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The Ethical Challenges Faced by Healthcare Workers During the COVID-19 Pandemic

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Abstract

This essay analyzes the ethical challenges that arise during crises in healthcare settings, drawing on an approach to healthcare ethics that stresses the importance of understanding ethical decision-making during healthcare delivery. Such situations profoundly challenge long-held ethical commitments and decisional procedures that have typically informed healthcare practices. Both the content and form of clinical care provision will be impacted by how clinicians, including medical practitioners, healthcare workers, and others, feel about the procedures deployed in healthcare delivery. Thus, the 'everyday or normal' healthcare setting contains important indices or evidence of how care providers may face moral decision-making in the depth of the healthcare system. Data relating to those facing these profoundly distressing decisions is virtually impossible to replicate in a standardized manner. What follows seeks to first provide a broad account of familiar ethical principles that have informed contemporary bioethics, before rethinking these categories through different crises that provoke reinvestigating human subjectivity and the practice of healthcare professionals. Subsequent sections will address four case studies to appreciate the new ethical challenges informing ethical decision-making within the context of the experience of pandemics and health crises. In facing a pandemic or other global health crisis, the values underpinning familiar ethical categories such as respect for autonomy, non-maleficence, beneficence, and justice, and upholding human rights as an absolute should be renegotiated. This essay will not address the

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difficulties that arise at a more general level in public health surveillance, public health policy, quarantine, or travel restrictions for non-infected people. The primary focus is on situations directly involving healthcare decision-making, that is, those caring for the sick. (Ayubi, 2021)

Keywords-Ethical challenges, healthcare workers, COVID-19 pandemic, resource allocation, human rights, critical care, limited resources, responses to crisis, liability, mental health.

This paper explores the ethical challenges faced by healthcare workers combating the COVID-19 pandemic. It begins by outlining and contrasting common reasons for these difficulties before discussing some of the consequences for the healthcare workforce. This paper will focus exclusively on the experiences of healthcare workers and some of the moral, social, and legal implications of those experiences. Potential proprietary COVID-19 treatments have led to a focus on principles of distributive justice and fair ways to allocate these resources. However, in the context of COVID-19, the just distribution of one scarce resource can exacerbate shortfalls of other resources. During the first wave of the pandemic in 2020, for example, public health authorities anticipated that the demand for critical care hospital services would exceed supply and drew up tiered responses to situations of scarce critical care services. Many resources, strategies, and policies mentioned above concern the way in which patients are treated based on their likelihood to benefit from treatment. These critical care responses also reflect principles of solidarity about resources, elaborated further in the sections that follow. Only some healthcare workers will deliver critical care, and their professional decisions will uphold or betray respect for human rights. These strategies are in place to assist them in maintaining respect for human rights even under extreme conditions. Finally, as these high-stakes decisions must be made within limited time, no healthcare worker may bear personal legal liability for making or contributing to such decisions in ways that are consistent with law, ethics, and human rights. The implications will be concerning for many people, not least because failure to uphold these rights has mental health consequences for those healthcare workers.

1. Introduction

The COVID-19 pandemic has brought to the fore not just the unprecedented strain on healthcare systems and healthcare workers but also the tough, 'wartime' ethical decisions that arise when providing medical care under rapidly evolving circumstances, often with significant uncertainty. It is an exigency, a case where such professional moral principles and existing ethical frameworks cannot easily be applied, since a number of medical ethics concepts established in ordinary circumstances – well-being, patient autonomy, the best interest principle, and the life or quality of life lottery – are affected by these exceptional circumstances of scarcity of resources, a large number of individuals, and their potential to regain life with

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full mental capacities, uncertain progression of a novel viral infection, and quarantine measures in the first place to prevent the further spread of the disease. There is an urgent need for reflection on the ethical issues raised by the current COVID-19 pandemic in order to organize and frame the most humane and ethically, legally, and economically justified public health strategies. In the extant literature, healthcare ethics in situations of crisis or disaster are increasingly being explored. In ethical disaster management, the principles of urgency, balancing of goods, fairness, protection of and respect for autonomy, duty of care, responsibility, trust, transparency, proportionality, informed consent, public participation, and partnership with the community are discussed and are seen as a useful part of an ethical framework serving as a guide for public health actions. It is the aim of the present essay to contribute to the discussion about ethics in times of COVID-impacted 'wartime' by exploring ethical challenges and principles, with a particular focus on healthcare professionals who face ethical dilemmas on a daily basis and with the affected population by the disease. (Morley et al.2020)

