

Selected Ethical Issues and COVID-19

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Introduction

COVID-19 has had an ongoing worldwide impact. As of today's date (May 20, 2022), COVID-19 has led to the deaths of 1 million people in the United States and over 6 million deaths worldwide. COVID-19's sudden onset left clinicians, healthcare institutions, and governments with little preparation time. Medical and mental health professionals experienced multiple ethical challenges as they "scrambled" to provide treatment. The clinician's fiduciary duty to their patient often conflicted with public health's moral emphasis on population health. In some healthcare settings, the implementation of utilitarian public health ethics led to rationing and decisions about who was most likely to benefit from intensive care units and ventilators, which were in short supply [1].

For psychotherapists struggling with the dilemma of providing online mental health services in situations where confidentiality could be compromised, there was a conflict between fulfilling professional, ethical obligations and providing care to those experiencing emotional distress. In a similar vein, the rapid shift to telehealth, a modality in which few clinicians received training and in which there was relatively little empirical data to guide practice [2], contributed to professional discomfort. Clinicians struggled with issues of professional competence [3] and whether to provide care under conditions in which they felt poorly prepared.

This paper examines these ethical dilemmas and attempts to frame the key issues to facilitate clinical decision-making.

Some of these issues, such as access to medical and mental health care and the rise of the internet as a medium for clinical services, predated the pandemic but became much more prominent with the demand for medical services, social upheaval, and rapid development of governmental public health policies. In addition, uncertainty regarding mode of transmission, populations at particular risk, availability of effective treatment and prevention of the condition, and limited treatment capacity in the face of unprecedented patient illness all generated moral challenges.

Confidentiality

Contact tracing was widely implemented for providing the spread of COVID-19. There are well-established pre-existing reporting requirements for specific diseases and situations where an identifiable party is at risk for harm. In most of the U.S., new cases of sexually transmitted infections (STIs) are reported to the local health department. The local health department, in turn, initiates the process of contact tracing. To determine those at risk for STIs public health professionals interview the infected individuals and encourage them to disclose the names and other related identifying information of persons with whom they had sexual contact [4]. With high numbers of COVID-19 cases and limited health department personnel, S.T.I. contact tracing may have been less thorough than usual during the pandemic [5]. While public health policy requires that those potentially at risk be contacted, tested, counseled, and, when indicated, treated, the identity of the index patient does not

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necessarily have to be disclosed. With the rise of instant messaging, applications have developed so that the infected party can conceivably contact their past partners with a standard message supplied by the health department [6].

Breaking confidentiality to prevent harm is also standard practice when a clinician concludes a reasonable probability of child abuse or neglect. Healthcare providers and, in most states, adults who witness or learn of possible abuse are required to report their concerns to the State Office of Child Protective Services. While prosecutions for failure to report are rare, professional disciplinary actions have occurred when there is evidence that a healthcare professional did not make the mandated report. As in other situations where there is potential harm to an indefinable person, confidentiality is outweighed by the duty to protect the child.

In cases of COVID-19, patient confidentiality, while officially remaining intact, was often challenged through reporting and notification actions. Particularly in the first months of the COVID 19 pandemic, anyone who had potentially been exposed to a patient who was actively ill with the condition or a patient who had recently tested positive was frequently ordered to self-quarantine. In the United States, the identity of the infected index patient, in most cases, appeared to be protected by the Health Insurance Portability and Accountability Act (HIPAA). However, there were instances in which the index patient's identity could readily be determined despite HIPAA compliance. For example, the author lives in a relatively small rural community. In the early days of the pandemic, the local newspaper carried informational reports specifying geographic locations that someone who had recently tested positive for COVID 19 had frequented. In addition to identifying the site when it was a public location (church, restaurant, bar, etc.), the notification also indicated the date, day, and specific time the index case had been present. Persons who had been at that location at the specified time were encouraged to seek testing. These stories were detailed enough that a reasonable person who had been at

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that location could likely infer the identity of the infected individual. For example, the local newspaper reported that anyone who had frequented a popular local bar at 7:30 in the morning on a particular weekday might have been exposed. It is likely that the clientele of this establishment particularly at that hour of the day was a tiny and select group. In another instance, the newspaper essentially traced the movement of an index patient as they traveled across the county and visited specific sites such as a local restaurant and a community center. Again, the particular day and time of the individual's visits were reported.

