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Wearing masks and face covers as social responsibility during the COVID-19 pandemic

- *Statement of the World Emergency COVID19 Pandemic Ethics (WeCope) Committee (23 April 2020)*

As experts in many fields, coming from many cultures and nations across the world, we declare that the scientific evidence is clear that there is an expected advantage to both individuals and those around them to wear proper face covers including masks in public during the COVID-19 pandemic.

In the early stages of the COVID-19 epidemic and pandemic, a number of medical professionals, medical authorities, governments and the World Health Organization (WHO) had denied there were advantages for wearing masks, opposed wearing them, and/or warned persons who wanted to wear masks that there was a risk of using them due to what they saw as general inappropriate use and/or providing a false feeling of safety. Unfortunately, in only a few countries mask use was encouraged by the governments, despite long standing evidence of their effectiveness (Jefferson et al., 2001; Wu et al., 2004).

There appear to have been two common reasons for opposing mask use. One is a genuine ignorance of their effectiveness, and another is fear in many countries that there were insufficient masks for medical staff. Whatever the reasons, the communication was often flawed, contradictory, unscientific, and/or deceptive, likely causing harm through increased numbers who were infected. This also has resulted in loss of public trust in health leadership and management in some places, at a time when trust is critical.

Although by April 2020 most authorities have changed their advice to actively recommend or even compel citizens to wear face coverings and masks when in public, the questions over failed public moral responsibility and the accountability for this erroneous advice should be looked at as a lesson of the COVID-19 pandemic. While some authorities order all persons to wear masks in public because of the social advantages, in case where there are limited supplies, or affordability, other face coverings may still protect against transmission. Also, we do not agree with fines or penalties against persons who do not wear masks in

Editorial address, and all correspondence to:

Prof. Darryl Macer

Email: darryl@eubios.info

public spaces, but encourage honest communication and education.

The Precautionary Principle is widely recognized in international law, yet it was generally not applied well during the COVID-19 crisis. Many people thought that they should wear masks and we applaud their informed choice, as well as the advices of some governments to wear masks, and efforts to distribute masks to the public. Article 4 of the Universal Declaration on Bioethics and Human Rights states that human beings have both autonomy and responsibility and that these should be balanced. We also still urge all in positions of authority, at least not to discourage mask use by concerned persons, for any political, cultural, racial, economic or other reasons.

It has been quite a contrast in the policies announced in different countries over whether people should wear masks to protect themselves and others from infection during the time of COVID-19 (Macer, 2020). This is a very simple example to illustrate the evolution of individual responsibility and group solidarity, although it is related to rather diverse cultural traditions around the world. We urge governments to be transparent in their assessment of the epidemiological analysis and statistics, and truthful in their public communication to uncover the scale of damage caused by any erroneous advice to citizens who wanted to wear masks, but did not wear masks because of inappropriate guidance from the health authorities.

In a world where authorities ought to be representatives of the people they serve, and a reference for the informed choices that people make, truth, transparency and inclusion in partnership with civil society are essential, and the respect for social responsibility is an ethical imperative.

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Members, World Emergency COVID19 Pandemic Ethics (WeCope) Committee:

- Dr. Thalia Arawi (Lebanon)
 Dr. Lian Bighorse (San Carlos Apache Nation, USA)
 Dr. Rhyddhi Chakraborty (India, UK)
 Mr. Anthony Mark Cutter (U.K.)
 Dr. Mireille D'Astous (Canada)
 Dr. Ayoub Abu Dayyeh (Jordan)

- Dr. Nilza Maria Diniz (Brazil)
 Dr. Hasan Erbay (Turkey)
 Prof. Nader Ghotbi (Japan)
 Prof. Soraj Hongladarom (Thailand)
 Prof. Dena Hsin-Chen Hsin (Taiwan)
 Dr. Anower Hussain (Bangladesh)
 Prof. Bang-Ook Jun (Republic of Korea)
 Prof. Hassan Kaya (South Africa)
 Dr. Sumaira Khawaja-Punjwani (Pakistan)
 Prof. Julian Kinderlerer (South Africa)
 Dr. Lana Al-Shareeda Le Blanc (Iraq)
 Prof. Marlon Lofredo (the Philippines)
 Prof. Darryl Macer (New Zealand) [Meeting Chair]
 Dr. Endreya Marie McCabe (Delaware Nation, USA)
 Prof. Erick Valdés Meza (Chile, USA)
 Dr. Ravichandran Moorthy (Malaysia)
 Prof. Firuza Nasyrova (Tajikistan)
 Prof. Maria do Céu Patrão Neves (Portugal)
 Prof. Deborah Kala Perkins (USA)
 Dr. Osama Rajkhan (Saudi Arabia)
 Ms. Carmela Roybal (Tewa Nation, USA)
 Prof. Mariodoss Selvanayagam (India)
 Prof. Mihaela Serbulea (Romania)
 Dr. Jasdev Rai Singh (England)
 Dr. Raquel R. Smith (USA)
 Prof. Takao Takahashi (Japan)
 Dr. Ananya Tritipthumrongchok (Thailand)
 Dr. Anke Weisheit (Uganda)
 Prof. Yanguang Wang (China)
https://www.eubios.info/world_emergency_covid19_pandemic_ethics_committee

Inquiries to: Prof. Darryl Macer Email: darryl@eubios.info
 Tel. +1-949-439-9307

Statement on ethical triage guidelines for COVID-19

- *Statement of the World Emergency COVID19 Pandemic Ethics (WeCope) Committee (31 May 2020)*

Rationale

This is our statement, as experts from many fields, cultures and nations across the world, having realized that tens of thousands of people have died in grim situations of the COVID-19 pandemic not only from the lethal susceptibility that some people have to this novel virus, but also because of insufficient infrastructure, human resources, protective equipment, and/or a lack of clear triage decision making protocols. The severe shortage of resources in response to the overwhelming number of patients needing life-saving treatment has reduced the ability of most healthcare systems to organize a reasonable and ethical method for triage. There have been instances of denial of access of critically ill persons to basic medical care from hospitals, excluding patients above a certain age from receiving life-saving treatments in overwhelmed Intensive Care Units (ICU), and instances where the poor and underprivileged were not given equal and fair access to quality healthcare.

In this context as an independent, multidisciplinary and cross-cultural committee, we urge all to reflect again on the moral foundations of the widely accepted principle of triage, and the reality of healthcare systems unable to cope with the pandemic. We here provide simple, practical, and defensible ethical guidelines for triage management of COVID-19 patients based on the principles of love of life, respect for human dignity,

distributive justice, fairness, non-discrimination, shared decision making, and beneficence. The ethical challenges of COVID-19 include observance of the duties to care, promotion of moral equity, planning for uncertainty, support for healthcare workers, protection of vulnerable groups, and provision of practical and ethical policy guidelines. Under no circumstances should the existence of the triage protocol justify negligent public health strategies.

Recommendation 1: *People need to know the ethical basis and moral justification when they, or their loved ones, are denied treatment or access to scarce resources such as ventilators or denied admission to a hospital.*

Ethical foundations of triage

Triage is the sorting and allocation of treatment to patients, according to a system of priorities designed to maximize the number of survivors. It involves articulation of a policy by medical administrators, and/or an assignment by medical professionals of degrees of urgency to patients to decide the order of treatment when there is a large number of them. There are different ethical theories to guide the process of triage in hospitals overwhelmed by COVID-19 patients in need of life-saving treatment. Egalitarianism seeks to treat patients equally; utilitarianism aims to maximize the greatest benefit to the greatest number, measured by the remaining life years that a decision may save; and prioritarianism argues for treating the sickest first, which is the usual practice at emergency rooms in the majority of healthcare settings.

Particularities of triage for COVID-19

Generally, patients who may be saved through immediate medical attention are treated first; others who can wait are given a lower priority, and those who are unlikely to be saved may not receive treatment with scarce resources that are needed to save lives in the first group. The provision of treatment, therefore, depends on available resources. The difficulty with emergency medical ethics is that the time required for emergency healthcare professionals to make decisions in case of any ethical conflict is limited. Patients may thus be divided into the three categories of *emergency cases* who require immediate treatment, *priority cases* with priority in the queue for rapid assessment and treatment, and *non-urgent cases* who can wait their turn in the queue for assessment and treatment. In COVID-19, the separation of *emergency cases* from others is based on the presence of serious respiratory distress, severe dehydration or shock, mental status changes, and chest pain. In light of reports of people who were not admitted to hospital, rapidly deteriorating when left unsupervised at home, ignoring the care of COVID-19 patients should be carefully examined in the context of the duty of care.

Ethical objections to selection of patients

Selection of patients based on personal characteristics (age, gender, profession, ethnicity, nationality, number of dependents, disability, and so on) violates two fundamental ethical principles: the principle of human dignity which values every human being equally, and the principle of social justice which requires equal

opportunities for all. None of the risk factors for predicting a grave outcome in COVID-19 has been proved as definitive in terms of prognosis and thus treatment should not be denied based on an underlying condition. Using old age as an excuse to deny treatment is discriminatory, unethical, and in contradiction with basic social and cultural values. The use of a 'simple cut-off' policy on age constitutes direct discrimination because comorbidities may put a younger person at a disadvantage compared with an older but healthier patient. There should neither be any race, gender or culture-based discrimination so that everyone is treated fairly, as all human beings have inherent dignity.

Recommendation 2: *Triage committees should be formed in hospitals in preparation for times of crisis, to help assist healthcare professionals decide which patients would get scarce resources based on clinical data.*

Triage committees in the context of ethics committees

The healthcare system should establish independent, multi-disciplinary ethics committees, if they do not already exist. Bioethics and triage committees should wherever possible make the difficult decisions, not the bedside health professionals who will keep doing their best for each and every patient. The triage committee should be a small but always available group of 3 highly respected professionals, with two healthcare professionals, for example a physician and a nurse, plus an ethicist. The availability of an ethics committee 24/7 helps in making unbiased decisions and reduces the burden of choice on the healthcare team, who at the time of triage are tasked with saving as many lives as possible.

It has been accepted for years in triage that the most important criterion is survivability, so that only patients who are unlikely to live, even with medical intervention, would be kept off scarce resources such as ventilators, and the highest priority would be for patients who are likely to recover with ventilator support. Ideally, the committee should examine each patient anonymously, and factors like race, ethnicity, and status should not influence their decision. If the committee gives a priority for children who are in the early phases of a normal lifespan compared to an older person in otherwise identical circumstances, it should be a public policy decision of the wider community, noting that it is a form of ageism. as discussed above. Fairness as well as transparency over triage rules are important so that the public can trust the healthcare system in respect with rationing decisions.

Independence of review and resources

We recommend separating the clinicians providing care from those making triage decisions through a "triage officer" who communicates the decision to the clinicians, patients and their family, regular review of decisions by a centralized monitoring committee to ensure that there are no inappropriate inequities, and regular review of the triage algorithm to update it based on new information. Sufficient resources should be provided to enable such a system including shared decision making, especially now with the hindsight that we have after months living with COVID-19.

Recommendation 3: *The protection of the vulnerable is a core ethical principle.*

There should be an upfront commitment to core values at the start of any triage statement. Under certain circumstances, triage is needed to optimize the benefit of the healthcare system to the citizens, when the number of severely sick patients needing intensive care is more than the capacity of the healthcare system to try and save them all. Some frail patients may not be good candidates for aggressive life-saving treatments, especially when the chance of success is dim. We recommend trying to have an informed discussion with frail patients and relatives of the patient before making difficult decisions.

