Reflections on COVID-19 and the ethical issues for healthcare providers

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Abstract

Purpose – Healthcare governance places medical ethics at the forefront of defining and maintaining the quality of care. Examples of serious ethical issues include sexual abuse of patients (Dubois, Walsh, Chibnall *et al.*, 2017), criminal prescription of opioids (Johnson, 2019) and unnecessary surgical procedures (Tayade and Dalvi, 2016) or shortages in service delivery because of little knowledge or experience especially during pandemic outbreaks (Hay-David *et al.*, 2020). In many cases involving medical ethics, patients are identified as the first victims; however, this study aimed to consider clinicians and other healthcare practitioners as other probable victims (Ozeke *et al.*, 2019).

Design/methodology/approach – The World Health Organization (WHO) estimates that tens of millions of patients worldwide suffer disabling injuries or death every year due to unsafe medical practices and services. Nearly, one in ten patients is harmed due to preventable causes while receiving health care in well-funded and technologically advanced hospital settings (WHO, 2016). Much less is known about the burden of unsafe care in non-hospital settings, where most healthcare services are delivered (Jha *et al.*, 2013). Furthermore, there is little evidence concerning the burden of unsafe care in developing countries, where the risk of harm to patients is likely to be greater, due to limitations in infrastructure, technologies and human resources (Elmontsri *et al.*, 2018).

Findings – While these problems are endemic in health care, they are exacerbated in times of health and social crises such as the coronavirus disease of 2019 (COVID-19) pandemic. This pandemic has few precedents, being most closely paralleled with the global influenza pandemic of 1918 (Terry, 2020). Initially compared to the severe acute respiratory syndrome (SARS) outbreak of 2002–2003 (Parrym, 2003), COVID-19 is already proving much more deadly. The WHO's estimates of the number of SARS cases from the start of the outbreak in 2002, until it was brought under control in July 2003, was 8,437 cumulative cases, with 813 deaths (WHO, 2003). The European Center for disease prevention and Control estimated that as of May 15, 2020, that 4,405,680 cases of COVID-19 have been reported with 302,115 deaths (ECDC, 2020)

Research limitations/implications – The outbreak of COVID-19 was declared in February 2020 in the Islamic Republic of Iran, and up to March 2020, the cases of morbidity reached 12,729, with 611 deaths (Bedasht, 2020). The current figure at the time of editing (May 16, 2020) is 118,392 cases, with 6,937 deaths (Worldometer, 2020). Acting in cognizance of its ethical responsibility to the citizens of Iran, the Iranian government has taken the following action to attempt to mitigate the deleterious effects of the virus: in each province, one or more hospitals have been evacuated and allocated to patients with pulmonary problems with suspected to COVID-19. Access to intensive care units and specialist equipment is a primary ethical issue that concerns the Iranian healthcare system. The issue is exacerbated by the knowledge that these facilities are not distributed equitably in the country. Therefore, equity is the first ethical concern in this situation.

Practical implications – All nurses, clinicians, practitioners and specialists have been asked to volunteer their services in hospitals in the most infected areas. This raises ethical concerns about access to personal

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protective equipment (PPE) such as appropriate masks, gowns, gloves and other equipment to protect healthcare workers from infection. Access to PPE was restricted because of government failure to stockpile the necessary amount of disposable medical equipment. This was related to lack of domestic capacity to produce the equipment and problems accessing it internationally due to political-economic sanctions that were imposed on Iran by the USA and some European countries. Such shortages can quickly lead to a catastrophic situation; current evidence demonstrates that about 40% of healthcare workers are vulnerable to the COVID-19 infection (Behdasht, 2020). However, it should be noted that this is not a problem limited to Iran. As of March 2020, the WHO was already warning about PPE shortages and the dangers this posed for healthcare workers around the world (WHO, 2020).

Social implications – A Disaster Committee was created by the Iranian Ministry of Health to take responsibility for decision-making and daily information sharing to the community. The ethical dilemma that arises in terms of reporting the situation is the conflict between transparently presenting accurate and timely information and the creation of public panic and fear that this may cause in the community.

Originality/value – As a steward for public health, the Ministry of Health was afforded direct responsibility to maintain intra-sector relationships and leadership with other organizations such as political executive organizations, municipalities, military agencies, schools, universities and other public organizations to reach consensus on the best methods of controlling the COVID-19 outbreak. An important ethical issue is found in potential areas of conflict between the therapeutic and preventive roles of the Ministry of Health and those related to public health and the civil administrations.

Keywords Health policy, Health economics, Ethics

Paper type Viewpoint

Healthcare governance places medical ethics at the forefront of defining and maintaining the quality of care. Examples of serious ethical issues include sexual abuse of patients (Dubois *et al.*, 2017), criminal prescription of opioids (Johnson, 2019) and unnecessary surgical procedures (Tayade and Dalvi, 2016) or shortages in service delivery because of little knowledge or experience, especially during pandemic outbreaks (Hay-David *et al.*, 2020). In many cases involving medical ethics, patients are identified as the first victims; however, clinicians and other healthcare practitioners may also be victims (Ozeke *et al.*, 2019).

The World Health Organization (WHO) estimates that tens of millions of patients worldwide suffer disabling injuries or death every year due to unsafe medical practices and services. Nearly, one in ten patients is harmed due to preventable causes while receiving health care in well-funded and technologically advanced hospital settings (WHO, 2016). Much less is known about the burden of unsafe care in non-hospital settings, where most healthcare services are delivered (Jha *et al.*, 2013). Furthermore, there is little evidence concerning the burden of unsafe care in developing countries, where the risk of harm to patients is likely to be greater, due to limitations in infrastructure, technologies and human resources (Elmontsri *et al.*, 2018).

