J R Coll Physicians Edinb 2020; 50: 274–6 | doi: 10.4997/JRCPE.2020.311 **PERSPECTIVE**

COVID-19 at the intersections of science, morality and practice – reflections of the physician's soul

Latika Gupta[1], Ashish Goel[2]

Keywords: coronavirus, ethics, pandemic, medicine, psychology

Financial and Competing Interests: The authors declare that there is no conflict of interest relevant to the manuscript.

Correspondence to:
Ashish Goel
Department of Medicine
University College of Medical Sciences
New Delhi
India

Email:
ashgoe@gmail.com

You don't talk to me, she cried,
Or meet me with arms open wide!
Fear not, keep faith, I replied,
Hold tight, for it's a bumpy ride;
If not, just meet on the other side…

(inspired by the words of Private Josh Lee in the 1918 Spanish Flu pandemic)[1]

In times like these, when most from the medical fraternity are in the quest for solutions to the viral illness, many have turned inwards for answers of a different kind, but important nevertheless. Reflecting off the turbulent waters of their soul, hoping against all hope. The glaring paradoxes that have come to define these times are often felt by many, but weigh the heaviest on the frontliners engaged in this unique battle against an invisible enemy.

This brief is a physician's abreaction to the cutting intersections of morality and science,[2] ironically, worst experienced with a brave face to the world, while fearing to face the war within. This account borrows heavily from personal experience and understanding, and little from previous evidence, with the intention to broadly discuss the following aspects of working in a pandemic situation: the level of care, mortality and death, lack of leadership, and research.

Level of care and despair (equitable distribution?)

At the helm of the personalised medicine revolution, scientists and physicians have taken pride in recent technological advancement and sophistication in management facilities. Ironically, these furtherances, floated with the intent to bring congruity in medical care to start with, amplified incongruity by inflated cost of care instead, pushing it beyond the reach of the less privileged. While both healthcare providers and recipients now expect a certain standard of care, the ethicists' outcries for similar investments in improving public health have gone unheard.

However, in this war of humankind against a cruel virus, when numbers tumble in a domino effect, society is destroyed and socialist distributive justice goes for a toss.[3] Resources (both material and human) fail to escalate in similar proportions, or as rapidly, and care providers struggle to put in a superhuman physical effort while fighting the conflict within. Despite increased call on physical and internal reserves, providers struggle to come to terms with the surrounding and increasingly poor outcomes and end up blaming their own incompetence. Physicians often bear the burden of failures, more so in societies where medics are surmised to possess divine skills and demeanour, while the caregiver perseveres and eventually crumbles beneath the ever-increasing weight of self-expectations and expectations from the environment.

In such a setting of acute stress, physicians, like other human beings, are likely to resort to avoidance and denial as stop-gap coping strategies. While this can buy them time to postpone dealing with emotions to avoid being overwhelmed, it can be detrimental when their actions are central to the disaster response at the hospital. Positive coping strategies, though essential, are a function of personality, stressor and the environment. Putting all medics into the common bag of caregiver role might not do justice to the human being in them. In a unique situation where there are no definitive/

[1]Assistant Professor, Department of Clinical Immunology and Rheumatology, Sanjay Gandhi Postgraduate Institute of Medical Sciences, Lucknow, India; [2]Associate Professor, Department of Medicine, University College of Medical Sciences, New Delhi, India

scientific answers, optimism and task-oriented coping go for a toss, leaving emotion-dominant responses as the only resort. Ethical decision making is a function of the threat, choices, appraisal and, most importantly, coping flexibility according to the demands of a specific situation.[4] In a disease which spreads by mere talking and touching, ostracised frontliners separated from friends and family disintegrate from the anxiety of illness in self or loved ones, alongside the growing trauma of separation, cognitive and physical exhaustion, and moral failure at their own worthlessness/helplessness.

Morality and mortality (non-maleficence?)

