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ETHICAL DILEMMAS APOCALYPSE AMIDST COVID19 PANDEMIC

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ABSTRACT

Background-The respiratory disease brought about by the COVID19 (Coronavirus) is a pandemic with serious clinical manifestations, including death, and influencing nations on all landmasses. On March 11, 2020, the World Health proclaimed that the worldwide spread of the novel Coronavirus infection, was a pandemic. The sheer size of numbers coupled with high virulence of the infection has set off nationwide lockdowns across huge wraps of the globe. In such an emergency, there are ingredients at risk to stir up our ethical principles, sharpen our ethical dilemmas, and lead to situations of languishing over guardians. **Main Body-** In India, a few states have uniform guidelines, while other states have no approaches at all. Doctors constrained by the density of work, the absence of promptly accessible beds and the conceivable outcomes of moving patients to settle on agonizingly experienced decisions that were in contrast to their basic ethical principles and source of immediate burden. While Coronavirus has taken our whole concentration in treatment, we appear to have overlooked our non-Coronavirus patients? **Conclusion** - The ethical challenges that have emerged are probably going to persevere for quite a while on account of the drawn-out impact of changes in health care practice, economies, and social norms. The requirement for cautiousness about viral contagion need not diminish a likewise significant message: COVID or NO COVID, we are still here to care for you.

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INTRODUCTION

The respiratory disease brought about by the COVID19 (Coronavirus) is a pandemic with serious clinical manifestations, including death, and influencing nations on all landmasses (Neves, 2020). On March 11, 2020, the World Health proclaimed that the worldwide spread of the novel Coronavirus infection, was a pandemic (McGuire, 2020). The sheer size of numbers coupled with high virulence of the infection has set off nationwide lockdowns across huge wraps of the globe. Accordingly, the Coronavirus pandemic raises a specific arrangement of worries for our medical services frameworks, for India, just as the worldwide network.

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A few states have uniform guidelines, while other states have no approaches at all (McGuire, 2020). Since most health care resourceswere being utilized for Coronavirus patients, the circumstance likewise raised worries inside the ICU for patients without Coronavirus requiring ICU affirmation.

In such anemergency, there are ingredients at risk to stir up our ethical principles, sharpen our ethical dilemmas, and lead to situations of languishing over guardians (Covid-19, 2020) Confronted with these significant changes in patient management, doctorswere found napping, constrained by the density of work, the absence of promptly accessible beds and the conceivable outcomes of moving patients to settle on agonizingly experienced decisions that were in contrast to their basic ethical principles and source of immediate burden (Robert, 2020).

MAIN TEXT

ETHICAL DILLEMMAS

In India, we manage a colossal weight of NCD's (non-communicable diseases). NCD's kill 41 million people each year, equivalent to 71% of all deaths globally (WHO). On 1st June, 2020 WHO conducted a survey of 155 countries and discovered stressing issues in the management of health care for people with non-communicable diseases, many of these are at higher risk of severe complications from COVID-19 (COVID-19). In over 90% of nations, health care staff had been partially or completely reassigned to pandemic obligations. The delay of public screening programs (e.g., breast and cervical cancer) was likewise far reaching, reported by over half of the nations. Yet in India, without a doubt the infection is savage, so far the rate has been under one percent for reasons unknown. It has still disabled our healthcare systemby taking our total concentration in attempting to remain above empedocles in this Coronavirus violent storm (Panwar, 2020). The lacuna is anything but a modest sign concerning the drawn out status of health inIndia and the world. While Coronavirus has taken our whole concentration in treatment, we appear to have pretermit our non-Coronavirus patients? (Panwar, 2020). In the flow context, it is those patients who are more ineffectual and are not having the option to get the assistance they require.

For some, new risks may visage afterthought of usual norms of care. For others, the decisions to protect caregivers and maintain critical care capacity come in consideration. The huge decrease in seeking patients both routine and emergency care during the COVID19 pandemic is dominant part of social indemnity around the nation. Due to reverence contracting coronavirus infection patients prefer staying at home and suffer rather than risk coming to the hospital. Consequently, patients with beseeching health problems may be opt to stay at home rather than calling for help. Further, when the condition gets worsened medical attention is seeked for when treatments are less verisimilar to be lifesaving. The other reason might be lack of impartation to the hospital while others are brushing aside medical care since they have lost their medical coverage alongside their status (Podcasts, 2020), some are concerned about to impede the medical system while some are unheeded by health care systems that are quickly arranging to deal with of Coronavirus patients (Panwar, 2020). It is indispensable that we not just spotlight on the acute care of covid-19 patients, but that we likewise retroactively debar patients without COVID19, especially those with time-sensitive and medically complex conditions who are prorogue their care.