Palliative care

Triage should prioritize patients who are most likely to benefit from intensive care, in order to maximize the number of lives that can be saved. Triage policies must consider palliative care for patients whose triage decision does not include life-sustaining care, as well as those who are likely to die from COVID-19. Patients who are in a medically futile situation must not be ignored, and can be provided with palliative care to ensure they are pain free. The available usual basic care considered as non-extraordinary measures, such as food or fluids should not be withheld, either. When patients are severely affected by pre-existing conditions, end-of-life care ethics do not necessarily consider that treatment should be initiated, when it may result in additional suffering, burden or distress for patients. If treatments are expected to aggravate patient suffering, level of care decisions may allow the choice of palliative care without aggressive treatment. Openness and transparency of communication facilitate the difficult discussions about end-of-life decisions. Efforts need to be made to allow family members to be present at the time around the end of life, as regrettably many persons have passed away separated from family members.

Recommendation 4: *Age, gender, race, ethnicity, existing disabilities, morbidities and/or chronic background conditions should not be used to exclude and/or deny the needed treatment or care to COVID-19 patients.*

Only certain situations may be ethically considered as a priority in triage. Such a consideration should be based on clinical and objective factors, and comply with the protocol approved by a hospital, regional, or national ethics committee¹, in consultation with the broader community, as follows:²

¹ In some countries there may be national laws that restrict the choices suggested in these recommendations; however, these are addressed to persons at all levels including policy makers, administrators, practitioners, patients and family members. We do not suggest persons break their national laws, but reflect and consider legal and administrative reforms.

² Deviations from the protocol should be accepted only when approved by an ethics committee, but we note that in some places across the globe, there may be critical human resource constraints. We also note that including a representative of patients' rights groups in triage committees may be an advantage.

- a) A competent patient may make an autonomous decision on level of care, such as choosing palliative care over intubation/ventilator use when the chance of success is very low. Patients can also provide an advance directive, or a 'durable' power of attorney as their surrogate, in case they succumb into a more serious situation in later stages.
- b) After a patient has been provided with mechanical ventilation, the ventilator may not be withdrawn unless the treatment is determined to be futile and it is needed to try and save another patient who may benefit from it.
- c) Do-not-resuscitate-orders are an ethically acceptable practice for patients when medical doctors have good reason to judge resuscitation would be futile.
- d) When a number of patients are being considered for allocation of a rationed resource such as ventilators, priority is with those who are more likely to benefit from it. Estimation of likely healthy life-years saved may be included in determination of the potential benefit. This is the only situation where age may be considered, not to deny treatment, but to decide saving whom may significantly increase the life-years saved. The difference in the predicted healthy life years saved should be significant to justify such a consideration.
- e) Healthcare workers engaged in the care of COVID-19 patients who get sick and need a rationed resource such as ventilators, can be given priority over non-healthcare workers, because saving them will be to the benefit of many other patients.
- f) Prioritization in the form of affirmative action may be considered by the committee as discussed above under "*Ethical Objections to Selection of Patients*".
- g) Prioritization in the form of affirmative action may be considered for other emergency responders who become sick while performing their duties to save the lives of others.

Members, World Emergency COVID19 Pandemic Ethics (WeCope) Committee:

Dr. Thalia Arawi (Lebanon)
 Dr. Mouna Ben Azaiz (Tunisia)
 Dr. Lian Bighorse (San Carlos Apache Nation, USA)
 Dr. Rhyddhi Chakraborty (India, UK)
 Mr. Anthony Mark Cutter (U.K.)
 Dr. Mireille D'Astous (Canada)
 Dr. Ayoub Abu Dayyeh (Jordan)
 Dr. Nilza Maria Diniz (Brazil)
 Dr. Hasan Erbay (Turkey)
 Prof. Nader Ghotbi (Japan)
 Prof. Abhik Gupta (India)
 Prof. Soraj Hongladarom (Thailand)
 Prof. Miwako Hosoda (Japan)
 Prof. Dena Hsin-Chen Hsin (Taiwan)
 Dr. Anower Hussain (Bangladesh)
 Prof. Bang-Ook Jun (Republic of Korea)
 Prof. Hassan Kaya (South Africa)
 Dr. Sumaira Khawaja-Punjwani (Pakistan)
 Prof. Julian Kinderlerer (South Africa)
 Dr. Lana Al-Shareeda Le Blanc (Iraq)
 Prof. Marlon Lofredo (the Philippines)
 Dr. Manuel Lozano Rodríguez (Spain)
 Prof. Darryl Macer (New Zealand)
 Prof. Raffaele Mantegazza (Italy)
 Dr. Aziza Menouni (Morocco)
 Dr. Endreya Marie McCabe (Delaware Nation, USA)
 Prof. Erick Valdés Meza (Chile, USA)
 Dr. Ravichandran Moorthy (Malaysia)
 Prof. Firuza Nasyrova (Tajikistan)
 Dr. Suma Parahakaran (Malaysia)
 Prof. Maria do Céu Patrão Neves (Portugal)

Prof. Deborah Kala Perkins (USA)
 Prof. Osama Rajkhan (Saudi Arabia)
 Ms. Carmela Roybal (Tewa Nation, USA)
 Prof. Mariodoss Selvanayagam (India)
 Prof. Mihaela Serbulea (Romania)
 Dr. Jasdev Rai Singh (England)
 Dr. Raquel R. Smith (USA)
 Prof. Takao Takahashi (Japan)
 Dr. Ananya Tritipthumrongchok (Thailand)
 Dr. Lakshmi Vyas (UK)
 Prof. Yanguang Wang (China)
 Prof. John Weckert (Australia)
 Dr. Anke Weisheit (Uganda)
https://www.eubios.info/world_emergency_covid19_pandemic_ethics_committee

Inquiries to: Prof. Darryl Macer Email: darryl@eubios.info Tel. +1-949-439-9307

References are available in the background paper:

Nader Ghotbi, Marlon Patrick P. Lofredo, Maria do Céu Patrão Neves, Mireille D'Astous, Rhyddhi Chakraborty, Esra Bilir, Thalia Arawi, Anke Weisheit, Hasan Erbay, Jasdev Singh Rai, Anthony Mark Cutter, Mouna Ben Aziz, Darryl R.J. Macer, and other Members of the World Emergency COVID-19 Pandemic Ethics (WeCope) Committee. (2020). Ethical guidelines for COVID-19 triage management. *Eubios Journal of Asian and International Bioethics*. 30(6) (June), 201-207.

Ethical guidelines for COVID-19 triage management

- Nader Ghotbi, Ritsumeikan Asia Pacific University (APU) Beppu city, Oita, Japan Email: nader@apu.ac.jp
- Marlon Patrick P. Lofredo, the Philippines
- Maria do Céu Patrão Neves, Portugal
- Mireille D'Astous, Canada
- Rhyddhi Chakraborty, UK
- Esra Bilir, Turkey
- Thalia Arawi, Lebanon
- Anke Weisheit, Uganda
- Hasan Erbay, Turkey
- Jasdev Singh Rai, UK
- Anthony Mark Cutter, UK
- Mouna Ben Aziz, Tunisia
- Darryl R.J. Macer, New Zealand

Context

These are difficult times. All around the world, tens of thousands of people, young or old, rich or poor, from all walks of life have died in grim situations of the COVID-19 pandemic, especially in places suffering from insufficient infrastructure, human resources, protective equipment, and/or lack of clear triage decision making protocols. There have been instances of dumping of bodies in rental trucks next to elderly homes, of denial of access of critically ill persons to basic medical care from hospitals, or giving up on treating the elderly (just because of their age). In this context as an independent, multidisciplinary and cross-cultural committee, we humbly share this review to urge all to reflect again on the ethical foundations of the widely accepted ethical principle of triage in light of dozens of statements on this topic, and the reality of healthcare systems unable to cope with the pandemic. Observing the needed precautions to prevent from the transmission of the virus, and aiming for the treatment of the disease are the best ways to reduce

harm in the community, and under no circumstances should the existence of the triage protocol justify negligent public health strategies. We are all human, but let us do the best we can to move forward, and learn together.

Ethical foundations of triage

Triage is the sorting and allocation of treatment to patients, especially battle and disaster victims, according to a system of priorities designed to maximize the number of survivors. It involves articulation of a policy by medical administrators, and/or an assignment by medical professionals of degrees of urgency to persons with injuries or illnesses to decide the order of treatment when there is a large number of patients or casualties. Generally, the persons who are thought to be saved through immediate medical attention will be treated first, others who can wait will be given a lower priority, and those who are unlikely to be saved will not be treated if lives can be saved in the first group. One of the most important reasons for the difficulty with emergency medical ethics is that the time required for emergency healthcare professionals to make decisions in case of any ethical conflict is limited (Erbay, 2014). The provision of treatment depends on available resources. As an ethical minimum, patients who are in a medically futile situation must not be ignored, and can be provided with palliative care to ensure they are pain free. However, in extreme and/or resource poor situations there may be a shortage of all medicines including pain relieving medication.

People need to know the ethical basis and moral justification when they, or their loved ones are denied treatment or access to scarce resources such as ventilators or denied admission to a hospital, and may even be unable to receive minimal healthcare, which is a basic human right.³ Different ethical theories are available to guide the process of triage in hospitals overwhelmed by COVID-19 patients in need of life-saving treatment. For example, egalitarianism seeks to treat patients equally; utilitarianism aims to maximize the greatest benefit to the greatest number, measured by the remaining life years that a decision may save; and prioritarianism argues for treating the sickest first (Romeo, 2020), which is the usual practice at emergency rooms at least in the majority of healthcare settings. Steinkamp and Gordijn (2003) compare four methods of ethical case deliberation including clinical pragmatism, the Nijmegen method of ethical case deliberation, hermeneutic dialogue, and Socratic dialogue, but believe that no single method of ethical case deliberation is ideal for all kinds of moral problems; each method has strengths and weaknesses that must be examined in relation to the moral problem. Therefore, they recommend methodological plurality. Patrão Neves (2020) distinguishes between 'rationing' and 'rationalization' in attempts to mitigate the scarcity of

³ This paper will not discuss the right to healthcare, which the authors believe should include a right to be admitted to a hospital, because as we note in many countries in the world people do not live close enough to access a hospital, even under normal circumstances.

resources and to guarantee an equally respectful treatment for every patient.

Examples of triage principles for COVID-19 around the world

There have been reports of medical doctors excluding patients above a certain age (above 60 in some reports, above 80 years of age, in others) from receiving life-saving treatments in overwhelmed Intensive Care Units (ICU) (*Bloomberg, The Guardian, The Sun News, 2020*). Using age as the only factor to decide on triage seems discriminatory, unethical, and in contradiction with basic social and cultural values. However, the severe shortage of resources in response to the overwhelming number of patients needing life-saving treatment may have reduced the ability of the system to organize a more reasonable and ethical method for triage. That is why, many healthcare institutions resort to a scoring system and some to a lottery.