1.1. Background and Context

Around the world in 2020, most communities are struggling with some variation of a new disease: COVID-19, caused by the virus SARS-CoV-2, known informally as the novel coronavirus. The pandemic has strained healthcare systems in almost every country. The number of patients who present with shortness of breath, low oxygen, and lung injury has exceeded the supply of intensive care units and ventilators, medical staff, personal protective equipment, and hospital space. The diversity of people needing healthcare and the limited staff and spaces available have produced long clinic wait times, overwhelmed telephone advice lines, and the need to adapt physical spaces to reduce infection risk and maintain social distancing. This demand for medical services appears on top of typical, but already high, healthcare utilization for other serious medical conditions. Even as demand for medical services increases, some staff are out sick. Some workers have left their jobs, and others are choosing to work from home while dealing with family care or shelter-in-place. Some individuals delay going to the clinics and emergency departments for symptoms of time-sensitive conditions, such as heart attacks, strokes, and other life-threatening infections, that could lead to additional morbidity and mortality. For some communities and socio-demographic groups, the risk of facing these challenges and outcomes is greater than for others. People with specific races, nationalities, and low socioeconomic status may face a higher risk of viral exposure, diagnosis, complications, and death due to complex factors like living arrangements, differential job types, and access to personal protective equipment. Collectively, these pandemics exacerbate existing inequalities in healthcare system function and illness from delayed or worse healthcare. When one looks to how societies react to pandemics in the past, since the outbreak of the Black Death in the 14th century, some patterns emerge. Virtually every proposed solution involves some trade-off associated with basic value distinctions, and

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hence a moral-ethical question. Many economically inclusive health strategies require that society have the intrinsic ability to rapidly cure. Most protective health strategies demand disproportionately high sacrifices be made by some of the population to protect the greater good. Countries differ in the policy choices they make to balance these ethical trade-offs, and states may actually change their policy to adapt to the state of their healthcare capacity, the timing of their pandemic, and the state of their economy. When states choose studies with these kinds of trade-offs, they are posing systematic moral questions akin to public health ethics questions such as the distribution of scarce resources to the vulnerable and working for the good of the people by requiring sacrifices from some individuals. The next section analyzes some of the moral challenges. These background conditions point to three related points about the set of moral dilemmas facing current healthcare workers during the COVID-19 pandemic. The personal relationships we have now with staff as they do so highlight complex ethical dilemmas that echo some typical concerns associated with public health ethics. However, the amplified nature of the ambient social conditions, as well as the continuously evolving landscape in which healthcare workers must operate, make it difficult to automatically, or solely, rely on previously established ethical norms and traditions in public health.

2. Ethical Principles in Healthcare

As professionals, healthcare workers are guided by four fundamental ethical principles: autonomy, beneficence, non-maleficence, and justice. These principles are perhaps even more significant in some ways during this global health crisis than otherwise. Autonomy refers to an individual's right to self-determination, which healthcare professionals should respect. For example, critically ill patients can decide to accept various courses of treatment, including choosing to forgo life-sustaining interventions; for deceased patients, autonomous families must be consulted about organ donation. Beneficence calls for healthcare workers to maximize benefits and minimize harms and burdens associated with various clinical decisions. In many circumstances, healthcare workers are guided by the principle of non-maleficence, which demands that we avoid doing harm to patients. The principle of justice requires that we distribute available resources fairly, ensuring that any risk of harm is distributed fairly and any benefits are allocated in an equitable manner. This involves three dimensions: who should get treatment first, who should not get treatment, and finally, who might be denied treatment if resources get too scarce. (Jeffrey, 2020)

Healthcare professionals, therefore, are tasked with balancing the potential benefits and burdens when delivering care. Even in ordinary circumstances, these principles will sometimes come into conflict. During a pandemic, such as the current crisis, the consequences of turning off scarce resources for one patient are immediate. At the same time, the consequences for patients waiting for these resources are delayed, indirect, and less certain, but still significant. Only the first group of patients benefits immediately from receiving scarce resources. All these

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circumstances contribute to the complexity of providing care during a pandemic. (Schwartz et al.2021)

2.1. Autonomy

The first of the four principles, "autonomy," emphasizes the moral importance of personal choice and recognizes the patient as a moral agent, capable of deliberation. In the healthcare context, respecting autonomy involves presenting patients with relevant information about their diagnosis, realistic treatment options, and potential outcomes. Importantly, this principle holds that patients have a right to decline offered treatments. The informed consent process exists to achieve these goals, even during emergencies. Indeed, international medical ethics guidelines emphasize the centrality of patient autonomy in healthcare, specifying that a patient has the right to accept or to refuse treatment after receiving adequate information. However, the concept of autonomy is complex.

