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**Title : Medical Ethics in COVID-19 Pandemic: An Indian perspective**

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**Abstract**

The COVID-19 pandemic is an unprecedented challenge to post 20th Century Medicine. The medical community has formally codified ethical conduct in the 20th century. Yet, never before has medical ethics faced the degree of challenge as it has in the last century. The pandemic has exposed these fault lines. Since pandemics are a public health challenge, the ethical errors in this pandemic management pertain to public health policy and strategies that were adopted in dealing with it. Public health management requires an effective communication and education strategy. Likewise the advances in science has also made us trust technology rather than basic principles of biology, immunity and mind-body medicine. This article, written with an Indian perspective, examines ethical issues and challenges in dealing with a deadly pandemic in the new world of technology and information overload.

**Medical Ethics in the COVID-19 Pandemic:**

**An Indian perspective**

The COVID-19 pandemic, has indeed raised a lot of ethical questions vis-a-vis the medical fraternity in India. These pertain to our ethical duty to both the individual as well as to society. There, of course, has been a stellar performance of those medical professionals, who plunged headlong into COVID duty. However, in my opinion, as a profession, we did not provide guidance to our government, to evolve a public health policy that was ethical. Let us examine the ethical issues in our handling of the COVID-19 pandemic.

The four pillars of ethics are non-maleficence, beneficence, justice and autonomy. The practice of ethics needs us to balance the relative value of each, in different situations when there is a conflict between these principles. It is my personal view that, ethics is not just being good; it is being smart. Ethics is an implied social contract between members of the society, to ensure that maximum good to maximum people is possible when a long term perspective is taken. Thus ethics is not just fairness and love but it is self-interest and wisdom. Likewise, there is a sharp rise in the demand of medical resources during pandemics which accentuates ethical concerns around distributive justice. There are four alternative approaches to distributive justice: Libertarian, Utilitarian, Egalitarian and the Restorative approach **(1)**. The utilitarian and egalitarian usually are considered fairer, as neither the rich, nor the poor, are at a disadvantage when these principles are applied.

When we look at our actions in this pandemic, and examine if it has achieved the greatest common good by the most equitable way, we find that we have committed a public health ethical blunder. We allowed the creation of a medical ethical disaster, by simply standing and watching the government and the media hijack the narrative, to the detriment of the society. Medical ethicists did not use their sphere of influence to advise the Government and direct a response which is ethical and practical. They failed to provide the right expert counsel to the Government when it came to health policy. Alternatively they did not muster their clout enough to have their voice heard. The medical profession is thus complicit in ushering in another pandemic; a pandemic of fear and irrationality.

**Ethical error 1:** Not balancing benefits v/s risk; beneficence (protection from infection) v/s non-maleficence ;( not promoting fear)

We failed to correct the messaging of fear. We failed in our messaging as public health specialists. Public good, (beneficence) required the public to know about the seriousness of the pandemic. But, we unwittingly created fear (maleficence). Fear is known to adversely affect immunity; and immunity is our best defence in most viral infections.

Fear is a powerful primal emotion. Our experience with human behaviour should have alerted us to the possibility of fear snowballing into paranoia. Paranoia leads to ostracism. Fear of ostracism leads to illness concealment. In the already disadvantaged sections of the society fear of ostracism pushes them to desperation. This could explain the unfortunate incidents of violence against doctors in areas of a lower socio-economic status. All of these complicate management of any epidemic.

**Ethical Error 2:** Autonomy, Beneficence and Justice v/s Non-Maleficence: We failed to promote family care and home care for the asymptomatic and mildly symptomatic COVID patients. We failed to estimate that no health care system can be effective without adequate human resource. A country like India does not have tertiary care to care for all patients affected in a pandemic such as COVID-19. However, the physician to patient ratio in India is approaching the recommended WHO ratio of 1:1000**. (2)** Thus, it was required in India, that the mild cases should have been managed at home. This was not implemented in the first wave in India, since we were unwilling to risk transmission of infection (non-maleficence for the healthy). But this deprived the patient, the autonomy of choosing his place of care and the benefit of the care of one’s near and dear ones. It overburdened the health care workers. Thus, we unwittingly caused harm to seriously ill patients in need of care, and to the overburdened health care workers. We eventually realized this and allowed home quarantine for mild cases; but the messaging of fear had already got amplified. This at least partly explains the frenzied demand for hospital beds.

