PUBLIC HEALTH

DOI 10.35630/2022/12/psy.ro.2

Received 14 December 2022;
Published 6 January 2023

SARS-COV 2 PANDEMIC AND THE PRINCIPLES OF MEDICAL ETHICS

Vasile Valeriu Lupu[1], Ingrith Miron[1],
Anamaria Ciubara[2]✉, Valeriu Lupu[3],
Anca Lavinia Cianga[1], Iuliana Magdalena Starcea[1]✉,
Stefan Lucian Burlea[4], Alexandru Bogdan Ciubara[2]✉,
Ancuta Lupu[1]

[1] Pediatrics, "Grigore T. Popa" University of Medicine and Pharmacy, Iasi, Romania;
[2] Faculty of Medicine and Pharmacy, "Dunarea de Jos" University of Galati, Galati, Romania;
[3] Pediatrics, Emergency County Hospital, Vaslui, Romania;
[4] Faculty of Dental Medicine, "Grigore T. Popa" University of Medicine and Pharmacy, Iasi, Romania;

✉ anamburlea@yahoo.com

ABSTRACT

During the coronavirus pandemic, it was clearly seen how vulnerable society is with its entire health and sanitary security system, how vulnerable medicine is to a biological attack (whether it was natural or manufactured in a laboratory) and how chaotically society reacts as a whole, when faced with an unknown danger.

It was quickly seen that medical science and technology have its limits and risks, that they do not always serve the cause of the suffering man, that biotechnology and genetic manipulation pose a major danger to humanity and that, for the simple reason that it is the product of human reason, always doubtful and hesitant. It has gone so far as to the principles of medical ethics were breached, whether we are talking about non-maleficence or beneficence, decision-making autonomy or nondiscriminatory attitude toward access to resources, with serious damage to the individual - medical system relationship.

Keywords: pandemic; medical ethics; doctor-patient relationship; coronavirus

The realities that the medical staff and the medical system had to face in this pandemic context, would have an extremely negative impact on the basic principles of medical ethics, which have been lasting for about 2500 years. Present since the Hippocratic era, in the form of the Hippocratic oath (which every physician takes at the beginning of his/her career even nowadays), each of the four basic principles, which form the backbone of the oath, have been taken over by modern medical ethics and extended then as elements of

morality in the field of bioethics (Altman, 2011; Callahan, 1973).

PRINCIPLES OF MEDICAL ETHICS IN TIMES OF PANDEMIC

When we discuss the ethical issues in medicine, we have to take into account the four principles that govern the ethics of the medical profession.

1. *primum non-nocere* – first, do no harm (or the principle of non-maleficence);
2. *the principle of beneficence* - to do only good for our patients;
3. the principle of *autonomy in making medical decisions* – in fact the principle of the right to decide about oneself;
4. *the principle of justice* – which means nondiscrimination in approaching the patient, meaning the respect for the patient and his/her suffering, fair access to health and its resources.

These principles must govern not only the doctor-patient relationship, but also the relationship between medical system and community because they are inter-conditioned (Sandu 2021a; 2021b). In addition to the principle of justice, we can mention the confidentiality of the medical act, the avoidance of discrimination in the provision of healthcare and, in particular, fairness in terms of the allocation and access to resources, without any visible or subliminal discrimination (Beauchamp, 2011).

Often in history, these principles have been systematically breached, most often by virtue of medical paternalism, meaning that the doctor or health authority knows best what is right for the patient, regardless of his/her will. This approach not only breaches the principles of medical ethics but also seriously undermines fundamental human rights, which may result in a genuine abuse (Maximilian, 1979).

Unfortunately, we find the same situation in what regards the approach to the coronavirus epidemic, which is still evolving in our country, when most of the principles of medical ethics have been breached (Powell et al., 2008). In this context, the doctor-patient relationship was abruptly interrupted, by limiting medical activity only to address the coronavirus infection and medical and surgical emergencies (Lupu, 2020).

The principle of not harming by using the measures taken, directly or indirectly, has been breached when many of the country's citizens have been forced to isolate themselves long enough to create major difficulties for at least two sections of the population; the elderly and children. For both categories, movement (as is well known) is essential; for the elderly - in order for them to maintain their vitality, and for children - for their development. However, beyond the somatic impact, it is the strong impact on the psyche at all ages; cloistering, stress, fear, panic, mental tension with nervous manifestations that, often, tensioned the family atmosphere and more. Anxiety, depression, neurosis are the results of such a situation, with a negative impact on both people in such situations, as well as on the family environment (McGuire et al., 2020).