Italy and Spain among other countries, offer universal healthcare coverage to all citizens yet some healthcare institutions, and/or communities reported that they were left with no choice but to exercise, at times, triage policies based on age. The COVID-19 crisis is also happening in countries where the poor and underprivileged don't have an equal and fair access to quality healthcare as well as in refugee camps and underserved areas which have their own ecology of disease that leads to differential access to treatment based on socio-economic factors. For example, urban slums and refugee camps suffer from a lack of adequate infrastructure to allow the practice of hygiene, social distancing or even access to clean water and basic healthcare. Pandemics like COVID-19 can have a disastrous effect under such circumstances and the triage system may also favor the wealthy and powerful.

Rosenbaum (2020) describes the triage of patients during the COVID-19 pandemic, in Italy, and refers to the use of old age as a factor to deny ventilator usage for two reasons: "to dedicate its limited resources to those who both stand to benefit most and have the highest chance of surviving". The example used is saving a 65-year-old patient instead of an 85-year-old patient because the saved patient would live longer and also have a bigger chance of being saved. The utilitarian approach to triage in this case implies saving considerably younger patients who have an apparent advantage in chance of survival. The same paper suggests three principles for triage: separating clinicians providing care from those making triage decisions through a "triage officer" backed by an expert team of nurses and respiratory therapists, who communicate the decision to the clinicians, the patient and the family; regular review of decisions by a centralized monitoring committee to ensure that there are no inappropriate inequities; and regular review of the triage algorithm to update it based on new information (Rosenbaum, 2020).

In the UK, triage usually follows the so-called Smart Incident Command System which grades casualties to Priority 1 (needs immediate treatment), Priority 2 (can wait for a short time before transport to definitive medical attention), Priority 3 (can be delayed before transport), and Priority 4 (most likely to die even with treatment) (Jill et al. 2006). The NHS has listed the

following groups as vulnerable during COVID-19: cancer patients undergoing active chemotherapy, radiotherapy or immunotherapy, or with malignancies in blood or bone marrow (leukemia, lymphoma, or myeloma), patients under immunosuppressive therapy, and those suffering from cystic fibrosis, severe asthma, COPD, rare diseases and inborn errors of metabolism, and pregnant women with heart disease (www.nhs.uk/conditions/coronavirus-COVID-19/). With these groups of vulnerable patients, if demand outstrips the supply of resources for intensive care, it is recommended that ICU triage should not be based on age or existing comorbidities, and should not be discriminatory over the value or worth of individuals. Rather, the decision should be fair, compassionate, consistent and solely based on clinically relevant factors and ability of the patients to benefit (BMJ 2020).

France is considering a four-tiered scoring system that attempts to predict who has the best chance for survival, based on the severity of a patient's illness, existence of comorbidities and other risk factors, and the patient's chance of returning to a decent level of health; the scores are added up into a point system, which also prioritizes children, pregnant women, and first responders such as firefighters and healthcare workers (Daley, 2020).

In the USA, the triage system for COVID-19 patients relies on a more complex system, with two primary principles of "saving the most lives and saving the most life years," which means the number of additional years of life that a patient may live after treatment. Such consideration still is more to the benefit of younger patients (Gutel, 2020). Triage in USA follows secondary principles as well, such as prioritizing the treatment of healthcare workers engaged in the disaster response and consideration of the "life cycle status," which again favors the survival of younger patients (Gutel, 2020). Berlinger et al. (2020) from the Hasting Center have referred to the ethical challenges of COVID-19 in the face of duties to care, to promote moral equity, to plan for uncertainty, to support workers and protect vulnerable groups, and to provide policy guidelines; they have also provided ethical guidelines for institutional ethics services responding to COVID-19. According to Dr. Arthur Caplan, a professor of medical ethics, there should be no race, gender or culture-based discrimination so that everyone is treated fairly and age should not be the primary factor in triage because comorbidities and underlying conditions may put a younger person at a disadvantage compared with an older but healthier patient (Hamblin, 2020). New York city had a team of experts and professionals from among medical doctors, ethicists, public health experts, and lawyers draft a guideline for ventilator allocation in 2015. The guideline recommended the formation of triage committees in hospitals in preparation for times of crisis, to decide which patients would get ventilators based on health data provided by physicians (Thompson, 2020). These triage committees should take the difficult decisions, not the bed side health professionals who will keep doing their best for each and every patient. The triage committee should be a small but always available group of 3 (an odd number) highly respected professionals, with either two physicians, or a physician

and a nurse, plus an ethicist. The most important criterion is survivability, so that only patients who are unlikely to live, even with medical intervention, would be kept off ventilators, and the highest priority for using a ventilator would be for patients who are likely to recover with ventilator support. The committee should examine each patient anonymously, so personal factors like age, race, and status would not influence their decision.

However, Brooks (2020) has reported a particularly higher mortality among African Americans in USA that may be due to social determinants of health as well as common comorbidities which may have placed them at the end of the triage list; this of course would be considered as discriminatory. Similar ethnic biases have also been found in Europe (Godin, 2020). There is also an argument against discriminatory attitudes toward the disabled and the mentally challenged which raises a new flag of unfairness and social discrimination (Please refer to the WeCope Committee report on COVID-19 and Persons Living with Disabilities).

Some commonalities from guidelines for triage in COVID-19

In this paper we aim to provide simple, practical, and defensible ethical guidelines for triage management of COVID-19 patients based on the principles of distributive justice, fairness, non-discrimination, and beneficence. We have come to these principles through literature review, and online interviews with professionals all around the world including medical doctors and ethicists, and use ethical arguments to provide answers to help governments, policy makers, hospitals, medical doctors and other healthcare workers with the hard decision of triage for COVID-19 patients in overwhelmed facilities. These guidelines should be clear and practical so that healthcare workers can use them without confusion over difficult terminology or philosophical debates. As much as possible, guidelines and procedures should be established on the ground of a fair process approach and procedural justice (Kinlaw, 2007).

Pandemics raise ethical dilemmas related to the conflict between the duty to care and the duty to treat (Klugman, 2020; Selgelid, 2009; Godkin, 2003). The duty to treat is challenged by the scarcity of resources and having people at multiple points in the chain of access to services that are under limitations of triage; those answering the telephone calls, dispatching ambulances, admitting patients into a medical building, and deciding what type of treatment may be offered after admission into the medical facility. One procedure being used in Phoenix Indian Medical Center, for example, has been to set up a tent outside the facility for initial screening of all persons to identify which persons can enter the facility, and where should they go. Another procedure being used in many countries is to telephone ahead before even coming to a medical facility, to advise persons if they even have a chance to enter a facility, or if they are advised to stay at home. The duty to care, on the other hand, has led many nations to call their healthcare workers heroes because they are risking their lives caring for COVID-19 patients amidst a lack of sufficient personal protective equipment (PPE) and other safeguards (Hsin and Macer, 2004). The refusal to treat

could have a drastic effect on triage. The heroism of healthcare workers is the main source of support for COVID-19 patients, especially when protective personal equipment (PPE) is scarce and full protection is not available.

To guide healthcare workers in their duties to care and treatment in a triage situation, the World Health Organization (WHO) released the Emergency Triage Assessment and Treatment guidelines that divides patients into three main categories: *emergency cases* who require immediate emergency treatment, *priority cases* who must be given priority in the queue for rapid assessment and treatment, and *non-urgent cases* who can wait their turn in the queue for assessment and treatment (WHO, 2005). In COVID-19, the separation of non-urgent cases from others is based on the presence of respiratory distress (severe breathlessness, respiratory exhaustion, increased respiratory rate), oxygen saturation less than 93%, severe dehydration or shock (SBP less than 90 and/or DBP less than 60 mmHG), mental status changes (confusion, agitation, seizures, drowsiness, GCS < 15), and chest pain (CDC, 2020).

However, a difficult question is what to do when too many patients need a scarce resource such as a ventilator. Vincent and Taccone (2020) suggest limiting the use of life-sustaining therapies for ICU and hospital patients with poor predicted outcomes associated with old age, frailty, comorbidities, or profound disability, or a lack of personnel, beds, or materials. Domenico et al. (2020) recommend that *"If no effective treatment is found quickly, triage decisions will have to be taken concerning access to hospitals and ICUs"*. They suggest that the triage should prioritize patients who are most likely to benefit from intensive care, in order to maximize the number of lives that can be saved. They also recommend that triage policies must consider palliative care for patients whose triage decision does not include life-sustaining care, as well as those who are likely to die from COVID-19 (Domenico et al., 2020). The available usual basic care considered as non-extraordinary measures, such as food or fluids should not be withheld, either.

Patrão Neves (2020) considers that the selection of patients based on personal characteristics (age, gender, profession, ethnicity, nationality, number of dependents, etc.) violates two fundamental ethical principles: the principle of human dignity which values every human being equally, and the principle of social justice which requires equal opportunities for all. Therefore, it is important to make a distinction between rationing and rationalization. Rationing may be ethically acceptable when the criteria of selection are transparent and refer to non-vital resources. Rationalizing refers to the most reasonable ('rational') use of limited resources solely under the criterion of making the most of it; the goal is optimization of available resources, making them as efficient as possible. Therefore, in life and death decisions, such as providing respiratory support for COVID-19 patients, rationalization may be the only ethical approach because it does not value some persons in detriment of others, but chooses the optimization of scarce resources.

Truog et al. (2020) explain that some triage guidelines require saving the most lives, which implies a consideration of the patient's short-term likelihood of

surviving the acute medical attack. Rationing should be conducted through a triage officer or committee (which may include ethicists) by those who are not directly engaged in the care of the patient, and is done in three steps. First, exclusion criteria are applied, such as whether an irreversible shock has occurred. Next, the mortality risk is evaluated through Sequential Organ Failure Assessment (SOFA) score, to see whether the patient should be given priority for initiating ventilation. Third, assessments should be repeated over time, so that patients who are not improving may be removed from the ventilator to make it available for another patient (Truog et al., 2020). The tricky question here is when one can really argue that a patient is not improving, after a day, 2-3 days, or a week? They recommend that physicians proactively engage in a discussion with patients and their families before the patient's condition has started to deteriorate. Such discussions need to be made in the best possible way and include the requirements of safety and social distancing. They recommend that ventilators be allocated to those patients who are most likely to benefit from them, because after a patient has been provided with mechanical ventilation, withdrawing the ventilator would be a difficult decision to make. However, if the treatment is determined to be futile, it needs to be done to try and save another patient who may benefit from it (Truog et al., 2020). Discussions on 'do-not-resuscitate-orders' have been made in USA (Cha, 2020; Na, 2020).

In Quebec, patients can decide the level of care that will be provided. A formula is provided by INESSS (Institut national d'excellence en santé et services sociaux, at <http://www.inahta.org/members/inesss/>) with the aim to respect a person's wishes and to determine the medically-appropriate care that will be delivered. When patients are severely affected by pre-existing conditions, end-of-life care ethics do not necessarily consider that treatment should be initiated, especially when it may result in additional suffering, burden or distress for patients. The planning of advance care decisions is delicate and sensitive. Openness and transparency of communication can facilitate the difficult discussions about end-of-life decisions. If treatments are expected to aggravate patient suffering, level of care allows the choice of palliative care without aggressive treatment. The four levels of care are: prolong life with all necessary care (Goal A), prolong life with some limitations to care (Goal B), ensure comfort as a priority over prolonging life (Goal C), and ensure comfort without prolonging life (Goal D). A competent patient can make an autonomous decision over the levels of care or provide an advance healthcare directive. Levels of care can also be a result of shared decision of a doctor and the representative of the patients.