In a pandemic it is inevitable that more and more people will die, not only because of the virulence of the infective organism but also from the lack of available resources. While a deserving patient may not have access to an unavailable ventilator, another may succumb from failure to reach the appropriate facility in time, as medical utility becomes the guiding principle in triage.[5,6] Although triage has been effectively used in disaster situations, there are essentially two problems in its use. On one hand, healthcare workers in hospital-based systems are not trained to triage effectively and quickly most salvageable patients. On the other hand, effective triage will come with its share of guilt, agony and mental trauma in the face of the doctrine of non-maleficence so deeply ingrained into their minds during their training. A healthcare worker will forever bear the burden of visual recollections of the patient they had to leave.

Another interesting fallout in managing the pandemic is the cardiopulmonary resuscitation (CPR). Undoubtedly, CPR has saved many lives, but its impact is rather glorified, and its utility overestimated.[7,8] Furthermore, practice is complicated in the absence of a formal policy on do-not-resuscitate (DNR) orders.[9] In a pandemic, when the infective illness has reached a critical level in an individual, so as to cause a cardiac arrest, it is futile to debate what might be gained by an aggressive attempt at resuscitation, at the extreme risk of personal exposure.

Leadership and management (autonomy of a different kind?)

Many doctors struggle to understand the lack of response from those placed higher in the command chain, more so when these are the ones they have always looked up to for guidance in previous endeavours. However, this dearth of initiative is not a novel phenomenon.[10,11] The answer lies in the understanding that every individual at each position in the chain is struggling with an unprecedented threat, a muddle that they have neither been trained for, nor have any experience to handle. Everyone passes through the same cycle of denial, shock and acceptance, slowly and painfully.

Most decisions are thus knee-jerk responses to managing crisis and lack understanding, contemplation and vision. The transitional period is thus riddled with chaos and confusion, punctuated by unclear, conflicting and contradictory directives with a short half-life. Those few who owe their placement in leadership positions not to talent, but loyalty and complex seniority constructs, look for guidance and instruction which is not forthcoming. At the same time, the talented ones in managerial positions continue to burn in the frustration and agony of inability despite capability. A policy paralysis becomes visible in poor or even no decision making and reluctance in communication, adding to the anarchy.

In the mayhem that ensues, leadership is all about passing the buck – from federal agencies to the medical care system. In this faulty reverse pyramid, where the medical hierarchy morphs into a deaf zombie under pressure from the top, human lives turn to numbers and treatment charts are but lifeless data. Deviation, or even questioning a faulty protocol, runs the risk of being fired at the drop of a hat. Everything is about cover-ups, amid suppressed media and sheathing truths in the various layers of bureaucracy. All compassionate beings can do is to recede into a nonexistent turtle shell, soothing their wounded soul with the balm of seraphic hope.

Lamentably, previously established systems will continue to fail under the strains until newer ones are instituted. In the intervening period, every manager (read physician) will have to deal with a new degree of autonomy based on their own morality and training amid poor resources and leadership. And one is but forced to wonder, was I not here as a (wo)man of science?

Research or care (beneficence – the greater good?)

These challenging times have also transpired into a sardonic infodemic, with the virus in pursuit to claim the virtual space in addition to the human body.[12–14] Every researcher worth their salt has initiated or received invitations to participate in assignments exploring unique aspects of the new virus focused on (read limited to) their interest areas; akin to the elephant and the blind men. Nearly 7,500 publications have made their way to PubMed alone in the space of four months, translating to over 60 new releases a day; and this is only bound to increase in the coming days. On the one hand, every researcher is sprinting to publish something, and on the other, every journal is in a race to get to him/her first. The net result is the acceptance of a horde of substandard, poorly designed work with disastrous impact.[15]

The clinician is riddled by another paradox, wherein the ever-growing need for reliable information to treat the next patient is met with the dismally low probability of obtaining valid data from a scientific realm where angels fear to tread.[16] Thus, the frenetic frontline doctors, while struggling to decipher the intricacies and varied presentations of a frightening new infection, are also lumbered with the compilation of tedious monitoring and administrative procedures that they are neither trained nor habituated to fulfil. Is it ethically befitting to ask them to fill in just a few more pages to feed the insatiable warhorse for the beneficence of science and society, in an environment where they also constantly fear

for their own lives in an indefensible war? Furthermore, the legitimacy of the data generated in this situation is only a matter of conjecture.

