

Research Article

Ethical Challenges for Patients and Healthcare Providers with the Approach to COVID-19 Context: A Review

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Abstract

Emerging diseases create ethical challenges in medical centers, so that health care providers have a moral duty to respect the rights of patients. Failure to comply with ethical principles leads to challenges and consequences that decrease patient satisfaction and reduce the quality-of-service delivery. In this review study, the published articles were retrieved using the main keywords in the databases including Medline, Web of Knowledge, Google Scholar, Scopus, and Cochrane Central Register of Controlled Trials in the Cochrane Library in 2020, and 42 articles were analyzed and reviewed. To extract the data, two researchers simultaneously reviewed and analyzed the articles. To increase the validity and reliability of the study, two researchers evaluated the quality of the articles separately. The most important challenges raised in the articles include two categories: ethical challenges of patients with emerging diseases and ethical challenges of healthcare providers with emerging diseases. It seems that in addition to dealing with the ethical needs of serving patients, dealing with issues related to the medical staff, especially the ethical aspects of their service, should also be considered.

Keywords: emerging disease, COVID-19, ethical challenges, management, health care centers

1. Introduction

Medical staff, as one of the most important providers of health services, must be aware of and respect the ethical aspects of care. With the increasing progress of medical science, the diagnosis of various diseases, the discovery of effective drugs in the treatment of incurable diseases, and the emergence of emerging diseases, the need for an ethical

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approach in medicine has become an undeniable necessity [1, 2]. The term “emerging diseases” refers to diseases that are caused by unknown new infectious agents or by known infectious agents that are geographically spread or have undergone drug resistance and are increasing in prevalence and are practically infectious diseases [3]. According to this definition, we are currently facing more than 30 emerging infectious diseases [4]. Recently, the emergence of COVID-19 disease has also been suggested as one of the deadliest emerging diseases in recent years. By the end of September 2020, more than 35 million people had been infected with COVID-19, leading to more than one million deaths worldwide certainly due to the onset of the second and even third waves of the disease in some countries [5]. Thus, the presence of such infectious diseases emphasizes developing programs to control and prevent the transmission of these infections in hospitals and the community. The Centers for Disease Control and the World Health Organization have proposed workable programs in this area, the most basic of which is the observance of standard precautions for all patients by healthcare staff, as well as the observance of necessary separation for some patients [2, 6]. To prevent the spread of these diseases, it is important to pay attention to the ethical aspects of care. When people are infected with emerging diseases, they are limited by close or distant relatives in the broader sense of society[7]. These pervasive effects on the public may be marginalized, resulting in discrimination and limited access to health services, education, and social programs, and considered risk factors for clients’ rights [8]. The medical staff, especially doctors and nurses are required to protect the client’s rights and prevent their injury, both material and immaterial [9]. As health professionals, they have a moral duty to defend their patients’ rights [10]. Nurses’ support of the patient includes actions such as informing and learning, honoring and respecting, supporting, protecting, and ensuring the continuity of care [11]. The inherent nature of nursing is respect for human rights, including cultural rights, the right to life and choice, respect for dignity, and respectful behavior [12]. Legal violations such as receiving information, education, and care increase people’s basic vulnerabilities (medical care and social services) to emerging diseases [13]. Reducing this vulnerability requires measures that enable individuals and communities to make effective choices in their lives and thus be able to control the health risks they may be exposed to [14]. Non-observance of ethics will lead to challenges and consequences that will reduce patient satisfaction and the quality-of-care delivery [15].

Another ethical issue is the safety of nursing and medical staff during a pandemic and emerging disease. From the earliest days of the COVID-19 outbreak around the world, all countries have experienced a combination of illness and death, bitter experiences

that have targeted the mental health medical staff in hospitals, causing many hospital nurses and physicians to experience burnout [16]. Hospital staff in COVID-19 referral centers are at risk for mental disturbances [17]. Isolation, anxiety, and sometimes being in uncertain economic conditions have overcome the mental health of this white-clad army and have created all kinds of mental and psychological tensions for them [18]. The medical staff is in contact with thousands of COVID-19 patients these days, and in most cases, they see the death of many clients [19]. Despite some concerns about the coronavirus and the risk of contracting it through patients suspected of having the virus, the medical staff is carrying out their mission without fear, with high morale and hope for the future that comes from work conscience [20]. However, this role is gradually associated with the exhaustion of the medical staff, the occurrence of mental disorders, and, as a result, disruption in the areas of ethics and conscience [21]. In general, it seems that in assessing the ethical challenges associated with emerging diseases, especially the COVID-19 pandemic in the present century, it will be necessary to examine the various aspects of the ethical challenges facing the medical staff, especially nurses. Therefore, as a systematic structure, it is necessary to confront and interact with the ethical challenges of patients and medical staff. What we have done in the present study was to evaluate the ethical challenges associated with patients and also the ethical challenges for nurses during emerging diseases with a final tendency to develop COVID-19 disease.