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the Iranian government has taken the following action to attempt to mitigate the deleterious effects of the virus:

(1) In each province, one or more hospitals have been evacuated and allocated to patients with pulmonary problems with suspected to COVID-19. Access to intensive care units and specialist equipment is a primary ethical issue that concerns the Iranian healthcare system. The issue is exacerbated by the knowledge that these facilities are not distributed equitably in the country. Therefore, equity is the first ethical concern in this situation.

(2) All nurses, clinicians, practitioners and specialists have been asked to volunteer their services in hospitals in the most infected areas. This raises ethical concerns about access to personal protective equipment (PPE) such as appropriate masks, gowns, gloves and other equipment to protect healthcare workers from infection. Access to PPE was restricted because of government failure to stockpile the necessary amount of disposable medical equipment. This was related to lack of domestic capacity to produce the equipment and problems accessing it internationally due to political-economic sanctions that were imposed on Iran by the USA and some European countries. Such shortages can quickly lead to a catastrophic situation; current evidence demonstrates that about 40% of healthcare workers are vulnerable to the COVID-19 infection (Behdasht, 2020). However, it should be noted that this is not a problem limited to Iran. As of March 2020, the WHO was already warning about PPE shortages and the dangers this posed for healthcare workers around the world (WHO, 2020).

(3) A Disaster Committee was created by the Iranian Ministry of Health to take responsibility for decision-making and daily information sharing to the community. The ethical dilemma that arises in terms of reporting the situation is the conflict between transparently presenting accurate and timely information and the creation of public panic and fear that this may cause in the community.

(4) As a steward for public health, the Ministry of Health was afforded direct responsibility to maintain intra-sector relationships and leadership with other organizations such as political executive organizations, municipalities, military agencies, schools, universities and other public organizations to reach consensus on the best methods of controlling the COVID-19 outbreak. An important ethical issue is found in potential areas of conflict between the therapeutic and preventive roles of the Ministry of Health and those related to public health and the civil administrations.

It is clear that healthcare providers and health policy makers are in the front lines in combatting the danger of COVID-19. While healthcare providers are at most risk of being infected themselves or having to make difficult decisions about rationing equipment or care, health policy makers are at risk of public condemnation if their actions fail to protect the citizens from the effects of this pandemic. It seems that in such crisis conditions, while health workers and policy makers are not the first victims of any problematic decision or shortages, they are the secondary victims of COVID-19 through both state and public accusations of failing to provide care and resources in an equitable and fair manner.

In this regard, evidence shows that part of the factors related to the induced demand are structural (Karimi *et al.*, 2015). Systematically, there is no appropriate supervision over medical interventions. As a result, physicians are free to select which services they will provide. During a crisis such as COVID-19, doctors may be influenced by community pressures to provide diagnostic tests or medications that are not clinically indicated, thus reducing supplies required in other areas or by other, more ill patients. Another factor is the

organizations in which they work. If an organization admits a large number of patients beyond its capacity and capability, physicians' and other health workers' performance may diminish due to stress, fatigue and a feeling of helplessness. It is clear that this circumstance is more severe in the COVID-19 outbreak. Again, this is not a problem unique to Iran. The Journal of the American Medical Association (JAMA) network published an article from China, the epicenter of the outbreak, indicating that health workers caring for COVID-19 patients reported symptoms of anxiety, depression insomnia and distress (Lai *et al.*, 2020).

Furthermore, the question of how healthcare policy and law should treat professional ethics is a key to many ongoing legal controversies, especially during the critical conditions surrounding COVID-19. To the extent that health policy and law can strive toward optimality in resource allocation, the social welfare impact on professional norms, including the ethic of fidelity to patients and suppression of pecuniary influences at the bedside, are important public policy matters.

Conclusion

Medical ethics pertains to a set of values that governs the doctor–patient relationship. In this regard, health systems can play an important role, especially in policy making (Nouhi *et al.*, 2019). Ethics has two sides; from the individual physician's or health worker's perspective that means providing equitable and compassionate care to patients without any judgment of their sexual orientation, religious beliefs, race or ethnic background. From a health organization management or government perspective, ethical care is the ability to access all of the requirements of delivering healthcare services (Tavana *et al.*, 2015). During global emergencies such as the corona pandemic hoarding, monopolization of staff and equipment, political blockades or trade refusals and every intentional restriction to the access of health equipment show that the global response to the COVID-19 pandemic is not sufficiently grounded in medical and humanitarian ethical principles. Greater international cohesion is required to solve what has rapidly become a global problem (Bahadori *et al.*, 2012a, c). It seems disingenuous to expect physicians and healthcare workers to observe ethical codes of behavior while suffering from limitations caused by a lack of ethics on national and international scales (Bahadori *et al.*, 2012b; Hakimzadeh *et al.*, 2014; Teymourzadeh *et al.*, 2014). Now, as more than 140 countries are engaged in the fight against this pandemic, it brings to mind a quote from Saadi, the Classical Persian poet, "Human beings are members of a whole, in creation of one essence and soul, if one member is afflicted with pain, other members uneasy will remain." Until the global family of nations begins to act for the good of all, this pain and feeling of unease cannot be eradicated. Saadi recognized this truth in the 13th century; it is not too late for us to recognize it and apply its lessons in the 21st century.

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