**Ethical error 3**: Beneficence for the patient’s family V/s non-maleficence to members of the society. Families with a sick member need support physically, financially and emotionally. Instead, they got ostracism from the community. Lack of social support would certainly add to the physical challenges of caring for a sick. Keeping the house clean, keeping up the morale, helping with buying essentials and getting food on the table require some support especially in a nuclear family with small children. Often many members of a family could get affected, and this could pose a greater challenge in self-care. Maid servants and other help were also out of the question. If the earning member is sick, then there are financial challenges too. We can well imagine the plight of the elderly staying by themselves. Equally, anybody staying alone would always dread the fate of falling ill, with the prospect of no neighbour willing to help .We did not spread the message of social support for the families of the sick; later however , we tried some correction; too little, too late.

**Ethical error 4:** Abjuring beneficence: failing to counter misinformation. We did not counter rumours and scientific myths effectively. Some of the myths that were eventually dispelled include the need to wash vegetables with vinegar, salt and sodium bicarbonate, before cooking. **(3)** Likewise the need to disinfect sundry items including currency notes in ultraviolet light, the need for a bath every time you return back after stepping out were other such myths. The myth of transmission by dead bodies still survives. It seems difficult to believe that dead bodies will continue to generate aerosols or ooze COVID 19 viruses on the body surfaces. Yet we generated, powerful images of bodies packed in the anonymity of a plastic bag, disposed of as if they are ticking time bombs. The prospect of an unsung, unceremonious exit can be depressing both to a patient and to a patient’s relative. This further amplified the fear into terror of the disease. We almost made science a religion and went back to the days of witchdoctors.

**Ethical error 5**: Ethics of providing the right counsel: the ethics of an evidence based approach.

No questions are being asked about the knee-jerk medical reaction to recommend the use of ventilators, remdesivir, hydroxychloroquine, tocilizumab. None of these were evidence based; they were either empirically used or were an educated, reasoned choices. We inadvertently, mentally anguished patients, who thought they were dying because the correct standard of care was either in short supply or was not affordable. In hindsight, many of these measures might have even been counterproductive. We must admit that such lack of evidence can assail even other aspects of COVID-19 pandemic management including personal protection protocol or even public health advisories. It is nobody’s case that we must not experiment with medicines in course of managing an infection especially when it is caused by a new microorganism. But, advisories are often spewed by experts who profess the assurance of a religious leader recommending a ritual to provide protection against various ills. This causes false hope and needless despair in patients.

**Ethical Error 6:** Beneficence, Justice and Autonomy of accessing private medical care v/s non-maleficence of risk of community spread of infection. Also the right to dignity and practise a profession to add meaning to life was compromised for the medical professionals.

We did not caution the government against shutting down all other health care facilities including family medical clinics. We are now discussing the importance of a triage to optimize utilization of medical resources in COVID-19, during the second wave**. (4)** The family physicians could have been and should have been pressed in for this role from the beginning. Whatever the risks, private medical practitioners, especially, the family doctor, is an important ally for health education and emergency care and sometimes simple reassurance. The messaging of fear was overplayed to the point where medical professionals were unwilling to sign up for COVID duty. Clinics remained shut or open for limited hours, in the time when the medical profession was needed the most. We seemed to have forgotten that medical professionals have been routinely taking these risks since time immemorial .The study of microbial disease has been possible, only because a lot of courageous doctors and scientists have researched and treated diseases like small pox and rabies in the past. How would medical science have progressed, if people were so terrified of tuberculosis and leprosy? The personal protection practised by medical professionals in outpatient departments, has always been abysmal in India. This is even worse in primary health care centres and rural centres. Yet we seem to consider the risk of infection seriously only for COVID, when we have been risking MDR TB all these years.

The fear of COVID-19, had been played out so strongly, that the medical profession itself, swallowed the idea. The government order for closure of clinics, further bolstered the fear in medical practitioners. An idle mind is a devil’s workshop. Serving and caring, reduce time to spend in fear. Shutting down clinics allowed the medical professionals to combine inertia and fear to become petrified to resume their practice. This lead to a situation, where most private practitioners refused to sign up for COVID duty when called upon by the Government. The Medical Council had to issue a stern warning to obtain a grudging compliance. Thus fear, destroyed the moral fabric, among many doctors.

As a corollary the Health Care Workers (HCW) on COVID duty were overworked. At least a part of the medical work force in COVID centres succumbed to not just COVID-19, but to a lethal combination of fear of this new disease, fatigue and hopelessness of a long drawn battle with no end in sight and a despair that reinforcements and relievers would never arrive.

**Ethical Error 7:** Beneficence of care to patients V/s non-maleficence of risk to treating HCW. Were the doctors provided adequate personal protection and did not the Health care Workers owe it to themselves to ensure their own personal safety?