2. Methods

To find documentation related to Ethical challenges for patients and healthcare providers with the approach to COVID-19, two researchers began to deeply search the various databases of an article published including Medline, Web of knowledge, Google scholar, Scopus, and Cochrane Central Register of Controlled Trials (CENTRAL) in the Cochrane Library for all eligible studies published in a time ranged February to December 2020 by the considered keywords including: “emerging disease”, “COVID-19”, “ethical challenges”, “management”, and “health care center” based on the Mesh vocabulary. Disagreements were resolved through discussion and decided by a reviewer. No limitation was considered for the country or date of the papers published. All English language-based studies were included in an initial assessment. In this review, all cross-sectional, case-control, clinical trials, reviews, and editorials were included. We also tried to contact authors by letter writing to obtain unpublished data or full texts. The inclusion criterion for retrieving the studies was to describe the changes in ethical

contexts related to emerging diseases and COVID-19 with the approach to patients and healthcare rights. Overall, 54 articles were initially collected by database searching. After removing two articles due to evidence of duplication, 52 records were primarily under-screened. Based on the titles and abstracts, eight records were excluded and the remaining 44 citations were assessed for further eligibility. Of those, two were also excluded due to the incompleteness of the data and contents. In the final, 42 articles were eligible for the final analysis.

Selected documents were scanned. The collected content was divided into two areas (i) Ethical Challenges of Patients with Emerging Diseases (COVID-19) and (ii) Ethical Challenges of Healthcare Providers with Emerging Diseases (COVID-19). If necessary, the content will be reviewed by researchers

3. Ethical Challenges of Patients with Emerging Diseases (COVID-19)

3.1. Patients' rights

The World Health Organization has defined rights for patients, including the right to high-quality care and treatment, the right to equitable access to health care and services, the right to access information, the right to confidentiality, the right to consent, the right to vote or independence, the right to health education, the right to protest and complain, and the right to compensation [20, 22]. Due to the special nature of patients with these diseases especially COVID-19, it is very important to pay attention to the patients' rights in this field [23]. The first developments in this field of thought took place after the emergence of AIDS, and today it has become doubly important with the advent of COVID-19 disease [24]. In addition to enduring a life of fear, pain, and despair about the future, the sufferer also receives feelings of rejection, discrimination, humiliation, prejudice, hatred, and other concerns and sanctions from society [25]. The social stigma of emerging diseases is another challenge that patients are facing [26]. Feelings of stigma lead to a weakening of self-concept and loss of self-confidence, patients' sense of self-worth, and a stigmatized perception of self. Stigma is a social construct that is the main challenge in controlling the disease and establishes human rights violations in sick individuals and groups [27].

3.2. Respect for the patient's independence and autonomy

Patient independence is a key component in providing ethical care. All care providers have to ensure that the patient's independence is respected during the care [28]. Patient independence is the ability to make informed or rational decisions for him/her and to act on such decisions [29]. It requires the use of information provided by nurses and physicians to make the most rational health decisions, as well as the patient's ability to defend him or herself and understand the best decision over time [30]. Respecting this principle poses challenges in dealing with patients with emerging diseases. If the patient refuses to accept treatment or observes isolation, his/her health and society will be endangered. Relying on the custodial model in patient care, with the traditional approach of care based on the decision of the treatment staff, is more prominent in this field [31]. If the patient receives adequate information and training on the risk of disease transmission or the risk of disease mortality, it may be possible to overcome this problem to some extent and make the right decision to continue treatment with the patient's participation [32]. While healthcare providers have a wealth of medical experience, patients prefer participatory decisions if they receive adequate training.

3.3. Ethics in quarantine

Quarantine restricts the individual freedom of the patient and requires respect for the patient's rights to freedom and independence as far as possible and moral decision [33]. Traditional public health practices generally focus on preventing the spread of the disease by imposing restrictions on the rights of those who are infected or most vulnerable to infection [34]. Quarantine has long been an example of coercion and restrictions to ensure public health. It should be noted that maintaining public health takes precedence over individual independence and interests, but public health interventions must be done in violation of the minimum individual independence and its moral justification, but certain rights are absolute, meaning they can never be restricted, even if necessary for public welfare [35]. These include the right to immunity from torture, slavery, and the right to a fair trial. Interference with the freedom of persons to move to quarantine a disease is an example of a legal restriction that may in some cases be necessary to maintain public health and can be considered legitimate under international human rights law, but sometimes unplanned actions taken by public health officials can violate both human rights and the principle of the best public health benefit [36]. There are

countless examples around the world where this type of violation of human rights has taken place.