The blockage of the medical system for current pathology and chronic pathology, seriously damaged the health of the vast majority of the country's population. That attitude primarily refers to the application of the principle of justice in the allocation of resources and affects the principle of nondiscrimination in that allocation (Dudzinski et al.,2020).

The segment of the population that had the misfortune to be caught in the red areas of Europe woke up, upon returning to the country, restricted in terms of their fundamental freedoms by isolation at home or institutionalized quarantine under the pretext of the epidemiological context. Without any form of consent (informed or not), positive detection by the specific test (although it has a margin of error) was and is followed by a compulsory hospitalization for isolation and treatment, regardless of whether the symptoms are present or not, initially until the sterilization, and more recently for evaluation for 48 h (Ignatie, 2020).

The person's autonomy was breached without considering the personal option, especially since the medical option (of common sense) for asymptomatic people and mild or even moderate forms, is home treatment, especially since there were already clinical observational data based on which, although the contagiousness of the virus is high, the virulence targeted only the elderly with comorbidities and comorbidities in general, regardless of age.

THE INDIVIDUAL WELL-BEING VS. COLLECTIVE WELL-BEING IN AN EPIDEMIC CONTEXT

An aggravating factor was the psychological impact of the media, which presented in unison and catastrophically, apocalyptic scenarios and comments that were rather frightening than encouraging, thus increasing daily stress. In this context, the principle of the good, so claimed for, and in the name of protecting the community, goes far beyond the individual well-being, which appears to be sacrificed for the common well-being, and everything seems to take the form of a health dictatorship (Ignatie, 2020).

The well-being, not only was no longer an individual matter, of the person in question, but was even taken over and managed by the public order and military authority under the cover of military ordinances. The application of this principle no longer belongs to the direct relationship, a doctor - patient, which becomes one with an adverse tone, or to the community - medical system relationship, which also becomes aversive, and moreover, calls into question both the ethical and deontological aspect in healthcare activity (Fairchild et al., 2020).

This well-being is all the more difficult to understand, as individual well-being does not always coincide with the collective well-being. It is difficult to explain to a patient that his/her hospitalization is for his/her own benefit or for that of the community, as long as he/she is completely asymptomatic or has minor symptoms, as was the case with more than 80% of those infected. Because the magnitude of the inflammatory process, in the end, translates into a form of disease the manifestation of which will depend on the biological background of the individual (limited or not), depending on the comorbidities he/she may have, on his/her ability to react to biological aggression, finally realizing the individual perception of the disease. Hence, the individual variability of clinical manifestations, which for an individual means a light form and for another may mean a medium or severe form and vice versa (Lupu, 2020).

As for contagion, it can be limited by following some recommendations, because, however, we are not a third-world country and we have the example of some countries that have successfully applied this procedure. Then, we must not lose sight of the fact that the absolutization of some symptoms, such as fever highlighted by thermal scanning, is subject to errors for the simple reason that its origin has an extremely wide range of causes, therefore has a low specificity. This widespread method of detection, applied as in the livestock sector and imposed by the authorities, goes far beyond the principle of autonomy (personhood) and creates a state of insecurity, in addition to deeply harming the privacy and dignity of the person (Callahan, 1973).

All that remains is for a person to present, accidentally or motivated, a temperature of 37.5 to be forcibly extracted, interrogated and subjected to procedures and humiliations that contravene to the fundamental rights and freedoms. So, the reaction of the person and of the community in terms of the observance of the ethical principles, is fully justified because one thing is the recommendation and information and another thing is the obligation to impose rules that, often, prove to be unfounded, arbitrary, disproportionate and even counterproductive (Warren, 2020). Here is a matter of trust in authorities which proved to be very low. However, we shall not repeat the issue of the last principle, that of justice in addressing the problems of patient's health and resource management. Here the issue is the equity in terms of access to health services, allocation and proper use of material resources (Dudzinski et al., 2020).