Schuklenk (2020) has emphasized on the preeminence of fairness as well as transparency over triage rules in any country, state, city, or hospital so that the public can trust the healthcare system in respect with rationing decisions. The British Medical Association (BMA) warns against direct and indirect discrimination in prioritization decisions, as when medical doctors resort to quick decision-making for its associated benefits. For instance, this attitude can be indirectly discriminatory against the elderly; the use of a 'simple

cut-off' policy for age is unlawful and constitutes direct discrimination. For example, a "healthy 75-year-old cannot lawfully be denied access to treatment on the basis of age" (BMA, 2020, p. 6). The guideline published by Michalowski et al. (2020) of the University of Essex also rejects the use of advanced age as a triage criterion because it discriminates against the elderly. Melnychuk and Kenny (2006) criticized the utilitarian approach by Christian et al. (2006) for the fact they the values and principles used are not explicit. They recommend the formulation of policy based on three values: equity, trust (fair processes and fair treatments) and solidarity. In Lebanon and in the Arab world, such discrimination is also considered a breach of religious practices which might leave the decision maker with a troubled conscience and soul (Arawi, 2020).

Doctors and healthcare workers may contract SARS-CoV-2 and suffer from COVID-19; therefore, ethical triage should also provide recommendations for the medical community (Emanuel, 2020). In fact, many healthcare workers have died, and some died directly because of limited personal protective equipment. The Statement on European Solidarity and the Protection of Fundamental Rights in the COVID-19 Pandemic mentions the "disproportionate burden of this pandemic in caring for patients" on healthcare workers. This was also seen in SARS (Hsin and Macer, 2004). The Ebola outbreak in West Africa (2014-2016) has shown the risk of harm to healthcare workers. Since the priority should be to increase the capacity of healthcare systems to handle the cases to the benefit of all, the recommendation to prioritize healthcare workers is not linked to their age or status. It is also imperative that healthcare workers often seek out, assess, and absorb information that underlie their treatment decisions and options.

Fever clinics in Wuhan, China used a flowchart for treatment of COVID-19 disease which is an algorithm for decision-making support (Zhang et al. 2020). The main factor implying gravity of the patient's condition was dyspnea/hypoxia with SpO₂ less than 93%, but also elevated C-reactive protein (CRP) and bilateral large ground-glass opacities in the chest CT-scan, which require admission for oxygen therapy. Ayebare et al. (2020) modified the above algorithm by not using a chest CT-scan in the situation of low-income countries because it did not appear to significantly change the management strategy. A growing number of hospitals are considering the use of automated tools to overcome the shortage of staff in the face of overwhelming patient loads, so that they can manage the COVID-19 pandemic (Hao, 2020). In many countries, healthcare workers face a difficult situation over the lack of protective devices which further hinders the job of triage at the point of admission. Under such circumstances, artificial intelligence (AI) could help with a better and quicker scoring of patients based on the agreed upon clinical as well as prioritization criteria. The use of WIFI also enables the sharing of information among the healthcare personnel in charge of triage without putting them at risk of contamination. Medical doctors in Korea have reported that artificial intelligence (AI) using deep learning techniques outperformed medical doctors in triage of trauma patients (Kang et al. 2020). The use of AI may help with an objective implementation of triage

criteria and have it done more quickly. However, as the review by Wynants et al. (2020) has shown, the current prognosis prediction models for COVID-19 are of poor quality and cannot be recommended for use. Nonetheless, there is a possibility to use telemedicine technologies to help realize a pre-triage (Hollande, 2020). An ethical consideration is to make sure that AI data are protected in respect to confidentiality of patients' information.

Considering the differences in protocols and opinions regarding triage in the COVID-19 pandemic as shown above, there is a dire need for a global ethical framework that makes clear the values and principles that will guide pandemic response planning. Such a framework can clarify the values and principles that may guide the planning of the response to the pandemic. The development of such a framework involves actual effort in the preparation of policy and its application; ethicists would have an obligation to provide a clear understanding why certain values are privileged and others are not.

Conclusions

This review of literature and the online interviews of medical doctors, ethicists and other professionals has demonstrated the difficulty and challenges faced by the healthcare systems, medical doctors, nurses and other healthcare workers in providing the needed treatment and care to an increasing number of patients in the COVID-19 pandemic. In many places around the world, hospitals have been overwhelmed with subsequent shortages of trained staff for emergency care (especially intubation), as well as the needed ventilators for respiratory support, usually provided in ICU departments. Under these circumstances, triage is needed to optimize the benefit of the system to the citizens. There should be an upfront commitment to a couple of core values at the start of any triage statement. One of the core ethical values is that the protection of the vulnerable should be regarded as a core principle.

Many of the previously developed decision-making systems and guidelines for triage may be applied in the new context of the COVID-19 pandemic. Availability of an ethics committee 24/7 could help in making unbiased decisions and reduce the burden of choice on the healthcare team. Such a committee may consider a priority for children who are in the early phases of a normal lifespan. Some elderly and frail patients may not be good candidates for aggressive live-saving treatments, especially when the chance of success is dim. Trying to have an informed discussion with an elderly patient or relatives of the patient may be helpful before making the decision. It may even be a good idea for people to have a discussion with their elder parents earlier, particularly as the consequences of the disease, even after recovery, are extremely debilitating, particularly for elderly people. The number of severely sick patients needing intensive care may be more than the capacity of the healthcare system to try and save them all. However, none of the risk factors for predicting a grave outcome and thus deny treatment to some patients has been proved as reliable in terms of prognosis (Wynants et al, 2020).

Recommendations for ethical guidelines

- 1) People need to know the ethical basis and moral justification when they, or their loved ones, are denied treatment or access to scarce resources such as ventilators or denied admission to a hospital.
- 2) Triage committees should be formed in hospitals in preparation for times of crisis, to help assist healthcare professionals decide which patients would get scarce resources based on clinical data.
- 3) The protection of the vulnerable is a core ethical principle.
- 4) Age, gender, race, ethnicity, existing disabilities, morbidities and/or chronic background conditions should not be used to exclude and/or deny the needed treatment or care to COVID-19 patients.

Only certain situations may be ethically considered as a priority in triage. Such a consideration should be based on clinical and objective factors, and comply with the protocol approved by a hospital, regional, or national ethics committee⁴, in consultation with the broader community, as follows:⁵

- a) A competent patient may make an autonomous decision on level of care, such as choosing palliative care over intubation/ventilator use when the chance of success is very low. Patients can also provide an advance directive, or a 'durable' power of attorney as their surrogate, in case they succumb into a more serious situation in later stages.
- b) After a patient has been provided with mechanical ventilation, the ventilator may not be withdrawn unless the treatment is determined to be futile and it is needed to try and save another patient who may benefit from it.
- c) Do-not-resuscitate-orders are an ethically acceptable practice for patients when medical doctors have good reason to judge resuscitation would be futile.
- d) When a number of patients are being considered for allocation of a rationed resource such as ventilators, priority is with those who are more likely to benefit from it. Estimation of likely healthy life-years saved may be included in determination of the potential benefit. This is the only situation where age may be considered, not to deny treatment, but to decide saving whom may significantly increase the life-years saved. The difference in the predicted healthy life years saved should be significant to justify such a consideration.
- e) Healthcare workers engaged in the care of COVID-19 patients who get sick and need a rationed resource such as ventilators, can be given priority over non-healthcare workers, because saving them will be to the benefit of many other patients.

⁴ In some countries there may be national laws that restrict the choices suggested in these recommendations; however, these are addressed to persons at all levels including policy makers, administrators, practitioners, patients and family members. We do not suggest persons break their national laws, but reflect and consider legal and administrative reforms.

⁵ Deviations from the protocol should be accepted only when approved by an ethics committee, but we note that in some places across the globe, there may be critical human resource constraints. We also note that including a representative of patients' rights groups in triage committees may be an advantage.

- f) Prioritization in the form of affirmative action may be considered by the committee as discussed above under "Ethical Objections to Selection of Patients".
- g) Prioritization in the form of affirmative action may be considered for other emergency responders who become sick while performing their duties to save the lives of others.

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Healthcare professionals acting ethically under the risk of stigmatization and violence during COVID-19 from media reports in Turkey

- Sukran Sevimli, M.D.

Department of Medical History and Medical Ethics, Dursun Odabas Research Hospital, Faculty of Medicine, Van Yuzuncu Yil University, Turkey
Email: sukransevimli@gmail.com

Abstract

Aim: The COVID-19 infection is transmitted either by human-to-human contact, social-physical contact, and respiratory droplets or by touching items touched by the infected. This has triggered some conflicted behaviors such as stigma, violence and opposite behavior applause. The aim of this study is to explore several newspaper articles about stigma, violence, or insensitive behavior against healthcare professionals and to analyze reason of these behaviors during these COVID-19 pandemic.

Method: The website of the Turkish Medical Association "Press Releases News" and online newspaper articles have been scanned using keywords and have been classified and analyzed according to the content of articles between the periods of March 11 to April 28, 2020. This is a qualitative study with content analysis. No official ethical permission was obtained as the study was conducted through open access internet news sites.

Result: 16 reports were selected from online reports that matched the keywords of the study. 13 of these reports included desensitization, violence, lack of precaution, stigmatization, and applause, and 3 reports included doctors' statements. After being categorized, content analyses were conducted.

Conclusion: This study revealed the necessity of multi-faceted evaluation of the problems faced by healthcare professionals who are at the forefront of the COVID-19 outbreak. This study has a primary role in the detection,

diagnosis and treatment of the pandemic and reveals that doctors are trying to fulfill their duties in an ethical framework despite stigmatized behavior. Authorities should provide various supports to protect healthcare professionals before, during and after the epidemic for the success of COVID-19 outbreak struggle.

Introduction

Pandemics are actually not new; the world has experienced pandemics about every 10 or 50 years since the 16th century (WHO, 2005). However, the novel coronavirus is affecting the world more now despite advanced medicinal advancements. Coronavirus, first described in the 1960s and found to be very common, has the ability to be passed from animal to human which is why most people have encountered it at some point in their life (WHO, 2007). The human coronavirus often causes mild to moderate upper respiratory diseases; it can cause a variety of diseases, from the common cold to more serious diseases such as the Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV) (WHO, 2005).

Previous cases of pneumonia of unknown etiology in Wuhan city of Hubei province, China were reported to the World Health Organization (WHO) on December 31, 2019. It was then when WHO announced the discovery of the novel coronavirus (2019-nCoV) and labeled it as the sixth "international public health emergency" on January 30, 2020 and later publicly announced a pandemic on March 12, 2020 (WHO, 2020).

The COVID-19 infection is transmitted by human-to-human contact, social-physical contact, and respiratory droplets or by touching items touched by the infected. It has been identified as having a median incubation time of 4-5 days, yet the ability for transmission of the disease may extend up to 14 days. These findings for COVID-19 and its infection methods are still the same; however, research may present new information that deepens the understanding of this virus.

Health stigmatization, humiliation, insensitivity and violence: The basis of health stigma is perception of the sick person as an object that is contaminated and becomes dangerous. This perception can lead to easily giving up on helping people who are stigmatized without any conscience and ethical concern.