3.4. Duty of care

In critical cases of emerging diseases, close relatives and the patient's family members should distance themselves from him/her [37]. The medical staff must take care of the patient in this situation, even though their health is endangered [38]. Fifty percent of those who died from SARS were healthcare workers who came in contact with infected patients at the hospital [39]. This statistic is even higher in the medical staff of patients with COVID-19 [40]. According to the law, doctors and nurses should not refuse to treat patients because of their dangerous condition. Physicians and nurses both have a professional legal duty to take care of the patients. They perform their duties to treat patients during an epidemic, although during resuscitation operations on patients with the emerging disease, the health of nurses, physicians, and other healthcare providers is often endangered and sometimes they get infected and die [41].

4. Ethical Challenges of Healthcare Providers with Emerging Diseases (COVID-19)

4.1. The ethical principle of reciprocity

The hospital has reciprocal responsibilities towards the health care staff. Institutions of health should consider the infrastructure to support medical staff in these situations, which includes communication with staff, how to minimize risk, appropriate measures to control infection, adequate support to motivate the staff to perform their duties, and adequate resources for them. These resources include personal protective equipment, skills training, creating a safe environment, convenient accommodation, means of communication between teams such as cell phones and e-mail devices, medical advice such as screening for pathogens, counseling and psychological support, preparation of antiviral drugs, and vaccination [42]. In the fight against COVID-19, the safety of nurses and other healthcare workers at the forefront is a major concern because they are asked to work in situations that pose significant risks and insufficient safety for them [43]. Our inadequate understanding of the virus, its pathophysiology, mode of transmission, susceptibility, and contagious characteristics of nature, as well as failure in the personal supply chains of protective equipment, is a major concern of healthcare workers.

Inadequate support for healthcare workers across the country will add to this concern. In this regard, the code of ethics stipulates that nurses must improve their health and safety [44]. Policymakers and leaders of the health care system must recognize the additional risks in the nursing staff and fully anticipate and prevent the practical consequences of those risks [45]. This concern includes not only the medical staff themselves but also the risk of transmitting the disease to their family members, especially those with specific medical conditions and underlying risk factors who are more vulnerable [46]. Nursing in this situation requires a high and sometimes disproportionate level of altruism and self-sacrifice, the leaders of supporting organizations must provide a favorable and appropriate response to this self-sacrifice and devotion [18].

4.2. Allocation of limited resources

The second major ethical issue is the limitation of resource allocation. In any crisis, such as the COVID-19 pandemic, it is imperative to prioritize care and resources in different care settings and units [47]. The allocation of available resources should be based on crisis management. The most important of these resources during the corona epidemic for patients include the allocation of beds for intensive care units, appropriate and sufficient oxygenation and monitoring tools, and the possibility of fast and timely triage for medical staff including proper financing of the medical staff, providing appropriate protective equipment against disease transmission, and proper planning to prevent their chronic burnout [48]. The treatment of patients with COVID-19 by the Social Security Administration and other insurance organizations and the wide range of activities these days have led to the financial expenditures of the treatment by these organizations, significantly exceeding the budget approved by them [49]. With the rapid growth of the virus and the need to increase the country's medical capacity to care for and provide services to COVID-19 patients, the admission and admission of non-emergency patients to public hospitals was banned in many countries [50]. In addition, all hospitals, as well as all specialized clinics, both academic and affiliated with organizations such as the Social Security Administration, were required to be on a full-time and, if necessary, 24-hour basis, ready to receive patients with COVID-19. In this regard, the admission of elective patients in all medical centers throughout the country was canceled. Also, to make shifts in affiliated clinics, an order was issued to increase the monthly activity of general practitioners [51]. This issue, although mandatory, was accompanied by a multiplication of the workload of physicians and nurses disproportionate to the salaries and benefits allocated to them.