In university residence halls or apartments, students who received the health department's notification of exposure could likely infer the index patient's identity. The public health goal of reducing transmission conflicted with the established ethical principles of protecting patient confidentiality.

While, to my knowledge, no reported incidents of aggression or other retribution towards these index cases occurred, quarantine among those exposed was often disruptive. As a result, workers lost wages, children did not attend school with working parents missing work to stay at home with them, and university students could not participate in classes despite paying high tuition. However, there were reports of targeted harassment of groups such as Asian-Americans [7] and migrant workers in Indonesia [8] who were harassed or discriminated against on the false belief that they had brought the virus to their communities.

An unintended result of the vaccine's availability was the negative characterization of the unvaccinated. In the early months of widespread vaccinations, it was generally believed that the vaccine protected from further infection. Those who became infected and had not been vaccinated could potentially put others at risk. Some businesses and restaurants required that patrons produce vaccine passports or proof-of vaccination cards indicating the type and date of vaccination. Invoking the principle of Darwinian natural selection, Goldman [9] argued that the unvaccinated posed a significant threat to those who were vaccinated [10]. There have been multiple accounts describing how physician "burnout" and "compassion fatigue" has been exacerbated by having to care for unvaccinated patients who developed severe symptoms of COVID 19 [11]. Among those who were vaccinated, infection associated with exposure to unvaccinated persons sometimes elicited frustration and anger [12].

Telemedicine and Tele-Mental Health

Before COVID-19, a small percentage of clinical services were delivered online. Chiauzzi et al. [13] describe how COVID-19 led to a rapid increase in telehealth services in Massachusetts. In February 2000, immediately before the pandemic lockdown, the state's Blue Cross Blue Shield Foundation reported only 200 daily telehealth encounters. By May of that year, telehealth encounters soared to 38,000 per day [13].

Another threat to privacy with the potential for patient harm was the rapid switch to providing clinical services through telemedicine. During stay-at-home orders, family members and other household members could listen to an individual's consultation with a physician or mental health professional. Of note, in the Massachusetts data, half of the online clinical encounters were for behavioral health services [13]. Particularly in psychotherapy cases, discussions of interactions with immediate family members are common. This threat of a family

member hearing themselves described in less than optimal terms could lead to significant damage to the relationship and, in extreme cases, harm to the patient. While ethical guidelines were such that interactions with mental health professionals were to occur without others present, there were no assurances that this privacy could be maintained; control over the social environment was often not at the discretion of the patient receiving treatment [14].

Telehealth-Quality of Care

While sparse, research to date suggests that mental health problems of such as major depressive disorder can be treated via telehealth as effectively as in a face-to-face encounter [15]. However, there are concerns about online treatment of more severe mental health conditions. Moreover, clinical decisions with significant consequences, such as inpatient commitment against a patient's wishes, may be more challenging when the interview occurs as a videoconference. For example, in a 1993 case, a patient challenged their involuntary commitment based upon a videoconference assessment [13]. In addition, the defendant challenged the quality of the videoconferencing information serving as the basis of the commitment as providing insufficient patient data compared with a face-to-face encounter [13]. However, the court upheld the commitment decision [13].

Risks of domestic violence raise different concerns about patient safety. During lockdown periods, a potential perpetrator could closely monitor the partners' interactions via telephone or video. Reporting being in danger, which could easily be overheard, could escalate the risk of harm. Data on the overall impact of COVID 19 restrictions on domestic violence is still forthcoming. However, a study conducted in Tunisia reported that violence against women increased significantly during the lockdown (from 4.4% to 14.8%) [16]. Psychological abuse was the most frequent type of violence reported by women. Women who had experienced abuse before the lockdown and were at a significantly greater risk of harm during lockdown [16].

While not raising any concerns about harm, a more innocuous example of the unintended effects of online communication occurred during online instruction. Students were synchronously connected to the instructor in teaching university classes through platforms such as zoom or go to a meetings. As a college professor, I had several intriguing experiences where a student's significantly younger siblings (ages 7 to 10) would become engaged in my abnormal psychology class. They often would wander into the room when type was occurring and would stay if something was of interest to them mainly if a video clip was being shown-and linger for a while.

Data Security, Privacy, and Quality of Care

Other risks in teletherapy include hacking into an ongoing therapy session or diagnostic evaluation. While not the equivalent of directly breaking into a zoom psychotherapy session, mental health records have been obtained by hackers. Some clinics have adopted platforms that provide access to teletherapy and also store patient records. While convenient, these platforms may heighten security risks. In Finland, hackers accessed patients' mental health records who had received services through a company with electronic mental health records [17].