Health stigma has been seen throughout history, where people display negative and discriminatory attitudes, stereotyping a person or group of people experiencing a particular disease, where the disease occurs, and things related to the infected diseases (e.g., HIV/AIDS, Ebola, SARS-CoV, MERS etc.) (WHO, 2007). Unfortunately, the extent of labeling patients has expanded during the COVID-19 pandemic, because COVID-19 has infected people in very fast and easy ways, and transmission can occur in a variety of forms, including through air, social distance under 2m and exposed clothing. It has led to high morbidity and mortality around the world, and has seriously affected interpersonal relationships. For this reason, the high risk of contamination has increased stigmatization towards patients (both confirmed and under investigation), including healthcare professionals (HCPs) who treat COVID-19 patients. People's approach to stigmatizing

infectious diseases has become more intense in the COVID-19 period, to the extent of stigmatization healthcare workers.

Pandemics and ethics in Turkey: The Hippocratic oath, medical deontology regulations (Türk Bakanlar Kurulu: Turkish Council of Ministers, January 13, 1960), medical ethics practices, and patients' rights regulation (Turkish Republic Ministry of Health, 1998) describe the physician-patient relationship and require physicians to place the patients' welfare as their primary consideration in Turkey. Within the framework of these regulations, as a general principle, healthcare professionals are responsible for carrying out health services completely under any risk, including natural disasters or pandemics.

As a matter of fact, the Ministry of Health canceled the holiday permits of health professionals across the country immediately after the first COVID-19 cases started to appear (excluding marriage, death, maternity leave and accompanying leave under article 105, and unpaid leave under article 108, and under exclusion article 104 of law No. 657) (Memurlar.net, 13 March 2020). Moreover, all health institutions across the country have started to work to solve medical, social and legal problems that arise with the COVID-19 outbreak in a short time. Therefore, the Ministry of Health prepared new information and consent forms to prevent from issues between patient/patient relatives and doctors on March 13, 2020, e.g. COVID-19 patient/contact follow-up (quarantine) information and consent form, inpatient information and consent form, consent form for patients outside COVID-19 diagnosis, COVID-19 patient relatives/companion information and consent form, and COVID-19 highly suspicious patient information and consent form.

In the meantime, the Ministry of Health, the Turkish Medical Association, and television networks started to inform the public with various videos and discussion programs about the COVID-19. However, the pandemic in question was not taken seriously enough; some patients tried to escape from the hospital, some left the quarantine, and COVID-19 suspects expected to quarantine themselves at home went to Mosque, shopping or even funeral ceremonies. Moreover, these preparations were not sufficiently considered by some segments of the society, unfortunately, and stigmatization and attacks on health professionals continued.

Research questions

This present study aims to explore the following questions: Does COVID-19 reveal stigma and violence? Does the attitude of some authorities or celebrities play an important role in stimulating and normalizing stigmatization and violence? The answers to these questions will contribute to an understanding of the shortcomings and inaccuracies regarding health stigma.

Findings and discussion

The present study's data is based on reports collected from online media. These reports demonstrated the public knowledge of COVID-19 and the three main attitudes seen as psychological support for HCPs;

however, stigma and violence against front line HCPs was still present. Therefore, this study has included comments of HCPs to better analyze the study situation, as they play the most crucial and even the primary role in this pandemic and want to fulfill these roles in the best possible way.

There is an interesting perception of HCPs present during the care of a patient as if they belong to another place or class; that HCPs should treat their patients in the best possible way, but they should also be blamed for problems in the healthcare process. There is an incomprehensible attitude as if HCPs are not human. They are human; HCPs also have human rights and the Universal Declaration on Bioethics and Human Rights, UNESCO article 11 provides that "No individual or group should be discriminated against or stigmatized on any grounds in violation of human dignity, human rights, and fundamental freedoms (UNESCO, 2005).

Applause on one side, violence, blame, stigmatization on the other

I. **I. Applause:** The morale of an applause campaign for healthcare workers fighting coronavirus started in Europe and was then followed with the recommendations of National Assembly Health Minister Fahrettin Koca of Turkey to be done the same. Turkish people applauded at 9PM to show support to healthcare professionals **Figure 1**. (BİA Haber Merkezi, 19 March 2020).

The President of the Istanbul Chamber of Medicine, Dr. Pınar Saip said: "We are very happy. We really needed this. The HCPs have been battling violence for a long time. We were seen as responsible for changes in the health system and the problems it caused. The excessive intensity that we experienced was challenging us; we were facing patients and their relatives. There was humiliation and disrepute. Now with the 'applause' issue, it was once again understood that we are on the same side."

At an open-air meeting, HCPs asked for work and economic conditions to be improved, other than clapping. Two of them were related to COVID-19 as follows: All healthcare providers should have 1 test in 5 days, and COVID-19 should be considered as a work hazard, COVID-19 is an occupational disease (Duvar Gazetesi, April 30 2020).

One of the doctors indicated that "this moral applause gives to us happiness. However, I wish that this support should not be limited to the timeframe that we faced the epidemic and breathed death. It should always be."

"Are the precautions taken for doctors sufficient?" Dr. Saip' answer is clear: "There were patients we met without realizing it. A pre-diagnosis before the diagnostic tests would have been more beneficial for prevention. Every healthcare institution needs to take action for its employees. There is still a shortage of protective materials in many family health centers, public and university hospitals. Hand sanitizers, liquid soaps, and necessary protective materials must be sufficient according to the work area. "If they do not become permanent, if the healthcare professionals get sick, then we may have difficulty in running the process"(Soybaş, 21 March 2020).

This support was meaningful for health workers, but unfortunately, violence, stigmatization, blame, humiliation and disrepute towards health workers did not end. People should think that COVID-19 cases have increased in a short time in Turkey, and HCPs have endeavored to treat patients although their lives were at risk.



Figure1. We applaud the health workers
(Source: <https://www.gazetebirlik.com/haber/uc-gun-saglik-calisanlarini-alkisliyoruz->)

Stigmatization and blame: Stigmatization and blame continued by celebrities, a governor and some people. There were statements of M. Anlı encouraging "violence to physicians". M.Anlı targeted the doctors because she was not given an injection! She wanted to have an injection in the car. M. Anlı told her Tath Sert program at ATV, that she went to the hospital due to migraine pain and that she was not given an injection though she called the doctor to inject in her car. However, the doctor rejected her request and invited her to go inside the hospital. Anlı stated on her television show program, after telling her story: "Then we say, doctors are not nice ... then we close the hospitals"(Habervakti, March 30 2020).

Anlı's comments were viewed as clear violence against healthcare workers. Following some statements by public doctors, nurses and other healthcare professionals working in the hospital that you do not want to enter, and with the public's opinion being negative, Anlı apologized after receiving criticisms; however, her apology was not clear.

A city Governor said: "137 of 567 cases were HCPs, they could not protect themselves". He spoke at a press conference: "Normally we would be talking about comeback today if it wasn't for the burden that our healthcare workers brought us. This was really difficult. We hosted our HCPs in the guesthouse. We did not charge for their meals. We also tried to provide them services. But because they were not careful enough in their relations there, they put both themselves and us in danger. They did not protect themselves, and they became a burden to us as well" (A3haber, 17 April 2020).

After he was criticized for this statement he said sorry. But still after that HCPs left the guesthouse they were staying, allocated for them in order not to infect their families. However, they continued to provide healthcare services, despite the risk of contamination and being accused of getting sick. The above description

did not reflect the facts, because healthcare professionals are serving patients with COVID-19, and the infected person in question was detected late, since HCPs were not tested frequently.

Healthcare workers were devotedly working in hard conditions because of the coronavirus. A dentist was dismayed after seeing a message hanging at the entrance of his apartment building. In the message, which was written on a piece of paper and hung at the entrance of the apartment: "To the dentist residing in this apartment, do not touch the doors and stairwells while entering and leaving the apartment (DHA, April 5 2020).

In Sinop, a site manager posted a decision that healthcare professionals must use the rear elevators and not the front elevators. Two female healthcare workers living in the apartment answered the article with the note: "Your discriminatory words break our working desires. We are trying to treat you without discrimination in the hospital while you separate us as a healthcare provider. Even though you know that our spouses are on duty abroad, we leave our little children alone at home, and go to watch for you, your discriminative attitude is far from solidarity and breaks both our professional dignity and the determination to work. Your attitude is never acceptable in these difficult days that the whole world should be in unity, solidarity and solidarity. We will take all precautions to check in and out. Let the residents who are disturbed by this, use the staircase option".

The warning letter of the site management that was shared on social media was removed upon the reactions (Habertürk Gazetesi, April 7, 2020). The Health Communication Association President said: "Violence is not just physical. Psychological and verbal violence also creates a trauma as much as the physical one on healthcare workers and doctors. Most of these people do not go to their homes, they stay in the hospital. However, believing that returning home and seeing such an article one evening is no different than a fist." (Soybaş, April 6 2020)

Unfortunately, violent incidents happen at various levels and degrees such as insults, shouting, humiliation, and threats in hospitals which have become normal in the health system. This attitude has also been adopted by some governors of cities, celebrities and politicians making the current situation worse. As seen in the online reports above, the accusation, humiliation, and labeling behaviors towards healthcare professionals who provide healthcare services at the time of the pandemic continue. Unfortunately, this attitude belittles healthcare workers far from appreciating their value. It is important to interact with risky patients and those who are concerned about losing a much loved relative, and this pandemic worsens the problem. The reports above reveal that the lack of communication skills is a fundamental problem on all sides. Of course, the patient-physician relationship occasionally experiences communication problems. However, a solution can be realized with improvement of the communication skills of the healthcare professionals, as well as individuals who have influence upon people whom can help solve the problem.

Healthcare professionals are not the one who bring the disease; they try to treat the patient with serious

risks involved. However, this situation has been reversed, and healthcare workers who have the knowledge and experience in the treatment of COVID-19 are perceived as ignorant-malicious persons and threats are now being thrown at them.

Such events show that some people have a negative perception against HCPs. Actually, the threat of the apartment manager included a hidden humiliation both to HCPs and to medical education. As it is known, infectious diseases threaten not only the patient but also the healthcare team. It is known that many healthcare workers have been infected while treating patients throughout history. This undesirable situation sometimes happens despite all the precautions. According to the Ministry of Health, 7428 HCPs were infected during the COVID-19 health service as of April 29 (Medimagazin, 2020b). This situation is not only in Turkey but also in all countries struggling with COVID-19 (e.g., Israel, Italy, China, UK, France, Spain, Iran, the U.S., Greece, Poland, Pakistan) where many HCPs have been infected, and unfortunately some of them have already died (Newsweek, 04.03.220).

Violence against healthcare professionals: Despite new regulations violence against doctors and health professionals continues. For health professionals in Turkey, parliament adopted 'Violence in the Health Act', on April 15 2020. This law covers "deliberately injuring, threats, insulting and resisting not to perform duty" in the Turkish Criminal Code, committed against healthcare personnel and auxiliary workers in public and private health institutions and organizations. The penalties to be determined according to the relevant laws will be increased by half (Sayın, 2020).

In another case, S.A., who came to hospital with a headache complaint, said that he wanted to be treated urgently. Okan K., the doctor in charge of the emergency room, told S.A. that his health condition was not serious, that the hospital was risky due to the coronavirus and that his home was safer. Thereupon, S.A. punched the doctor, and grabbed his throat (Medimagazin, 23 March 2020).