First, in healthcare, the promotion of patient autonomy must sometimes be qualified by the "nonmaleficence" requirement to not harm oneself or others. Are there cases in which patient autonomy is trumped by safety considerations of oneself or others? Moreover, some people might also think that autonomy is trumped by the moral duty to help others when doing so is easy, low-risk, and high benefit to the other, such as getting vaccinated. To what extent does morality require people to do what is easy? Let us go through some examples where autonomy conflicts with beneficence or public safety. Respecting autonomy by allowing forced quarantine removes an important driver for people to follow quarantine; this is because informed consent is supposed to be voluntary. However, if informing can make a positive difference to the level of vaccine uptake, it would amount to asking too much of healthcare workers to leave the decision on whether to provide information to patients. They must sit with their patients to discuss the risks and benefits and ultimately make a decision that they think balances the value of informing patients with looking after public health. It is difficult to know where the balance sits in this unique cultural moment and what sort of conversation should be had about it, but the importance of finding that balance is underscored by the myriad ways the pandemic has pitted individual rights against collective health needs. Everyone wants the pandemic to end, but many of us may prefer to do nothing to make it end. This is a problem. It is endemic within all unique communities where reliance on minority cooperation is crucial in order to reach any collective good. In an individual's case, this could relate to being willing to accept an experimental treatment, receiving an influenza vaccine, or agreeing with their physician's decision to administer supportive care in case they fall critically ill. As we will discuss, sitting with a dying patient to make these sorts of medical decisions, when expected to make hospital resources inadequate, is ethically novel because absolutism about ancient healthcare principles simply cannot be maintained. The substantive ethical question then becomes: how should the paternalism-informed respect for autonomy endorsed in

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contemporary medical ethics rub against concerns about preventing greater harm that could potentially require limiting or overriding patient choice? In the physician's eyes, making this decision for the patient could save others from death. We will consider a variety of arguments for why respecting or limiting patient autonomy in these dire straits might be the way to minimize net harm, and we will argue that the risk of moral indignation or malpractice litigation need not necessarily override this cost-benefit analysis. (Williams et al.2020)

2.2. Beneficence

At the heart of the principle of beneficence is our obligation as healthcare workers to act in the best interests of our patients – to ensure that care is effectively coordinated and resources are made available to achieve the best outcome for patients. The principle of non-maleficence, often associated with beneficence, requires healthcare workers to protect patients from harm. During a pandemic, when there are competing demands and limited resources, beneficence presents a particularly challenging situation. Some patients may not have access to potentially life- or function-saving services, and the fundamental obligations and responsibilities of healthcare workers are complicated. There may not be enough ventilators to give one to everyone that needs them. Non-beneficence may result in some patients receiving less than optimal care.

Ethically, it is not always in the best interests of patients for healthcare professionals to provide every available treatment, test, or procedure. Healthcare workers may believe that it is not in the best interests of a patient or patients, or that it is not a good value for the system to provide a certain treatment. Other times, healthcare professionals may find themselves in situations where all treatment options are practically equivalent. Prioritizing best interests with regard to beneficence occurs in situations where two or more clinically necessitated courses of action seem qualitatively similar or are beyond the limits of practical equivalency. Instead of giving every rejecting care, healthcare workers must deliberately choose among them. While all caring practice is ethically multidimensional, beneficence is typically overridden by other ethical concerns like fairness and patient values. Patient values and professional judgment are morally significant and play an important part in deciding whether a particular course of action is in the patient’s best interest. It is important to inform patients about all their treatment options, including those that are not beneficial.

2.3. Non-maleficence

Non-maleficence is the duty to minimize the risk of causing harm. The graphic describes the precautionary action to prevent harm, especially for vulnerable and high-risk patients. The positive effects in a pandemic context are the rehabilitation and support systems needed for reconstruction and normalization. It is a critical concept, and during a pandemic, the frontline healthcare workers and hospital patients already possess magnified risks due to the nature of

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infectious agents. Patients who would never acquire this infection outside of a healthcare facility are more likely to be vulnerable to a heightened infection risk because their systems are overloaded. Mitigating all this risk and reconciling it with providing health protection and support during a time of national crisis is the paradox of balancing ethical principles with public health ethics and other medical ethics principles. Identification of some healthcare interventions as causing more harm than a modest amount of good during a societal crisis characterized as a "highest risk" pandemic may be an example of one way that the ethical principle of non-maleficence can be used appropriately in the ethical decision-making process according to this analysis.