As long as the public health system is deliberately blocked, being strictly oriented toward a single condition, be it known or unknown, endemic, epidemic, or pandemic, a serious discrimination for the population affected by other pathologies occurs, starting from the current to the chronic one, the approach of which was limited only to resolving emergencies. It is difficult to explain the blockade of the 119,000 hospital beds for almost three months, for the hospitalization of 20,000 patients, half of them asymptomatic, while in the same period several hundred thousand patients with real medical problems could have been hospitalized (Lupu, 2020). In such situation a question could arise, where the human solidarity claimed by authorities is?

A discrimination occurs, both in terms of resource allocation and in terms of access to health services. A correct assessment of these issues, especially in terms of consequences, will have to be made, as it is not permissible to sacrifice a segment of the population because the excitement and fear of the moment apparently require the meeting of other priorities [10].

THE DOCTOR-PATIENT RELATIONSHIP IN AN EPIDEMIC CONTEXT

The doctor him/herself, as well as his/her practice or the unit in which he/she works, suddenly became a possible source of contamination, and therefore, in the collective mind the perception that these should be avoided as they were risky was created. This perception was also accentuated by the fact that the entire medical infrastructure was (and still is) oriented toward combating this pandemic. Coincidentally, the medical network became permissive only for medical and surgical emergencies, and therefore any other activity in the specialist outpatient clinic or inpatient clinics was drastically restricted (Lupu, 2020).

The rigors imposed on the system and staff went so far that the proposed equipment, especially for the ambulance service and intensive care units, acquired a bizarre appearance (mimicking the alien aspect) and which, apart from impressing in a negative way, offers only an illusory protection to the person who wears it, and the proof is the significant percentage of illness and contamination among the medical staff working in high-risk services. I am convinced that those who have worked in high-risk areas have already been immunized, and that a serological investigation could demonstrate this (Seto, 2015).

Fortunately, children and adolescents in general were less affected, as well as the elderly, except if they had comorbidities, which is clear from the list that mentions the people who, unfortunately, died. The

explanation simply lies in the fact that, as it is an ultramicroscopic biological infrastructure, the virus knows no barrier other than its natural course and the immunity of the contaminated organism (Seto, 2015). Therefore, it was natural that any measure taken would only delay the manifestation of the disease, not to mention the suffering and discomfort it causes the infected person, both medically and as a victim of medical bureaucracy (see the actual arrests of asymptomatic people and of people with mild forms, whose hospitalization had no medical or human justification, and moreover are accompanied by the psychic effects of cloistering and the risk of nosocomial infections (Warren, 2020).

This distancing and mutual avoidance, imposed and self-imposed, would undoubtedly also affect the doctor-system-patient relationship. In this context, about what doctor-patient relationship are we talking about? However, the doctor-patient relationship would suffer another blow, already anticipated above and which will probably tend to have an institutionalized character, namely, telemedicine, as a corollary to what the Internet and social media in general offer today as medical information. It is an artifice difficult to imagine, but also more difficult to accept, because it excludes the essential part of the medical act, namely; clinical evaluation of the patient by physical examination. A serious situation from the perspective of diagnosis, because the clinical examination, corroborated with a correct anamnesis resulting from the direct and unmediated questioning, has a weight of more than 70% in establishing the diagnosis (Fairchild et al., 2020).

Undoubtedly, modern means of communication can provide elements of diagnostic guidance and formal recommendations, valid for a short time, but followed by the entry of the patient in the shortest time on the natural path of health care, with the facts assumed by this; establishing the clinical form of the disease, the stage in which it finds itself during its course, its severity, the biological background on which it evolves, the associated comorbidities, the therapeutic prescription and the daily or periodic evaluation. These aspects can only be achieved by means of a direct doctor-patient relationship, and all the others can only be helpful and momentary (Warren, 2020).

CONCLUSIONS

The SARS CoV2 pandemic surprised both the public health systems and the medical world, which proved to be completely unprepared to cope with. It can be said that the four ethical principles of medical practice at the system level have been sacrificed in their entirety.

The principle of non-maleficence; was breached by the firefighting like approach of the pandemic, forced hospitalization of asymptomatic people and restriction of fundamental human rights.

The principle of beneficence; was undermined by substituting the individual well-being for the so-called collective well-being in which: forced and discretionary quarantine, the obligation of restrictions, restraints and constraints seriously affected the social and psychological balance of the individual and of the community.