Another incident occurred in Samsun around 3:30 PM of 24 March 2020. According to the information obtained, D.A. and his cousin Gamze K. went to Gazi State Hospital. The secretary in the hospital cautioned them saying, 'Just stay there' because of the coronavirus measures. The cousins wanted to be examined by a specialist but to no avail they were referred to the general practitioner Z.K. where D.A. was examined. When the doctor touched D.A. he exclaimed, 'You're hurting me, what kind of doctor are you?' and he started shouting. Meanwhile, Gamze K. started hitting Z.K.'s head, which they squeezed between the examination table and the wall (Figure 2). After the commotion in the room, doctor Z.K. reported the incident to the police (İnan, 23 March 2020).

In another incident, the sons of a patient, who was treated for suspected coronavirus, battered the nurse and the security guard. The sons of the patient who was treated in a private hospital with the suspicion of a novel type of coronavirus (COVID-19) in Konya, A.A. and İ.A. battered a nurse and a security guard. The two suspects were arrested and detained (AA, 2020).

Shocking images of the attack on the nurse who struggled with the corona virus appeared in Izmir! D.Y. wanted to report for her child. However, she did not give her child's periodic report because she was not her family doctor. Thereupon, Dr. D.Y., who went to the family health center where Akkus worked, allegedly tried to head to the room of the nurse A. Kavuklu, who was a witness in the case. Despite the interference of health center employees, D.Y., who was walking on Kavuklu, battered the nurse there. (Sabah Gazetesi, 04.04.2020).



Figure 3: Girls attacked the doctor (Source: <https://www.sozcu.com.tr/2020/gundem/genc-kizlar-doktora-boyle-saldiridi-5711625/>)

A doctor, who was attacked by the patient's relatives, rebelled: I'm afraid, do you hear me? Doctor EE. Genç, who worked at KTÜ Farabi Hospital, was attacked after a patient with lung cancer and breathing difficulties died. They entered the COVID-19 ward, with masks and overalls, waving their hands and kicking left and right, over the patient who passed away. Sharing her fearful moments from her social media account, Doctor Genç said, "What will happen next time, will I be able to return home to my family? (Figure 3). I don't know" she said (Akduman, 2020)



Figure 3. "I Don't Feel Safe" (Source: <https://www.bursa.com/kendimi-guvende-hissetmiyorum-n425090/>)

There was an attack against field investigation team on the street. The Ministry of Health formed an "infectious diseases and fighting guide (Regulation 22/2018)" to prevent and reduce infectious diseases (T.C. Sağlık Bakanlığı, 2018). The field investigation team's first aim is to find the source and the effect after the notification of the case and/or taking protection and control measures including the contacts. Wearing protective overalls, masks and gloves, the team goes to specified addresses and takes samples from the people to be tested. The teams deliver the samples they take to the reference laboratories. The results of the field

investigation team's work in the field are evaluated by a committee of public health experts. The last step is to keep persons under investigations (PUIs) and/or persons under monitoring (PUMs) for 14 days in a hospital or in their house, to break the chain of the pandemic. This method leads to early diagnosis of COVID-19 patients or suspects, helping to start treatment at the initial stage of the disease.

The field investigation team provide important information such as whether the danger still continues and whether other people are at risk can be obtained. Therefore, this team is taking a crucial role in fighting all infectious disease, and so it makes the fight against COVID-19 more effectively. The violence against field investigation team who are in the riskiest position group in the coronavirus epidemic and who lost many of their colleagues is not ending. One of the field investigation team members A.I. and B.A. with the driver of the institution, were attacked on the street on their way to the field investigation house in Bursa (Duvar Gazetesi, April 29, 2020).



Figure 4: the field investigation team (Source: Duvar Gazetesi, April 29, 2020)

There was also an alleged 'threat to death' to a family doctor in Izmir. In a statement made by the Izmir Chamber of Medicine the person was invited to the family health center for his child's vaccinations. The family physician explained that vaccination procedures were carried out while maintaining social distance. However, the family physician was threatened with death by child' relatives for having to wait in line (AA Haber, May 2 2020).

It is seen that the accusation against healthcare professionals and the violence continues and remains unchanged. It may be thought that the psychological balance of the society is affected by the deterioration of coronavirus, but there was violence towards healthcare professionals even before the coronavirus. Meanwhile, the law for prevention of violence in healthcare has finally been adopted in the period of COVID-19. This is a good development, but in the law, delays in the punishment of the violator against healthcare professionals will reduce the impact of this law. In fact, it is necessary to determine a serious policy for the prevention of violence throughout the country and to implement it seriously. In order to eliminate the problems brought by the system, this system needs to be revised.

The commercialization of health undermines the community's trust in the country's health system. Citizen M. Güleriyüz said, "I had a cough for two or three days. My cough did not pass. I went to a private hospital for the COVID-19 test. It was the nearest hospital to me.

They demanded 476 dollar for the test. There was a controversy over it. Gülerüz, who went out with anger, tried to enter the hospital door with his vehicle (Yeniçağ Gazetesi, 29.04.2020).

The COVID-19 pandemic forces a decision on citizens as private hospitals should not request examination fee and additional surcharge from patients undergoing treatment. However, as seen in the case above, COVID-19 test was not included within the scope of this ministry and a serious fee was requested.

In this context, complains against private hospitals were made in the past due to many violations. The inquiries have been opened for many hospitals, as many of these private hospitals have asked for unnecessary tests or examinations, and the strategy of increasing the patient's income seriously damages both the patient and the state such as 10 percent of cataract surgeries are unnecessary. After a fake treatment to the father of the president of the Social Security Foundation, in private hospitals an investigation was opened into the private hospital, because these hospitals used the identity of former patients to get the minimum wage (Medimagazin, 2020a).

Briefly, the commercialization of the healthcare system affects many private hospitals, and raises new problems and harm on health equality.

Limitations of study

The present study data were collected from online Turkish newspapers by Google research engine and also from web sites such as Ministry of Health that take official regulation into consideration. Collected reports were taken by key words between March 11 and 30 April 2020. These reports were discussed in the public and on social media and made in some judicial proceedings. Of course, online report can be evaluated in various ways in different contexts or interpretation.

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I would like to thank all healthcare professionals who continue to provide healthcare services with ethical attitude despite some negative backlash and the COVID-19 outbreak and also to journalists who continue to report the facts.

Conflict of interest

None

Conclusion

This study is about stigmatization and violence against HCPs in Turkey during the COVID-19 pandemic. This world crisis has seriously exerted great pressure on healthcare facilities and healthcare professionals, and society. Although healthcare professionals have presented healthcare service in the frame of the Hippocratic Oath, Medical Deontology Regulation, medical and public health ethics, and patients' rights, they have encountered stigmatization and violence. Stigmatization is an urgent issue because it triggers some negative perceptions such as prejudice, discrimination, and negative stereotypes. These perceptions cause the stigmatized people to be subjected to various acts of violence.

The online reports events included in the study prove this situation. Therefore, stigmatization should be considered as an urgent issue and a serious and feasible policy should be developed to prevent stigmatization and violence. In this way, we can protect the healthcare professionals who are committed to protecting and improving the public health, and therefore the society. We should endeavor more to remove violence in health from the agenda in Turkey.

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Dabawenyos helping Dabawenyos in a spirit of Bayanihan: CSOs and private persons' works of compassion during COVID-19 pandemic

- Erikka June D. Forosuelo

Cor Jesu College, the Philippines

Email: erikkajunedecreposito@gmail.com

- Rogelio P. Bayod

Cor Jesu College, Email: roger.bayod@gmail.com

Abstract

During emergency situations, cooperation among the members of the population is of great importance. Aside from the government leaders and officials who are expected to reach out to the affected populace, Civil Society Organizations (CSOs) and private individuals in Davao Region have been doing their works of compassion to provide the needed assistance to communities and individuals who are mostly affected during disaster and emergency situations. In fact, our works on the ground can attest that a lot of concerned people who felt the burning desire to render help would rather give their donations to these groups because they are assured that their assistance will certainly reach to the most affected families and individuals in the community. This paper tries to examine the different roles of engagements played by the Civil Society Organizations (CSOs) and private individuals to help those who are mostly affected during this Covid-19 pandemic. Drawing from their insights as well as from the available literature on the roles of CSOs and private individuals during emergency situations, this paper will argue that CSOs and private individuals in Davao Region have been very active not only in doing concrete works of compassion on the ground but also in challenging other stakeholders to take part in this work of compassion including the government leaders to prioritize compassion over their political ambition. It will then argue that the success of any intervention during emergency situations often depends on the cooperation of the members of the population.

Introduction

Civil Society Organizations (CSOs) continue to play an important role in the field of disaster management especially in disaster response and relief (USAID, 2019). In the case of pandemic situation such as Covid-19, CSO has the potential capacity to largely contribute to hasten relief operations through their active collaboration with private persons who are more than willing to share financial resources and voluntary services to address the immediate need of their fellowmen in times of calamities and disasters. What bring CSOs and private persons recognize the significance of community-based assistance in order to support local government effort to distribute relief goods during quarantine periods? "Compassion is like a baton in a relay race. People will always pass it on."—Datcher Keltner as cited by Girod, (2019). Majority of us have experienced acts of compassion as it has been manifested to us or as we have expressed it towards others. Girod (2019) mentioned that "Compassion is not just a one-and-done job. Compassion is an ongoing expression of sympathy and

empathy for a person who has hit a rough patch in their lives". This can live within us and it is contagious because it will motivate other people to do the same. Compassion is a chain reaction; it can be passed on from one person to another until everybody is doing it. It can also change a person's outlook in life including his or her responses given a critical and difficult situation. It is said that character is tested not when all is well but in the presence of adversities.

Dabawenyos are very active in helping each other in the spirit of *Bayanihan* especially during disasters and natural calamities. This act of volunteerism was very evident when our region was hit with series of earthquakes last year. As one of the early responders who reached out to the most affected individuals and communities, we saw *Mindanawons* helping their fellow *Mindanawons* (Bayod, 2020). In our experiences this time with the Covid-19 pandemic, we witnessed the same act of kindness through people rising up and volunteering and reaching out to individuals (poor people, students, front-liners) who are in dire need. Instead of sulking in quarantine, these people decided to be productive and became channels of blessings to others who are in need.

In this paper, we would like to mention them (with their consent already sought) and their undertakings during this pandemic. *What motivated them to reach out to people? Who have been their companions in this mission? What were the challenges they've encountered? What are their insights and also recommendations?* These are the questions that we asked to them and in this section, we will narrate their answers that we already clustered into themes.

