocation of resources does not even take a back seat but travels in a different car altogether.

Doctors and nurses are worried about getting infected and carrying the infection back home to their families and to those they come in close contact with. Social distancing is questionable and senseless in health care sector in the absence of personal protection equipment. Imagine a nurse, an ICU technician, an anaesthetist practising social distancing when in an emergency intubating a patient who is on the verge of collapsing; all in the absence of PPE. Hazmat space suits are out of the debate in a country like India. Health workers expect minimum protection to all involved in a complex process as one of treating a covid-19 positive patient or any patient who is a potential case but not tested and confirmed. Although ICMR guidelines have directed testing of symptomatic health care workers, testing was not done and even adequate quarantine period of 14 days was not ensured.

A doctor who dies after his struggle with COVID-19 is not allowed to rest in peace in the crematory. Local residents protest to not cremate his mortal remains. The hospital workers of the private hospital leave the dead body outside the crematory and flee their way back. The local residents even took turn duties at the night to not let the cremation happen. Two such incidents happened for COVID positive deaths in doctors. This trend is disturbing the morale among doctors. Doctors can be seen getting frustrated and venting out in social media. A doctor who is listening to this news from COVID-19 ward duty thinks if he has to continue working there knowing perhaps that due to his ill fate, his mortal remains will also end up alone. These points to the lacuna in communication, the sensitisation to people about the level of transmission risk of COVID-19 from a dead body. This brings us to the next important question; whether the state was over confident that deaths due to COVID-19 are not going to happen or it is in no way going to affect processes with regard to stigmatisation.

Ethics clashes with logistics. Ethics is unknown or incomprehensible to majority of the people including the health care workers, administrators let alone expecting it out of a common man. Ethics poses challenges. A district administrator sends message across social media quoting, “whoever got treated by (naming) doctor A from this hospital has to report to this unit and get tested for COVID-19”. A local body administration mikes around the locality calling people to come forward and report if they had taken treatment from this Doctor(with name and clinic details).

*How the state should respond?*

Urgently needed resources have to be purchased in anticipation of the impending need and have to be rationed judiciously. The importance of transparency in decision making and delineating for the public about the transmission dynamics should be done on priority basis. Rather than announcing numbers everyday like a scoreboard, it is the state’s imperative to announce details of hotspots such as particular districts which needs to pay more attention, containment plans, ways of contact tracing etc. This has to be done well within the ethical standards ensuring individual autonomy as a priority especially when this threatens even the last rights after a person’s death. A large territorial area with well expanded trade and business population, a fair population being educated according to the country’s indices, flourishing economy and a very strong headed population are reluctant to the feeble instructions from the government that the virus is here and refuse to learn lessons from the beginners. It is at a loss of words how the virus is transcending and gripping along in a multitude of places, regions and countries and ethical dilemmas have just taken a hit with many health care workers than it usually does.

References

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