Patients with end stage renal disease or chronic renal disease in need of regular dialysis, in which a patient requires dialysis typically thrice a week – this is a life prolonging treatment and missing even one session can have severe clinical outcomes. Cancer management, which often involves immunosuppressive therapy, tumor resection, and inpatient treatment, has been incommensurately affected by COVID19. Putting off the aspects of cancer care will have grievous outcomes. Other pattern alterations have emerged in light of recantation of elective surgeries (Rosenbaum, 2020). Also, concern for patient's requisite bone marrow transplants, given their high risk of infection and potential need for ICU care. Patients with refractory tumors who are impending the end of life, however for whom a data-base targeted therapy may hold v (Rosenbaum, 2020). In patients with cardiac diseases every minute of halt, the chance of having a unenviable upshot increases (Kramer, 2020) e.g. a known case of heart disease presents to emergency department with shortness of breath, chest pain requiring urgent intubation but due to COVID19 pandemic situation it is anticipated to first rule out COVID19 as per the protocol. According to the protocol doctors have to wait for COVID19 report till then the Trop-T levels of patient bedaubed causing to direct towards acute coronary syndrome. Though, this doubt would normally enkindle more earnest coronary angiography, the exposure about COVID19 status shelve the system. Treatment for a coronary episode, nonetheless, is cardinal (Rosenbaum, 2020). Patients in need of emergency services waited to assay care after hospitals had avert nonessential visits. In spite of the fact that doctors should frequently make decisions in the midst of exposure, we commonly center around the patient's peril, not our own. In an infectious disease noxious, our densifications must incorporate our own exposure risk — and how exposure would limit our power to care for future patients (Brown, 2020). There are patients abiding and maybe miskicking the bucket due to delay in treatment at certain spots. This might be a considerably sound that we are deliberately doing to our non-Corona virus patients. We need to give due credit to different valetudinarianism and chronic diseases, where patients require unwearingregular work-up, monitoring and treatment. This is important not only to rearing health and life, but to keep prospective hospital capacity. We should assort the non-COVID19 stipulation in three groups as shown in table 1. This Coronavirus canker has been up rating common indebtness so much that individual state is reassigned from an autonomous self to a self characteristically bound to others. The torment and intricacy of these alternatives is as of now intensified by shortages of PPE. One of the yet-to-be-told narrative accounts of the Coronavirus pandemic is the acknowledgment that the (essential) banishment on the presentation of less horrendous cases has incited blow-back to incalculable patients with ailments that authentically couldn't stand by. Although, invalidating procedures such as elective hernia repairs and knee replacements is comparatively straightforward, for many interventions the line between imperative and not imperative can be drawn only in review. [13] Many procedures reckoned 'elective' are not elective e.g., patients waiting for valvular replacements. There perhaps has never been a more significant gap between what we have to know and what is really graspable (Chamsi-Pasha, 2020).

From legislation points, such as how long to prorogue elective methods, to treatment decisions, regardless of whether to treat covid-19 with investigational therapies, the bet of "pretermit to savvy the universe we don't seek after" have flourished (Fink, 2020). Maybe the best tryout, in that phase, is an in cognoscible one how would we help individuals who are ditheryto seek care to regardless? Until this point in time much general wellbeing ratting with respect to COVID19 has nilpotent in on social distancing, hand hygiene, PPE for health care workers, and the need for increased testing.[11]Worldwide telemedicine is being used by 58% countries to supercedein-person interviews but these services are only for stable outpatients, not for those who are acutely ill.[15], [16]In a context that isn't possibly perilous, these lines ought to systematically be utilized over exhibiting up at a hospital, however people should still follow typical diplomacy for all medical emergencies during the pandemic, not simply those distinguished with the infection.

PRINCIPLES OF MEDICAL ETHICS

Principles[5]		Challenges[6]	Strategies[6]
Respect for autonomy	Person ability to make choices based on their own beliefs and values.	⁃ There is a barrier to effective communication and shared decision-making due to increase use of telemedicine. ⁃ Constraints on patient's attendants. ⁃ Uncertain evidence base informed consent for decision-making.	⁃ Ensure to take informed consent in all the cases. ⁃ To facilitate timely communication, invest in resources for communication aids. Also, by training the doctors, paramedics and staff.
Beneficence Non-maleficence	Benefit patients by acting in their best interests. Not to cause harm to patients	1.Vulnerabilities regarding the risks and benefits of treatment alternatives and strategies to manage risk of COVID-19 infection. 2.Constraints of increased use of telemedicine. 3.Physical distancing and use of Personal Protective equipment's (PPE). 4.Shortage of staff prompt to deployment of staff to areas of practice outside their scope of expertise. 5.Measures to reduce infection risks may result in delays in access to or reduced quality of care delivery	⁃ Ensure adequate supply of Personal protective equipment's, train people about hand hygiene to minimise the infection. ⁃ Develop and disseminate a uniform protocol for management of COVID19 as well as Non-covid19 patients. ⁃ Communicate with family members of the patients and try to explain them regarding the healthcare emergency.
Justice	Obligation to distribute scarce health care resources fairly	1.Scarcity of health resources limiting the quality of care and/or withholding of treatment.	1.Ensure all the protocols are evidence based and it should be updated each day according circumstances.