Motivations of *Dabawenyos* to help other *Dabawenyos*

Since we already witnessed these people responding to different crisis situations, many of them were our partners and companions in the community outreach activities that we had conducted. We asked them what motivates them to repeat what have been done in the previous volunteerism acts and relief operation initiatives to be able to reach out to people and communities in need of help, given a different scenario which is very challenging because this time, we are facing with the invisible-Covid 19. According to Janus & Misiorek (2019), "Volunteerism" denotes helping others without expecting financial rewards. Volunteering is an important social behavior, needed to sustain civil society (Cnaan and Park 2015; Smith et al. 2016). Volunteerism usually occurs in the context of an organization, which means that it is performed under the auspices of particular entities (Finkelstien 2009). In the findings of the study of (Naqshbandi et.al, 2020), social aspects of the volunteering experience are grounded in the inter-personal relationship between the volunteer and beneficiary. This implies that people or group of individuals are motivated to help because they can feel the sense of relatedness especially that they belong to the same region and they too, experienced similar plight of the pandemic. Additionally, based on the result of the study of Janus & Misiorek (2019), the rewarding factor which became part of the volunteers' motivation to extend help was, first and foremost, doing good. This is

affirmed by Yamashita, Keene, Lu, & Carr (2019) on the relationship between motivations and actual interest in volunteering, which is arguably a more proximate predictor of volunteer behaviors. This indicates that majority of our informants perceive the act of volunteerism as doing good which motivates them to help without asking anything in return. As a matter of fact, we were amazed and the same time affirmed by their answers. Their motivations to help those in need during this pandemic situation are: *family values and upbringing to be persons for others, to put flesh and make their faith and spirituality alive, sense of empathy to those in need and also their sense of gratitude to the front-liners.*

Family values and upbringing to be persons for others. Family values and upbringing to be persons for others inspired many *Dabawenyos* to reach out to their fellow *Dabawenyos*. Richaud and Rodriguez, (2020) mentioned that when warm and nutritive relationships have developed with parents and friends during childhood and adolescence, this motivates the tendency to help and comfort them in various circumstances of life. This indicates that family plays a vital role in influencing the children to develop the motivation to help others in times of need because children believe that if they see this act of kindness in the family where they belong, they will learn that it is innate to them and that eventually, they too will do the same for others. For example, Atty. Genevieve "Bebang" Brandares Paulino who is the Dean of our Law School Department narrates how the teachings and values of their parents inspired her to organize a task force to respond to the needs of front-liners, students and others. In our conversation with her, she narrates the roots of her compassionate works:

"I was brought by parents who taught us the importance of serving others, especially the less-fortunate. Sol started with giving food, masks, PPE SUITS, face shields to hospital front liners. But because other front liners, like the policemen manning the checkpoints requested for PPES too, I asked my clients and friends abroad to help me. Then I learned that there were law students who are residents of far-flung places who were stranded in Digos. They could not come home to their respective places because of the lockdown. So, I organized a Task Force in the law school to help address the problems and needs of the stranded students"

This was affirmed by her sister, Mrs, Bernadette Brandares Aves, who works as a college professor in our school. She reports:

"In our family, the Brandares family, we have been inspired by the examples set by our parents to share our blessings to those in need whenever there is an opportunity for us to share our blessings. I and Bene, my husband together with our children already planned to share a little amount. So when I saw my sister Bebang in Face Book, donating PPEs to the front-liners, I told Bene and my children that we will also donate a little amount to Bebang's initiatives. My children gave also out of their own allowance".

Other informants also shared how much their family inspired them to be generous to those in need. One of us

who asked not to reveal her name says that she was moved by the values taught by her parents.

To put flesh and make their faith and spirituality alive. Interestingly, all of our informants in this study are practicing Christians. Thus, they want to put flesh in order to make their faith and spirituality alive by doing concrete works of compassion during this pandemic situation. One informant in the person of Br. Noelvic Deloria, SC, a member of the Congregation of the Brothers of the Sacred Heart and who also works as a school administrator in one college in Davao City has these words: *“Who knows by this simple gesture, “our unselfish and dedicated concern can reveal to them (people in need) the compassion of the Lord and draw them to him.”* He adds that *“another motivation is the sense of mission during this time of crisis”*. Religiosity may contribute to individuals’ sense of purpose (Kornas-Biela, Martynowska, & Zysberg, 2020). Our religious belief and the teaching we learned from the church give us an inspiration to perform noble acts for others. It is in this context that we enliven our ultimate purpose in life that makes our spirit satisfied and happy because we have extended help to people in need. This is also the motivation of Nonito “Dondon” Llanos, III, a Philippine Red Cross Volunteer who had been very active in doing volunteer service during the series of earthquakes and also during this Covid-19 pandemic. Atty Genevieve Paulino says:

“As a Christian, the passion to be or service to others and the call of volunteerism were instrumental in giving me courage to continue extending help to my fellowmen in spite of the health risk which goes with it. Indeed, difficult times reveal our true character.” I have always believed that faith without action is dead. Our motto is, ‘Putting our money, where our mouth is.’ In short, walking the talk or practicing what we preach. It has been a way of life.”

Helping others and doing volunteer services make their Christian faith alive and operational.

According to Łowicki, Zajenkowski, & Van Cappellen, (2020) empathic concern is primarily associated with religious belief. This reveals that there are people who truly practice what they learned from the religious teaching and they are doing it unselfishly, not asking anything in return. Thus, to them, it is considered joy and life fulfilment when they are able to give help. For Beth Del Fierro, who has been doing a lot of missionary works in Mindanao for the last 20 years or more, she is motivated by the Golden Rule and her love of God:

“the Golden rule has always been my guide in everything I do. My love of God is my greatest motivation to help others in need. While participating in the circle of friends who are doing missions in the ground, I also packed rice and other basic stuff to give away whoever comes in our house and ask for food.”

Another informant is inspired by the Church teaching to help the lost, the least and the last in the society. *“I am also moved by the teachings of the church to be a responsible citizen by helping those who are least, lost and last.”* The experiences of our respondents affirm the statements of Hyun et.al, (2020) that Christian Education is not only giving lectures or setting God's commands but providing solutions and disciplines that can put faith into

real students’ life. Perhaps the teachings of the church are successfully instilled to the learners until such time that they found a venue to practice what they have learned in the real life setting, wherein help, assistance, aid are concretely embodied through the spirit of volunteerism, wholehearted giving of donations and participation in relief operations. Thus, Religion is a strong correlate of a majority of forms of social involvement and a strong predictor of volunteerism and philanthropy (Putnam 2000). According to Priyanka and Smita (2018), religion is closely related to altruistic activities.

Sense of empathy to those in need. As we go along with our discussions with them, we found out that their family upbringing as well as their faith and spirituality were influential in nurturing their sense of empathy which also motivates them to reach out and help those in need. This is beautifully expressed by our informant when she said:

“I felt the need to respond in this time of crisis because I imagined myself and my family if put in a situation where basic necessities are scarce, no salary and no money, while daily needs are eating up the day to day consumption. I know what it is to be in need, so I am sensitive to take action in my own little way.”

Also, as discussed by Lopez (2019), people were compelled to help based on a high level of empathy they were feeling. This is also the motivation of Marianne Eve Sanchez, our former student leader who works as a supervisor in multi-national company when she said:

“to know how it feels to have nothing to put in the table is what motivates me to respond to this pandemic situation and be able to extend help in any ways that I can”.

She was brought to feel the needs of others to respond to it in any way she can because she feels how it feels to have nothing. For Noetel et al., (2020), donating to support effective solutions to needy causes is motivating for many people. This holds true to our respondents whom, apart from imagining their own selves in the shoes of others who are in need during this time of pandemic, donating both in cash or in kind can be among the best and immediate solution to the crisis. Jeanette Albios who works as a caregiver in Singapore had been active in sending help to her neighbors during this pandemic also. When we asked what motivates her to be concerned about her neighbors, she replied, *“only one thing motivates me to respond to this pandemic situation - to be able to help those in need because as a poor, I know how they needed support in this situation.”*

Sense of gratitude to the front-liners. Most of these people gave quick assistance to the front-liners and later on, they expanded it to the rest of the members of the community. When asked why they immediately reached out to the front-liners, they said that they want to show how grateful they are for the sacrifices of these front-liners. One of them, Br. Nolevic Deloria has these words: *“We salute the front-liners in the SPMC hospital because they are the most vulnerable to being infected. In fact a number of them have already succumbed to the deadly N-Corona Virus. The housekeeping personnel are also very vulnerable. The morning shift is 148 persons,*

afternoon shift is 78 and evening shift is 73. Some may receive food packs but we know that they are the lowest paid among the front-liners, and therefore, they might not have extra money to buy more than what is given to them. So we thought of augmenting their meal by giving them at least one viand, and we try as much as possible to offer them nutritious food, thinking that they are doing so much physical work in keeping the hospital clean and well-sanitized; notwithstanding, the psycho-emotional stress of the whole situation of this pandemic. We would like to help in keeping them healthy and energized to fulfill their duties and responsibilities.” Dabawenyos helped their fellow Dabawenyos to let them feel the love and care during this time of pandemic. Those who reached out to them were inspired by the examples set by their parents, their faith and spirituality, and their sense of empathy and also to express gratitude for the sacrifices of the front-liners. Others were also inspired by the call of President Rodrigo Roa Duterte (PRRD) for Bayanihan during this time of crisis (Garcia, 2020). As emphasized by Pal, (2020), gratitude is like good will. It has no substitute. It only shows that despite the difficult situation, people who extended their help did not forget that they are indebted by the fact that while most people stay in their respective homes, others leave their families behind because they are frontliners, the persons who have close contact with people because it is their

Who were with them in this Mission?

We know that there are many people behind them who also helped them. We wanted to know who they are and how they approached and inspired them to be part in the mission. For most of our informants, their families and friends (here and abroad) were with them and helped them in their endeavors. This was also our experience before during earthquakes; we have friends and relatives abroad who sent us money for our relief operations. It is very different this time because Covid-19 affects the whole world. Community quarantine and lockdown were also implemented in most countries throughout the world which made it more difficult for our friends and relatives to send money. However, despite this scenario, there are still friends abroad who help our informants in their works of compassion. The social media, especially face book was very useful in contacting generous persons to take part in the mission. According to Br. Nolevic Deloria, SC: *“the social media has been very helpful in spreading the good virus to help. I posted the project on facebook and many friends of good will responded, some were already our partners in mission, and new ones were joining.”*

Social Media had been very helpful in creating network of helpers. That is why Atty. Genevieve Paulino says: *“I have no qualms in posting the help to others in Facebook not to advertise or for self-promotion but because. I WANT OTHERS TO KNOW THAT THERE IS SUCH RELIEF EFFORTS BEING UNDERTAKEN. In this way, they too will be motivated to help. Further, it is by posting in social media that that the donors or benefactors will see where their money is going.”*

Social media is also being used for transparency. A lot of donors would rather give their share to Civil Society Organizations because they are assured that their help

will really reach to the intended communities. For Dabawenyos, inviting others to take part in “Bayanihan” mission of compassion is not difficult. In fact, according to Beth Del Fierro:

“It doesn’t make a sweat when you pray and ask God to send friends with golden hearts. We are calling each other and right away get connected . We do believe that if there’s a will there’s a way. My friends and family who witnessed our missions especially my nieces and nephews who are now in business and most of them are in the medical fields are the ones spearheading the fundraising and looking for the supplies.”

Another informant also says:

“I also have with me my student leaders whose leadership abilities are innate to them that’s why even without contacting them, they wholeheartedly volunteered.” Mrs. Bernadette Aves adds, *“Aside from my family, I also encouraged my former BSBA students to share their blessings. I posted it in the JEBA Alumni group chat”*

For Br. Nolevic, his community, The Brothers of the Sacred Heart were his first companions in his mission, *“first, I have the community of Brothers. I asked for an emergency meeting in April 2020, right after lunch to discuss the possibility of the food mission. The Brothers responded quickly and we organized ourselves according to tasks, duties and responsibilities.”*

It is clear that the Bayanihan spirit is very much alive and present among Dabawenyos (Bayod, 2020; Garcia, 2020). We even witnessed that people are willing to sacrifice so that others may also have their share. The Bayanihan spirit is one of the values of social relationship which according to Bernardo (2019) is the spirit of cooperation and how it eases what might be a heavy burden for one person. It is true that Covid-19 affects everyone in the country and the whole world, and amidst this trying time, we can still witness acts of kindness of our fellowmen. While in some parts of the country, people have been complaining about not being included in the Social Amelioration Program (SAP) of the government, in some parts of Davao region, especially in Davao del Sur, there are some qualified beneficiaries of SAP who refused to get their share and instructed the Department of Social Welfare and Development (DSWD) personnel to give their share to the most needy. We also know of one Barangay (village) in Davao del Sur in which their Barangay Captain (Village Local Chief Executive) gathered his constituents and agreed among themselves to share the funds and the food packs equally to all to which the residents also agreed. However, we are not saying that there are no complaints. We believe there are but these can be pacified immediately because of the Bayanihan spirit of the local communities.