This was a very pressing dilemma but an overrated one. Personal Protection Protocol recommended was empirical and perhaps leaned on the side of caution. But there was no definite knowledge of the need and effectiveness of the said protocol. It was the need of the hour, to innovate and simplify the protocol keeping local realities in mind. We created fear and anguish in the minds of the HCW without adequate evidence.

Health care workers have handled pandemics in the past. The Plague , The Spanish Flu , and small pox, have all been handled without awareness or access to this degree of personal protection .Those were the times we knew less about transmission of infections and medical science did not have an armamentarium of antimicrobial drugs . Likewise personal protection was hardly known of, in those days. Even today, many such facilities are not available in developing countries in rural settings, where healthcare workers treat the ill with minimum facilities. Most general medical practitioners have not been routinely wearing masks even in urban centres. This one disease magnified risks that the medical profession in India has been routinely courting.

Further, this was the risk that we accepted to be a part of this noble profession of alleviating human suffering. Even the best personal protection equipment and protocol does not guarantee protection. If a doctor hesitates in the face of infection, he would not be true to his profession. Soldiers should have the best bullet proof vests and guns and night vision goggles, but they must fight without it, if required. Those are the legends of professionalism. Many doctors did us proud by doing so.

**Ethical Error 8:** Not modifying personal protection protocols for the Indian setting. All protocols are to be tweaked from a local perspective. The mode of transmission of all types of influenza is similar. Influenza is a major cause of death in many western countries. Is the protocol for managing all patients with other types of flu as stringent? There always have been differences, all these years, between cross-infection measures practised in outpatient care as well as in-patient care in India, as against the practices in USA. We needed to plan for something innovative, which was indigenized and yet in keeping with the principles of microbiology and transmission,

Disposables are not suited to Indian health economics. Neither is it suited to Indian health logistics, considering the number of patients that we cater to. Disposables are also often a bane for the environment. We promoted disposables and plastics leading to an enormous environmental cost without evidence of the need for such a stringent protocol. Our health economics should have lead us to promote, where possible, the use of reusable items with suitable disinfection and sterilization. We had a unique opportunity to show the world a more responsible way to protect ourselves, with a minimal impact on the environment.

**Ethical Error 9**: We not only did not advise against a Lockdown, we actually promoted it as a means to control the pandemic, without evidence of its effectiveness; a recipe for an economic disaster. Countries that have enforced a strict lockdown like India have not fared better in Pandemic control than Pakistan and Bangladesh in the subcontinent which had a less stringent lockdown**. (5)** Likewise, Sweden without lockdown, does not have worse figures than neighbouring Italy with Lockdown**. (5, 6)** There is not just an economic cost to a lockdown; there is a psychological and spiritual cost too.

**Lessons to be by learnt for future Pandemics**:

1. Fear promotes concealment of disease.
2. Do not spread fear, preach courage.
3. Never forget fundamentals of biology and microbiology while formulating advisory to the public and professionals.
4. Issue health advisories that are practical for the long term. It can be tweaked if necessary to become increasingly stringent, as data emerges.
5. Strengthening of cross-infection control in the care of the infected must be incrementally implemented and must be practical.
6. Modify international advisory to the practical aspects of local reality of facilities and training.
7. Health promotions must be promoted and repeated as a collective responsibility ; we did do it well
8. We must never allow things to reach a stage of naming and shaming, fining and punishing for non-compliance of public health measures advocated, except for wilful disobedience. Patience is a virtue in times of stress.
9. Do not shut dispensaries , private medical practitioners, especially family doctor is an important ally for health education and emergency care and sometimes simple reassurance
10. Engage with the Media and Social media and dispel misconceptions.
11. Formulate a policy on how much isolation is socially possible and how to balance patient right to dignity with potential infection of family members.
12. The society and neighbours must never abandon the family of a sick member. Promote methods, for neighbours to safely help such families, despite the potential to contract infections.
13. Isolation of sick must allow family members to care for the sick. The bond of family and friends is therapeutic and an immune booster. Care can be provided with a mix of suitable barrier protection and distance maintained.
14. Fear of isolation and abandonment can destroy the morale of a sick patient. A dignified farewell on death must not be denied. It brings peace to the dying patient and the family of the patient in traumatic times.
15. We must define early, how infective is a dead body, and how to make it less infective, to ensure that traditional rites can be performed
16. Never lockdown .We need volunteers , the society and doctors to jointly fight the pandemic ; we need all hands on the deck in an emergency
17. Educate and update people on positive developments and convey hope in the most realistic way.
18. Work is Worship. Idle mind is a devil’s workshop. Never Lockdown. The poorest are hit the most.

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