The principle of autonomy in decision-making has been abolished under the incidence of military ordinances and police measures, resulting in real abuses, sanctioned by the Ombudsman and the Constitutional Court.

The principle of justice and equity in terms of access to resources has been breached by the blocking of healthcare for pathologies other than COVID-19.

The public pressure and especially the media one, on the medical system and the staff in the system, created a real collective psychosis and even resulted in the demonization of the system as a vector of the disease or as a source of nosocomial infections.

In such situations the human solidarity and the authorities trust are seriously affected, unfortunately in a worse way.

ACKNOWLEDGEMENTS

All authors contributed equally to this article.

Paper presented at the 6th European Conference on Psychiatry and Mental Health Galatia, Galati, Romania, 23-27 March 2022

REFERENCES

1. Altman, M. (2011). *Kant and Applied Ethics.* Willey Blackwell.
2. Beauchamp, T. L. (2011). Making Principlism Practical*. Bioethics*, *25*(6), 301-303.
3. DOI: 10.1111/j.1467-8519.2011.01908.x
4. Callahan, D. (1973). Bioethics as a Discipline*. Hostly Center Studies*, *1*(1), 66-73.

DOI:10.3325/cmj.2016.57.307

5. Dudzinski, D. M., Hoisington, B. Y., & Brown, C. E. (2020). Ethics Lessons from Seattle's Early Experience With COVID-19. *American Journal of Bioethics, 20*(7), 67-74. https://doi.org/10.1080/15265161.2020.1764137
6. Fairchild, A, Gostin, L, & Bayer, R. (2020). Vexing, Veiled, and Inequitable: Social Distancing and the "Rights" Divide in the Age of COVID-19. *American Journal of Bioethics, 20*(7), 55-61.
7. Ignatie, P. S. (2020). *Mințile drill lockdown din epoca de aur al despotismului sanitar* [Drill lockdown minds from the golden age of sanitary despotism]. Episcopia Husilor [Bishopric of the Hussites]. https://episcopiahusilor.ro/mintile-drill-lockdown-din-epoca-de-aur-despotismului-sanitar
8. Lupu, V. (2020). Pandemia de coronavirus și sistemul medico-sanitar [The coronavirus pandemic and the healthcare system]. *Gazette of Vaslui*, 18.
9. Maximilian, C. (1979). *Timp și destin biologic-incursiune în evoluționismul modern* [Biological time and destiny-foray into modern evolutionism]. Romanian Encyclopedic Publishing House
10. McGuire, A. L., Aulisio, M. P., Davis, F. D., Erwin, C., Harter, T. D., Jagsi, R., Klitzman, R., Macauley, R., Racine, E., Wolf, S. M., Wynia, M., & Wolpe, P. R. (2020). COVID-19 Task Force of the Association of Bioethics Program Directors (ABPD). Ethical Challenges Arising in the COVID-19 Pandemic: An Overview from the Association of Bioethics Program Directors (ABPD) Task Force. *American Journal of Bioethics, 20*(7), 15-27. DOI: 10.1080/15265161.2020.1764138
11. Powell, T., Christ, K., & Birkhead, G. (2008). Allocation of Ventilators in a Public Health Disaster. *Disaster Medicine and Public Health Preparedness, 2*(1), 20-26. DOI: 10.1097/DMP.0b013e3181620794
12. Sandu, A. (2021a). Anxiety and frustration during the covid-19 pandemic. *Archiv Euromedica, 11*(6), 10-15. http://dx.doi.org/10.35630/2199-885X/2021/11/6.2
13. Sandu, A. (2021b). Identity changes in crisis situations. Anxiety, frustration and anguish due to the COVID-19 pandemic. *Analele Ştiinţifice ale Universităţii »Alexandru Ioan Cuza« din Iaşi. Sociologie şi Asistenţă Socială, 14*(2), 17-27. https://doi.org/10.47743/asas-2021-2-653
14. Seto, W. H. (2015). Airborne transmission and precautions: facts and myths. *Journal of Hospital Infection, 89*(4), 225-228. https://doi.org/10.1097/DMP.0b013e3181620794
15. Warren, M. (2020). *Roles for Ethicists in COVID 19 Response*. Impact Ethics. https://impactethics.ca/2020/03/18/roles-for-ethicists-in-covid-19-response/

back