In conclusion, the principle of non-maleficence states that one should strive to not expose patients to any unnecessary risk. This is especially critical during a disease outbreak featuring high rates of morbidity and increased populations that are already at heightened risk. Healthcare providers are charged with caring for individuals; ensuring the safety and best interests of patients are values that most healthcare professionals share. This, however, may be challenging during a pandemic when healthcare providers may feel a sense of urgency to provide care, and it could be perceived as if history is working against them. As discussed, healthcare workers should make an ongoing risk and benefit assessment of their patients that reflects their medical ethics duty to non-maleficence to maintain their status as humane care providers during a pandemic.

2.4. Justice

Justice is the principle in the realm of healthcare ethics that, in general, commands that benefits and burdens be distributed fairly. As such, it governs not only how resources in the face of scarcity are allocated, doled out, and shared, but also who should receive those resources. Within that space, the concept of justice commands consideration not only in connection to needs and the ability to benefit but also in light of what some might view as constraints that should be highly valued in their own right, from liberty of choice and movement to democratic decision-making. In the pandemic, the principle of justice is most evident in discussions of resource allocation, focusing on systemic, population-based, and structural considerations in addition to more traditional, or narrowly drawn, individual or case-based ethics of care.

In the early days of the pandemic, bioethicists were actively developing guidance on how to appeal during scarce resource allocation decision-making, and these guidelines ultimately were turned into policy in many practice settings. Specific concern was paid to maintaining fair attention to all present patient populations when resources were limited. Another kind of injustice may appear when allocation decisions are made according to criteria that explicitly value certain lives over others in what may be seen as an unjust society that does not regard every life as being of equal worth. Stories about moral heroes who stand up and behave justly

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offer direct guides for organizational conduct in the pandemic. In accordance with this notion of justice, the development of long-term solutions, like equitable distributions of pandemic supplies within an overarching framework of global health, was advocated. The impact was most severe and expected in certain populations and rural counties, with risks primarily due to structural inequalities based on social determinants of health. Structural racism affects not only the risk of acquisition but also outcomes, through poorer responses or less access to vaccines. Such a limitation of care violates codes of ethics as well as recent legal attempts to decrease disparities in care. It is argued that the concept of justice should guide not only the fair use of scarce resources but also the just nature that compounds such injustice. The application of justice principles to be pursued by public health policy also requires tackling what are known as social determinants of health, such as access to care.

3. Specific Ethical Challenges in the Pandemic

Healthcare workers are often expected to grapple with a range of ethical challenges in the course of their work. Yet the COVID-19 pandemic also raised some specific ethical difficulties for these individuals doing this intense work in caring for the sick. The COVID-19 pandemic was an unprecedented global event, largely in its sheer scale. Decision-making in healthcare occurs at the level of the individual, utilizing the clinical ethical principles of non-maleficence, beneficence, autonomy, and justice. The pandemic, however, required healthcare workers, organizations, and nations to make difficult decisions about the distribution of benefits and harms on a scale previously unknown. Now, healthcare workers saw a situation where they had too little that could help people, at least very many people, which resulted in resource allocation becoming a major ethical concern in ways that it often is not. (Kooli)(Robert et al.2020)

Healthcare workers faced the ethical challenge of how to manage resources that run out, and which they have a major part in accessing, due to their expertise and knowledge. Nurses and doctors had to determine this in potentially hundreds of disconnected triage situations with no criteria to guide them. How to use drugs, like ventilators or antibiotics, in all of the many clinical settings in which patients were admitted? Or, importantly and unusually, what treatments to withdraw or withhold? But to make matters more complex, healthcare workers, especially in countries like Italy and Spain, saw a situation in which bodies were literally piling up. Faced with a highly infectious and virulent pathogen spreading rapidly and with a population that could develop a severe form of illness, healthcare workers confronted not just the prospect of having too few resources and too many patients, but having to implement triage. Ethical standards in times of crisis were different from the standards of usual clinical practice. Medical professionals adopt these often unstated, usually implicit, values and principles to help them order out the conflicting and often value-laden claims that come into play in actual clinical and caregiving situations.

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3.1. Resource Allocation

During a worldwide pandemic, it is expected and logical that resources will be scarce. Plans for rationing are commonly found during health emergencies. However, the pandemic has left many healthcare institutions scrambling for life-sustaining equipment for healthcare workers, as well as facing manpower shortages. Some professionals have raised ethical dilemmas surrounding an ICU bed when two patients with the same outcomes are to be admitted, limited ventilators, and a lack of treatment options to decrease inpatient treatment time. Unethical examples of non-priority groups breaking the rules to get vaccinated early have been reported. Risk groups in certain regions were not getting vaccinated. Budgets for research were being allocated to general hospitals instead of a specialty infectious disease hospital.

