Dr Peter Piot is a Belgian virologist. He was one of the discoverers of the Ebola virus. At his current age of 71, he had spent decades working on HIV/AIDS and is a special advisor to European Commission President Ursula von der Leyen.

And he got COVID 19. In an interview, much of what he talks about is not the virus; it is about what he experienced[[1]](#endnote-1).

“On 19 March, I suddenly had a high fever and a stabbing headache. My skull and hair felt very painful, which was bizarre” he says. “It turned out I had severe oxygen deficiency…. I was concerned I would be put on a ventilator immediately because I had seen publications showing it increases your chance of dying…. At home, I cried for a long time. I also slept badly for a while…. I realize this one will change my life, despite the confrontational experiences I’ve had with viruses before. I feel more vulnerable”.

What Dr Piot describes is suffering. The pain, the breathlessness, the fear, the loneliness.

But health care systems round the world ignore suffering. They have responded to COVID 19 in the disease-focused way that is familiar to it – with the measures of prevention (lock-down, social distancing, quarantine of the affected and suspected, diagnosis (testing as many as possible for early detection) and treatment aimed at organ dysfunction, as it does not know of a cure. Rightly so; the disease needs attention; the virus needs attention. But it is unethical to forget the human being and to ignore suffering. Too little is discussed and done about preventing, identifying and managing the symptom burden, the psycho-social consequences of isolation, the post-traumatic stress disorder or the pathological grief of the bereaved, from whom their loved one was snatched away in an instant, sometimes never to be seen again, denied the rituals that are important in their belief systems and not infrequently, even one last look at the body.

What indeed is the duty of care of the healthcare provider? According to the Indian Council of Medical Research, it is to “mitigate suffering. It is to cure sometimes, relieve often and comfort always. There exists no exception to this rule[[2]](#endnote-2)”.

The suffering in COVID-19 is caused both by the disease and by social and governmental reactions to it like the lockdown.

On the physical domain, symptoms can be mild flu-like feeling for some and for others, intense suffering that they have never known. For those with serious illness, as it progresses, often lungs get affected causing breathlessness. Intense breathlessness is one of the most difficult symptoms to bear - the feeling that one is unable to take enough air leads to compounding that agony by the feeling, “Am I going to die without being able to take in any air?”. As the disease advances, many people get delirious. Ordinarily, delirium is not taken seriously by those around the patient. But the abnormal feeling that causes can be hard to bear especially when one gets hallucination. How can one get a moment of peace when one is afraid of demons waiting around, ready to attack any moment, or when the nurse who walks towards one seems to have fangs and to carry a lethal weapon?

We of the medical system are best at treating what we can see clearly on an imaging screen and those that can be excised, burnt or chemically destroyed. We tend to ignore what we cannot identify the cause of, like delirium, restlessness or agitation and for breathlessness. The current thinking would be to keep looking at a machine that will measure the oxygen in the blood, and if it falls dangerously low, to insert a tube of about 1 cm diameter down your windpipe - one of the most sensitive parts of your body.

As an intensivist of the past, I have been told what it feels like to have an endotracheal tube down the throat. A doctor who felt it for about five minutes said that it was the worst experience in his life. If the tube is kept inside for any length of time, it will be necessary to insert a catheter down it deep into your respiratory passages to suck out mucus. A doctor describes the experience of a young man who went through such repeated endotracheal suction and found the experience so traumatising that he started panicking uncontrollably whenever he saw a nurse approaching. “Every now and then he would have sudden stabs of intense sharp pain down his chest, and frequently a sensation of something hitting his innards which he later identified as suctioning of his trachea. This process went on being repeated and he got to such a state that the very sight of an approaching nurse filled him with panic. Desperately and repeatedly he asked whether there were any alternatives for suctioning. Then he lost control over himself and tried to pull out the tubes out so that the staff then bound both his arms and feet which worsened his fear and suffering[[3]](#endnote-3).”

In the coming days, weeks and months, many poor people would get Covid19. It is only to be expected that with the relaxation of the lockdown and community spread, the number will increase first before eventually dropping. Everyone who gets the disease will need palliative care. The majority will recover but during course of the illness, they need palliative care integrated with Covid19 treatment. The experience of having fever, the strange pain all over the body (even in the skull and hair as Dr Piot described) all need to be treated effectively. The breathlessness should be treated not only with oxygen but also with appropriate medication which would include controlled medicines. For those who are on ventilators, adequate pain management and sedation are all important*.* Westernintensive care units usually have satisfactory sedation protocols that cannot possibly relieve the discomfort completely but does reduce the suffering. Adequate sedation protocols are practiced only in a minority of hospitals in India. And it would be practiced even less as intensive care units and ventilators will have to be managed by less experienced staff in the face of the looming crisis.