SERVICES INTERRUPTED BY VARIOUS COUNTRIES DURING COVID19 PANDEMIC

Services	Countries reporting disruptions to essential health services (%)	Services	Countries reporting disruptions to essential health services (%)
Non-communicable diseases diagnosis and treatment	69%	Outreach programmes – Routine immunization	70%
Family planning and contraception	68%	Malaria diagnosis and treatment	46%
Cancer diagnosis and treatment	42%	Tuberculosis case detection and treatment	42%
Treatment of hypertension	53%	Antiretroviral treatment	22%
For heart emergencies	31%	Disruptions to 24-hour emergency room services	23%
Treatment of diabetes	49%	Urgent blood transfusions	19%
Critical mental health services	93%	Emergency surgery	63%

CLASSIFICATION NON-COVID 19 CONDITIONS

Emergency care	Myocardial Infarction (Heart Attacks), Strokes, Trauma (RTA), Lung ailments	
Semi elective	High precedence	Interventional Cardiology, Bypass, Transplants, Cancer Treatment, Pregnancy.
	Low precedence	Joint Replacement, Cataract
Elective	Managing NCD's; Joint Replacement, Cosmetic Procedures	

SUGGESTIONS

Non -COVID19 patients' high-risk conditions should be managed with proactive interference: Trauma and Emergency is the primary spot to chokepoint during the pandemic on the grounds that non-COVID19 patients who dodge regular care ineluctably ending up at an ER when their condition become intense. In the issue that these were typical occasions, just having telehealth for high-risk patients is not the best (Care of non-COVID, 2020).

To strength basic non-COVID19 services across hospitals, use "area pooling": Basically, it implies all the emergency clinics in a single district should cooperate to consolidate non-COVID19services, rather than spreading them out. One facility can handle all the cancer patients, for instance, while another takes care of all heart disease patients (Hindustan Times, Need to reboot health care system to also focus on non-covid patients/)

Covid-19 patients can be assembled by creating cohort wards based on COVID19 Status: Covid-19 patients with analogous basic conditions can be foregather in "cohort wards" to deal more prolifically. There needs to be sequestration of COVID19 and non-COVID19 areas, with suitable air changes and different measures to ensure that there is no cross airflow between such areas (Atkinson, 2009). It's truly going to be tied in with applying the aptitudes of the doctors and the attendants who are habitual to dealing with the patients with those particular intricacies and strings (Financialexpress, Care of Non-Covid Patients Must Not Take A Backseat Amid Coronavirus Times) The non-COVID19 patients should be optimized with treatment that may assist them with a short stay or ambulatory care choices (Financialexpress, Care of Non-Covid Patients Must Not Take A Backseat Amid Coronavirus Times). We ought to have healthcare facilities to manage both COVID19 and non-COVID19 care. Convening to accomplish this are operable and can be defined, for manpower, area segregation, patient flow, etc. (Han Jason, 2020) This will limit the interruption of disruption consideration for emergency

care, management of NCD's as well as maternal and child care (Song, 2020)

CONCLUSION

Primum non nocere (first, do no harm), said *Hippocrates*. [21] Let us not deny the fact that our other patients need proper care and treatment. From an ethical perspective, it can be repugned that esteem judgment is based on a prudent appraisal of the information procurable, taken as skimpy and advancing. It is worth incarnating on how to proceed in a health-related crisis (Neves, 2020) The ethical challenges that have emerged are probably going to persist for while on account of the protracted impact of changes in health care practice, economies, and social norms (Martin, 2020). The requirement for cautiousness about viral contagion need not diminish a likewise significant message: ***COVID or NO COVID, we are still here to care for you.***

ABBREVIATIONS

1. **COVID19:** Coronavirus
2. **NCD:** Non-Communicable Diseases
3. **TROP-T:** Troponin T Levels
4. **ER:** Emergency Room
5. **ED:** Emergency Department

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