AIMS: Critical shortages of medical supplies, personnel, and treatment options have created ethical challenges for healthcare professionals on the front lines during the pandemic. This section will address the ethical challenges and ethical decision-making that result from resource allocation and possible ICU triage during desperate times. The following two themes will be presented: Resource Allocation and ICU Triage. Ensuring that resources are equitably allocated puts into practice what many ethical theories and principles call for. The utilitarian theories require an action that maximizes the benefits for the greatest number of people. The goal of a fair and impartial distribution to decrease human suffering is paramount in a crisis. It may also be more difficult to determine how scarce resources are distributed in a way that does not seem to exacerbate social and economic divides. Further research may be beneficial to gather the public's opinions and educate on what to do when healthcare workers are forced to ration equipment. One conclusion suggests that efficient communication between healthcare workers and the community needs to be improved. Public trust and transparency facilitate a sound decision-making process. Most countries have sufficient legal coverage to assist doctors in their ethical decision-making process during the crisis.

4. Mental Health and Well-being of Healthcare Workers

Abstract: Healthcare is a difficult and complex profession, and the advent of COVID-19 brought high levels of stress as a result of high case loads, working in an intensive care environment, counseling distressed family members, uncomfortable personal protective equipment, managing conflict over triage, and the rapid flux of ethical decisions, among other challenges. Many healthcare professionals are experiencing extreme emotional exhaustion, emotional burdens, and moral distress. Solutions for the mental health challenges currently faced by healthcare professionals during public health emergencies such as the current pandemic are not going to be obvious. We argue that concern for the mental health of healthcare professionals should be a central, distinct, and ongoing feature of healthcare ethics during public health emergencies. Although public attention is often focused on the morality of

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treatment choices and resource allocation, support for healthcare workers' mental health is of independent moral concern. (Sriharan et al.2021)

The mental health of healthcare professionals should be supported as a distinct and central concern of healthcare ethics during COVID-19 and future pandemics. Many healthcare workers have faced and continue to face extreme degrees of emotional burden, emotional exhaustion, and moral conflicts. Stigma for mental health concerns affects healthcare professionals as part of the general population, but the healthcare profession has additional barriers to seeking help for mental health concerns, with additional barriers of fear of professional consequences and difficulty in reporting non-physical assaults. The strong sense of personal ethical responsibility felt by healthcare providers for their patients' COVID-19 outcomes is significant. The ethical implications of that moral responsibility mean that continuous high-stakes moral decision-making is a significant part of the unusual mental health challenge faced by healthcare professionals and workers at the present time. (Grover et al.2020)

5. Conclusion

In our essay, we have highlighted some of the many ethical issues that the COVID-19 pandemic has raised for healthcare workers, the institutions where they work, and society more generally. We have indicated that a strong account of these ethically problematic challenges should be guided by the principles that express what we see as important in health and social care: autonomy, beneficence, non-maleficence, and justice. We have seen that a number of ethical principles generate a variety of possible responses; however, they do not seem to permit reactions that, in some cases, have been adopted by professionals, including the patient's isolation and some groups of them being given preference over others. We have seen that these practices have stimulated conflicting points of view since the pandemic started and have certainly pointed out that it highlights the existence of ethically problematic situations that should have been addressed with the setting of a rigorous ethical path. In the best of cases, the responses we have seen have been reactive and, in some cases, inapplicable for lacking the right conditions of fairness. (Sahebi et al.2020)(Kooli)

The pandemic and the behavior of some individuals during it have highlighted the need to understand anew the essential ethical problems in health care and social environments and to lay the foundations for an ethical framework into which these and perhaps other questions can be better addressed. We have also indicated that another problem faced by health care workers is the emotional burden they have suffered when helping some people to die. In addition, this pandemic has shown how professionals have been affected themselves in this process, posing another question about how a health institution should support healthcare professionals to truly address the pandemic by supporting its workers. Finally, we have noted the pandemic's role in challenging existing health policies and establishing new ways of delivering healthcare, based

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not only on critical thinking, evidence, and experience, but also on ethical reasoning. It is important to continue reflecting on these topics so that in the future, the experience will help us to provide not only better health care to those who need it, but also to make those providing it look at it as legitimate, fair, and right. (Xafis et al.2020)

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