Governments and health systems are eventually likely to face another problem too. Let us assume that in every state we had enough ventilators to handle the routine needs. Even while COVID treatment is going on, they are still needed for other diseases. Even if a significant percentage of them can be made available for treating people with Covid19, it is still likely that there may not be enough. We have evidence already that once they go on a ventilator with Covid19, only a minority will survive. The figures published from New York on the 23rd of April point to a possible survival of 11.9%. This is unlikely to be the final word; let us certainly hope that the success rate will be much higher. Nevertheless; it is going to be the minority who will pull through; not the majority. As age advances, especially with comorbidities like diabetes, heart, lung, liver or kidney disease, the chance of success drops even lower.

In the presence of crisis, it is inevitable that many human rights like freedom of movement will be curtailed both in the interest of safety of the individual as well as *for the greater common good*; but when basic ethics are violated needlessly, questions need to be asked. The person with Covid has his autonomy violated when he is isolated against his will. This is understandable. But when his windpipe is intubated without his permission, thus causing intense suffering with only a tiny possibility of survival, that violates the fundamental ethical principle of autonomy in an extreme way. Two other ethical principles that are violated in futile artificial life-support measures are beneficence (doing good) and non-maleficence (not doing harm). The primary duty of care of the health care provider is “to mitigate suffering”. As the Indian Council of Medical Research points out, there exists no exception to this rule”. It is to cure sometimes, relieve often and to comfort always.

And the fourth basic ethical principle that may get violated is distributive justice. Available resources (including intensive care personnel and ventilators) will have to be used judiciously and equitably. If all patients are triaged to assess the possible benefits of survival and if in the face of the shortage of ventilators, preference is given to a young person with a good chance of survival as against an elderly with poor chance of survival “it is not ageism, but good healthcare[[4]](#endnote-4).”

I have painted a dark picture. I realize that I may be accused of spreading panic. but I believe it is necessary to face the truth. Once we face it, we are able to come with a realistic strategy to address the issues.

**The Solution**

On 19 May, the World Health Assembly resolution 73 called upon member states “to provide access to safe testing, treatment, and palliative care for COVID-19, paying particular attention to the protection of those with pre-existing health conditions, older people, and other people at risk, in particular health professionals, health workers and other relevant frontline workers[[5]](#endnote-5)”.

If we accept the primary duty of the health care system to mitigate suffering and if we accept its responsibility to abide by basic medical ethical principles even in the face of a crisis, we will need to incorporate palliative care into Covid 19 strategy at all levels (in the patient’s home, the hospital’s isolation ward or in the intensive care unit). To some extent, this happens automatically in western countries because palliative care is part of routine medical and nursing education and every nurse and doctor would be able to practice it up to a point. But modern pain management, principles of communication and end of life care have become a part of medical curriculum of the Medical Council of India only from 2019. Hence it is vitally important to provide training on these aspects to COVID-treating doctors.

In addition to empowering the medical and nursing staff to treat symptoms and making medicines available, it is important to create a system for treating psychosocial suffering. The involvement of counsellors or medical social workers in Covid19 management can help a lot. Even if the family is unable to personally visit the person, can virtual meetings not be made a routine practice? Being able to see the family on a mobile phone and being able to say “I love you” does matter more than what medical technologists can imagine. When faith-based rituals are challenged, can technology again facilitate them, for example, a last communion?

**Conclusion**:

Many unique features of COVID-19 challenge the basic fundamental ethical principles of autonomy, beneficence, non-maleficence and justice. It is important to focus on a primary duty of the health care provider to mitigate suffering. Many elements of suffering offered by COVID-19 need to be overcome with a strategy focusing on health-related suffering. Attention to symptom control can be ensured by online education of COVID-treating doctors and by making essential medicines available including controlled medicines. Much of psychosocial suffering can be lessened by equipping the healthcare providers with the required training and by recruitment and empowerment of medical social workers or counsellors and by the use of technology including mobile phones.

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