4.3. Disbelief about the disease

What increases the morale and workload of the medical staff more than ever and has become a vicious cycle is the lack of people's belief in the reality of the disease and fact the observance of the principles of disease prevention [52]. The findings of the studies indicate that from the perspective of physicians and nurses, the biggest challenge in dealing with COVID-19 is not taking the disease seriously in general [53]. Moreover, the lack of quarantine of infected cities is the main obstacle in controlling the COVID-19 pandemic, along with the proposed solutions to combat the virus, travel restrictions and control of entry and exit of cities, personal hygiene, provision of health equipment and protection, helping people make a living, identifying people suspected of having the COVID-19, and providing medical staff [54]. The nature of crises is to create rapid tensions in societies; however, it seems that the officials related to the crisis did not have a proper policy and plan for information in crisis in the beginning, and accordingly, a coherent strategy and program were not foreseen for information management in crisis [55]. Also, sometimes the delay in providing statistics quickly to the general public is a factor in increasing concerns in society and the production of pseudo-information and counter-information in society [56]. The rapid spread of COVID-19, which is one of the most important features of this virus, as well as the percentage of deaths due to the disease, has faced many countries in the world, especially developed countries, with a huge health challenge. When will it be sustainable is an unanswered question and requires patience. In many parts of the world, the leading strategy against COVID-19 is prevention and health, and this comes before treatment. A review of the experiences of successful countries shows that in the field of prevention and health, the issue of controlling the disease transmission chain has been considered a strategy and a key factor for success [57]. It took only seven days from the onset of symptoms of COVID-19 to the initial diagnosis of the virus that China immediately quarantined cities, homes, and infected areas, isolated, public policy in travel restrictions, established a central committee to respond to the epidemic chaired by the prime minister and provincial committees led by the governor, established central monitoring teams and sent them to the centers involved by the central government, mobilized all government facilities and hospitals, extended the New Year holiday period, controlled tragic and strengthening health education as the main strategies that all led to reducing the incidence of the disease in China and eventually to zero [58]. In South Korea, by worsening the situation in February, the government implemented quarantine and curfews in most cities; the closure of schools and universities, the prevention of rallies, the use of electronic

maps to identify sufferers and how to move them, the allocation of additional funds and the increase in the level of warnings were among the effective measures of this country [59]. Japan, has kept its corona mortality rate low despite having a vulnerable elderly population. Telecommuting companies and offices large and small, delegating authority to local governments according to instructions from the Ministry of Health, closing schools and universities and providing subsidies to employees to stay at home and care for their children, closing gatherings and public places and finally increasing COVID-19 diagnostic tests were the measures that the country has been able to use to reduce the prevalence of the disease [60]. In Iran, with the outbreak of this disease, schools, universities, and kindergartens were closed and distance education became the basis of education. Inter-city curfews were imposed and screening was carried out at the exit points of cities. Restricted closures and office shifts were among other solutions. Financial protection policies for free businesses affected by business closures were also considered. Emphasis on public education and advice on home quarantine are among the points that were emphasized after the outbreak of the Corona epidemic in Iran [61]. However, due to the temporary nature of these policies, along with the lack of seriousness of the people of society about the deadly reality of the disease, it caused the third wave of the disease with a slope and acceleration beyond the previous waves. As a result, the country continued to face high mortality, the inability of the health care system to meet the needs, and a lack of adequate funding to deal with the epidemic [62]. The policies of successful countries in managing the COVID-19 epidemic have been too seriously prevent the transmission of the disease, reduce the spread of the virus by reducing contact, and increase the physical distance between suspects and healthy individuals. In Iran, although self-declaration is being done through the infrastructure of the patient screening network system, in the crisis management department, the issue of tracking calls and controlling the disease transmission chain is still neglected and after identifying patients, its relationship with other people is not checked for their quarantine. There are also no comprehensive and integrated guidelines for reducing or stopping social contact and restricting the movement of the urban population, and it is hoped that such a system will be designed and implemented as soon as possible.

5. Conclusions

In these difficult days, when the black shadow of the corona does not seem to go away, the world has no more than one hero: the medical staff; who have been standing side by side with the corona for the past few months and have tried to pull people out of

the corona despite the constant danger that threatens them. While in recent months and in the current situation around the world, efforts are being made to appreciate the medical staff for their sacrifices and efforts. But in developing countries affected by the disease, staff shortages, short-term contracts, and unpaid benefits are heavier than the corona, which has bent the backs of nurses. Lack of personnel is one of the issues that nursing activists always point out. According to them, if the country's nursing force doubles, people will receive the minimum care. Currently, in addition to the pre-crisis shortage of nursing staff, most medical personnel are suffering from COVID-19 and are forced to leave work temporarily. Accordingly, it seems that in addition to addressing the ethical necessities of serving patients, addressing the issues related to the medical staff, especially the ethical aspects of their service will also be essential.

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