Some electronic medical records are integrated into telehealth platforms. These systems pose particular risks to confidentiality. In an incident reported in the popular press, Vastaamo, a mental health

clinic in Finland, experienced a data breach [17]. Vastaamo did not use encryption for patient data. In addition to providing mental health services in outpatient clinics, Vastaamo was also an early adopter of tele-psychotherapy. The hackers obtained patients' identifying information and accessed detailed notes on patients' therapy sessions. While the hackers initially targeted the company for ransom, shortly after that, the hackers started targeting individual patients, threatening to release details of therapy sessions unless the ransom was paid [17].

Other issues regarding the quality of tele-mental health services have recently arisen in the U.S.. The pandemic relaxed regulations around prescribing controlled substances such as methylphenidate and D-amphetamine. This policy change led to several new online tele-mental health services, such as Cerebral, that evaluate patients for A.D.H.D. and provide prescriptions for stimulant medication. Recent reports from former Cerebral employees suggest that they felt some pressure to give an A.D.H.D. diagnosis [18]. Additionally, the diagnosis was based upon a 30-minute online encounter which many in the field see as inadequate for a thorough evaluation of possible A.D.H.D. As of this writing, Cerebral, with over 20,000 patients, is being investigated by the U.S. Attorney's office for inappropriate prescribing of controlled substances [18].

Who Receives Treatment: Rationing Health Care

During the pandemic, clinical psychologists in hospital settings watched as their physician colleagues struggled with providing potentially life-saving care in the absence of adequate resources. Because of its virulence and rapid onset, COVID 19 readily overwhelmed healthcare systems. While European countries have a history of rationing medical care [19], the consumer orientation of U.S. health care typically leaves treatment decisions in the patient's hands [20]. The U.S. healthcare exception has been the organ transplantation registry system which recognizes that the number of available organs is inadequate given the medical need for transplantation [21]. However, in the U.S., outside of transplantation, patients have typically able to request healthcare interventions, including those with a low probability of success such as cardiopulmonary resuscitation (CPR) [22]. For example, it is noted that among those who die from certain types of cancers, treatment is often continued during the month of their demise [23].

In addition, the United States has had several highly publicized cases of patients who have been on life support and in persistent vegetative states for years [24]. In most of these cases, family members have requested continued artificial hydration, nutrition, and in some instances, ventilation. Rationing, however, has not been part of U.S. culture. Values of individual autonomy, reduced social solidarity, and a competitive market dominate U.S. healthcare. If one has enough resources, it is possible to purchase the highest quality care possible. Therefore, it is not surprising that heads of state from other countries come to the United States when needing surgery or cancer treatment. Even in cases of organ transplants, while it is difficult to "jump the line" at U.S. transplant registries for lungs, hearts, and livers, there are options. Those with financial resources can travel abroad where organs are readily sold on the black market and have a transplant performed in exceptional hospitals developed for medical tourists [25].

An example of American discomfort with rationing was the response to medical decisions made at New Orleans Memorial Hospital during the flooding associated with Hurricane Katrina. A physician and two nurses decided which patients could be readily evacuated and which

patients might be harmed by the evacuation process [26]. A total of 34 patients died at Memorial Hospital during the hurricane and its immediate aftermath; four patients, determined to be too disabled to be moved, received a lethal morphine injection. Dr. Pou, the physician in charge, and two nurses were charged with second-degree murder; while there was much questioning of the decisions, a grand jury declined to indict Dr. Pou and the two nurses [27].

Rationing Health Care and COVID-19: Standards for Decision-Making

During the COVID 19 surge, the need for rationing care in hospitals like those in New York City led to the development of protocols to guide these difficult decisions. When resources are limited, the question arises, who is most deserving of treatment? Age is one dimension that has been employed. A principle known as the "fair innings standard" refers to the fact that younger adults have not yet experienced life's developmental achievements (getting married, having a family, establishing oneself and career, owning a home) [28]. Conversely, those who have achieved these milestones are likely to be older and have already received the benefits of a fulfilling life. While this argument has been contested, in the U.S., age has been used as one of the criteria for lung transplantation [29].