Every medical student who once struggled to understand the definition of a pandemic now lives it in real life as the handicapped medical infrastructure grapples to be just and equitably distributed. In a time when 'doing no harm' is a flawed cliché, autonomy often breaks down into a roadside brawl between self-preservation and upholding the greater good. When there are too many for you to care for, nature will take over (care).

References

1 Wever PC, van Bergen L. Death from 1918 pandemic influenza during the First World War: a perspective from personal and anecdotal evidence. *Influenza Other Respir Viruses* 2014; 8: 538–46.
2 Facebook. US Embassy New Delhi. DostiUnitesUs: US Embassy, India; 2020 https://www.facebook.com/India.usembassy/posts/3108875215895153?comment_id=3127744437341564&notif_id=1588015503048209&notif_t=feed_comment (accessed 28/4/20).
3 Emanuel EJ, Persad G, Upshur R et al. Fair Allocation of Scarce Medical Resources in the Time of Covid-19. *New Engl J Med* 2020; 382: 2049–55.
4 Witt J, Elwyn G, Wood F et al. Decision making and coping in healthcare: The Coping in Deliberation (CODE) framework. *Patient Educ Couns* 2012; 88: 256–61.
5 Rothstein MA. Currents in contemporary ethics. Should health care providers get treatment priority in an influenza pandemic? *J Law Med Ethics* 2010; 38: 412–9.
6 Misra D, Agarwal V. To Act…….or to wait for the evidence: Ethics in the time of covid-19! *Indian J Rheumatol* 2020; 15: 3–4.
7 Von Gunten CF. CPR in hospitalized patients: when is it futile? *Am Fam Physician* 1991; 44: 2130–4.
8 Wallace S, Ewer MS, Price KJ et al. Outcome and cost implications of cardiopulmonary resuscitation in the medical intensive care unit of a comprehensive cancer center. *Support Care Cancer* 2002; 10: 425–9.
9 Rubenfeld GD. Do-not-resuscitate orders: a critical review of the literature. *Respir Care* 1995; 40: 528—35; discussion 35–7.
10 Hatchett RJ, Mecher CE, Lipsitch M. Public health interventions and epidemic intensity during the 1918 influenza pandemic. *Proc Natl Acad Sci USA* 2007; 104: 7582–7.
11 Morse SS. Pandemic influenza: studying the lessons of history. *Proc Natl Acad Sci USA* 2007; 104: 7313–4.
12 Kouzy R, Abi Jaoude J, Kraitem A et al. Coronavirus Goes Viral: Quantifying the COVID-19 Misinformation Epidemic on Twitter. *Cureus* 2020; 12: e7255.
13 Hua J, Shaw R. Corona Virus (COVID-19) "Infodemic" and Emerging Issues through a Data Lens: The Case of China. *Int J Environ Res Public Health* 2020; 17: 2309.
14 Zarocostas J. How to fight an infodemic. *Lancet* 2020; 395: 676.
15 Gupta L, Gasparyan AY, Misra DP, Agarwal V, Zimba O, Yessirkepov M: Information and Misinformation on COVID-19: a Cross-Sectional Survey Study. *J Korean Med Sci* 2020; 35: e256.
16 Goel A, Gupta L: Social Media in the Times of COVID-19. JCR: *Journal of Clinical Rheumatology* [Epub ahead of print 1/6/20]. doi: 10.1097/RHU.0000000000001508.