Faced with a surge of COVID -19 cases, some countries in Europe did establish age as a dimension in determining who should receive mechanical ventilation. Switzerland used an age cut-off of 85 years. In the United Kingdom, a reasonably complex algorithm is used for rationing care, including treatment such as kidney dialysis [24] through an agency affiliated with the National Health Service. In the United Kingdom, a COVID-19 decisional support tool was developed in which on which patients received a score on multiple dimensions related to potential survival with and without hospital treatment. In this system, anyone over 70 years old was considered on the borderline of intensive care unit admission. In Italy, medical authorities indicated that a firm age limit might eventually be established for rationing I.C.U. Care [30]. It is difficult to invoke age as a criterion without attention to its cultural meaning. For example, in sub-Saharan Africa, Ubuntu's ethical model asserts that those most valued demonstrate the highest character level [31]. These individuals tend to be older adults.

While it is difficult to predict treatment outcomes with certainty, patient prognosis has also been used as a factor for rationing care for COVID-19 patients. For example, in Germany and Italy, comorbid medical conditions and the patient's functional status were used as criteria [32]. Belgium included attention to the patient's cognitive status [33], with those demonstrating a pattern of permanent or likely deteriorating cognitive functioning to be lower in priority for mechanical ventilation,

Frailty has been systematically assessed by rating scales developed by the United Kingdom's National Institute for Health Care Excellence (NICE) [34]. Frailty is primarily based on functional status. However, research shows that the more comorbid conditions a patient has, the higher their frailty score. NICE did invoke frailty as a dimension to consider when rationing COVID-19 treatments [35]. The Frailty Index predicts poor outcomes in COVID-19 patients [35].

One of the critical ethical questions is rationing is who should make the decisions about treatment for specific patients? While those making rationing decisions have ranged from interprofessional

groups, critical care teams, and senior physicians, one principle that was quickly recognized was the potential for conflicts of interest. Those making these rationing decisions should not be the same healthcare professionals directly caring for a patient. This distinction maintains the fiduciary duty of healthcare providers by keeping direct clinical care separate from administrative decision-making about resource allocation [36].

In the early days of the pandemic, when personal protective equipment and later when vaccination became available, there were arguments made for the preferential treatment of healthcare professionals. Emmanuel et al. [37], while supporting this preference, argued that those who had volunteered for COVID-19 vaccine research should also receive priority when resources were limited.

A "second-order" solution to the ethics of rationing was implemented in the Northwestern U.S. in a region that had a surge of seriously ill COVID-19 patients. A decision was made to close a local general hospital's pediatric intensive care unit so that staff did not have to choose whether a premature infant or an elderly adult should receive one of the limited numbers of ventilators. This decision was presented as justifiable since there was a pediatric hospital nearby. Fernandes et al. [38] describe the solution as a way that the pediatric staff could avoid "drawing lots for tots."

Finally, there are long-standing health disparities in many Western countries. While health inequality is prominent in the United States, inequities are also present in countries with universal health coverage, such as Canada. For example, through much of the 20th century, colonialism and structural inequality were perpetuated by forcibly sending indigenous children to residential schools. The legacy of the residential schools remains and influences indigenous communities' views of dominant social institutions such as health care centers. While the rate of COVID-19 infection among Canada's indigenous people was significantly higher than the general population, vaccine hesitancy appears to be pronounced. Vaccine suspicion among the indigenous community has been related to the use of indigenous children in residential schools as subjects in medical nutrition research [39] without parental consent.

Given the triage algorithms developed, with pre-existing conditions as a factor, another group less likely to receive optimal COVID treatment were those with disabilities. These include persons with chronic psychiatric disorders such as schizophrenia. Recent data indicate that persons with schizophrenia are disproportionately represented among COVID-19 cases [40]. Critics point out that this constituted a form of discrimination in which some lives were seen as more valuable than others [41].

Conclusion

The COVID-19 pandemic revealed many limitations in medical and mental health services. Forced to quickly make difficult ethical and clinical decisions, health professionals often found it necessary to compromise long-standing accepted standards to provide the best available treatment. For example, the decision to provide telemedicine and tele-psychotherapy pitted potential quality and patient privacy compromises against providing limited or no services when psychological distress increased. In addressing resource shortages for COVID-19 patients, utilitarian ethics providing care for those most likely to benefit became a consideration to be balanced with the clinician's obligation to provide the best possible care for individual

patients. The pandemic has opened the door to many changes in medical and mental health care; these changes will likely persist well beyond the pandemic.

Competing Interests

The authors declare that they have no competing interests.

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