Challenges they encountered

There are always challenges in doing missionary works to communities. But during emergency situations, there are more challenges that responders in the ground encountered. This is attested in the findings of the study of Arcega (2019) that the challenges encountered by student leaders in different volunteered activities were high. These group of student volunteers also experienced problems while they participate in different volunteering

activities. However, regardless of the different problems they encountered, the Bayanihan spirit which is a Filipino value unleashed their passion, commitment, and dedication to contribute huge impact to their community. In the case of our informants, the challenges that they encountered in their mission are the following: lack of human and material resources, difficulty in looking for supplies, and information dissemination.

Lack of human and material resources. In our conversation while going to the communities to distribute the food packs and to talk to our affected students, we realized that during disasters, calamities and pandemic where everybody becomes a victim, we just can think of “if only’s”. If only we have more than enough, we could have extended more help; If only there are lots of volunteers who are with us, we could have mobilized faster. This pandemic brought a lot of human activities into a sudden halt. We cannot go out easily as we can. We really need to bring our quarantine pass to be granted permission to travel to communities to distribute some goods. As confirmed by Asefa, 92019), the major challenges of relief operation are poor inventory management practice, lack of coordination and collaboration among players in the relief operation, and inadequate funding. These are also the experiences of our informants. Nonito “Dondon” Llanos, III of Philippine Red Cross shared with us that:

“the biggest challenge we had personally encountered as Red Cross Volunteers was the limitation of our resources as most of our programs and activities solely depend on donations given by benevolent individuals and groups.”

While Dondon Llanos talks about limitation of material resources, Br. Noelvic Deloria talks more about human resources. Br. Noelvic says.

“Because we also have other responsibilities here in the house, we perform work from home, formation is going on, and the work of a superior continues with or without Covid. Even if we have a number of individuals who expressed themselves to volunteer, we could not accept them to fulfill the ECQ guidelines. We limit people coming in to our community. So much as we wanted to do it every day, we committed ourselves to do it three times a week, specifically Monday, Wednesday and Friday. To serve the 299 housekeeping personnel, we divided them into two groups, Group A – 148 Morning Shift, Group B – 78 Afternoon Shift and 73 Evening Shift, and we do it alternately. When the ECQ was heightened and there was already a limit to the days when the Food Medicine pass can be used, like I can only go out Tuesday, Thursday and Saturday (TThS) according to my code number, but our commitment is Monday, Wednesday and Friday (MWF) with the SPMC. So I asked for a special certification from SPMC that I may be allowed to pass through checkpoints as food donor. Considering my other tasks and the need to have some good rest, I just have to optimize the use of my time.”

For Marianne Eve Sanchez, her work in the company hinders her to really be active in doing volunteer work in the ground. *“Because of my limited time due to a full work week schedule and I cannot easily perform my intent to help such as volunteering”*

Difficulty in looking for supplies. Another challenge that we faced in the ground is the difficulty of looking for supplies such as face masks, alcohol, hand sanitizers, and other grocery items. This has been the experience of Ms. Jeanette Albios who is based in Singapore and who just sent money through her friends to buy some goods for the community. She says that her challenge is *“of looking for the groceries and rice for relief goods for my neighbors because in my place that time mostly not available.”* This is also the experience of Atty. Genevieve Paulino. Having plenty of contacts, she says there is *“not so much challenges, except for the delay of the suppliers in delivering the PPES because of lack of supply.* We also encountered this in our own groundworks but fortunately in the place that we operate, there are plenty of individuals who share their vegetables, eggs and other stuff to be included in our relief operations so we did not encounter much about this.

Information dissemination. As to information dissemination, this challenge is specifically mentioned by Br. Noelvic Deloria, SC but not mentioned by other informants. How does information dissemination become a challenge for Br. Noelvic?

“I think it is important to keep the donors and supporters informed, so that they would know how their money is spent. So I became active in posting the activities in the social media and to spice up a little bit the reporting, I made stories (Legend-like: about how the five chicken sacrifices themselves to become Chicken Afritada, and the marriage of Can Ton and Sotang Hon and eventually had their baby Bam-I, or Featuring somebody, like our cooks, and the people behind the mission) with a lot of pictures on how the cooking was made, and pictures of the recipients of the food at SPMC.”

This might be very challenging to him considering that he has plenty of work assignments and he still delivers the food to the hospital. But he needs to keep his donors and the public informed about what has been happening with their mission.

Their insights about the mission

When asked about their insights, most of them shared that *helping is a culture and therefore, it must be a way of life, it is good to be a cheerful giver and to make a difference to the lives of others.*

Helping is a culture and therefore, it must be a way of life. Majority of them said that help should not impose as it must be coming from the inside. This is frankly shared by our informant:

“I believe that helping is not imposed. It has to come from the heart. If we have the heart to empathize, then we learn to put ourselves in the shoe of people who struggle for their everyday needs.”

This informant is very Kantian in her approach to life. For Kant, every person knows the moral good and is self-legislating. Thus, his actions must be free from external interference or factors (Kant, 2002).

For Atty. Genevieve Paulino, to help is a way of life because this is love in action. She says:

"we always profess our love to an invisible God. How can we say that we love God if we cannot even express our love to the less-fortunate? That love can become concrete and evident if we help the poor. That is love in action."

This is affirmed by Byrne-Jiménez, & Yoon (2019) emphasizing that love is an energy that emanates from within to shield and care for others.

Be a cheerful giver. For most of them when you help you must have a happy heart because this is the expression of your love. In fact, for Marianne Eve Sanchez, *"there is no limit to help especially in this time of crisis. Small or big, as long as it is done with warm and sincere hearts, it matters"*. Another informant also shared her insights:

"I realize that in this time of ECQ, when my family and I are staying in our home and we have enough, I am motivated to share our blessings to families who are more affected in the pandemic. It is bigger than a grand lotto jackpot looking at the happy faces of people who were able to benefit of the noble endeavor."

Atty. Genevieve Paulino added, *"It is always good to help."* For these informants and for others, there is joy in giving. We also experienced this in our works even during earthquakes and this time of pandemic. Despite physical tiredness, our spirit remains very much alive. According to Show (2020), people give tithes with willing and joyful hearts. This is highlighted by Paul who says in (2 Corinthians 9:7) *"Each one must do as he has made up mind, not reluctantly or under compulsion, for God loves a cheerful giver"*. Indeed, there is joy in giving. We are invited to be a cheerful giver.

Make a difference in the lives of others. Marriane Eve Sanchez says, *"in this trying times, it is very important that we become part of the solution rather than the problem."* It is always good to make a difference to the lives of others. While a lot of people have become cynical about the situation, others remain to be positive and they would like to radiate this positivity to others. For Nonito "Dondon" Llanos, III, this is a time to really make a difference to the lives of others. He even quoted Vatican II in saying:

"as the old adage aptly puts it "no person is too poor, not to give something and no person is too rich not to need anything". This made me realized that we are all connected in this cycle called "life" and it is up to us to decide how we will make use of it. If we use our life to make a difference in this world, then we can say, we are rich beyond measure."

For Jeanette Albios, we can make a difference by always choosing to help, *"if you know yourself that you can help in this kind of situation or problem don't hesitate to help the people especially those in need."* People have a sense that life is meaningful when they experience purpose, significance, and coherence (Steger, Frazier, Oishi, Kaler, 2006). Morse, O'Donnell, Walberg, & Dik, (2019) said that meaning in life is considered to reflect an individual's subjective, global sense about the nature of her or his existence. This is true in the aspect of helping others because this means that individuals chose to create meaning out of their

existence by making a difference in the lives of the people with whom they extended their assistance and act of kindness.

Their advice or recommendations to other CSOs and to the politicians. We also asked them about their advice or recommendations for other CSOs and also politicians who are expected to do their part during this time of pandemic. For them it is good that CSOs and politicians should embrace giving as a way of life and for politicians to stop politicking during emergency situations such as in Covid-19 Pandemic. As emphasized by Larruina, Boersma, & Ponzoni, (2019), real possibilities for CSOs and local GOs to work together. This can be possibly achieved because municipalities and barangays are a lot smaller and are less bureaucratic as compared to the central government. In this way, there is easier and faster mobilization in terms of distribution of relief goods and other important human services needed during pandemic, disasters on natural calamities. According to Jeanette Albios: *"my recommendation for other persons who are doing Humanitarian mission during this pandemic is "don't stop to help people in need. If you know one person who is in need, just give help."*

For Nonito "Dondon" Llanos, III this is the time that we give hope to others. He says: *"to other private individuals sharing the same calling as especially in the field of volunteerism and public service, may our hopes continue to flicker in this difficult time and may we always have that burning passion to be a person for others."*

Another informant directs her recommendation to the politicians:

"for political leaders, this is not the time of "politicking". This is the time to work as a front-liners of the people in your jurisdiction. This is also the time to prove that you deserve the vote of your constituents who trust your capacity to become change agents and be the very first to respond in times of difficult moments like what we are currently experiencing."

Whether emergent or established, CSOs assist refugees through advocacy, the provision of extra services, and the help of volunteers (Fleischmann & Steinhilper, 2017). This is in the case of other countries when people lend a helping hand by sincerely donating through cash or in cash in their own capacities. It implies that CSO plays a very important role in linking the basic services in the community in times of adversities. According to Vaughan & Hillier(2019), *"local service provider CSOs are the first to respond when disaster strikes, and often are the only actors able to access some areas within fragile and conflict-affected states"*. At some point, these private groups are often the first to respond, and then later on government organizations come into the picture.

We would like to highlight the recommendations of Br. Noelvic Deloria, SC here because we found them very much applicable not only during this pandemic but in any other forms of community engagements that individuals and groups will do in the future. He shares seven recommendations. Just like the seven gifts of the holy spirit if these will not be taken seriously, it will result to seven woes. Thus, it is good to be remind by the following:

Context/situation mapping. It is important to know the context: the needs, the processes in the system, in this case, the SPMC), who to contact, etc.

Survey of available resources. Before we commit ourselves to respond to the need, we check on our available resources, material and human resources, identify gifts and talents of individual persons needed to come up with an organizational structure that is going to work. A group of people must be involved who are convinced of (bought into) the particular mission; that it is worth taking.

Realistic planning and designing. If we feel confident enough to respond to the need(s) given the resources we already identified, we determine the desired reality or output, and dream-design how it could still be more effective, efficient and energy-giving, in a way, that the work become inspiring and life-giving first to the doers and then to the recipients.

Strategizing. We need to strategize how things be given, and continuously evaluate and listen to feedback, and innovate the process and the product, accordingly.

Apply praxis paradigm: action-reflection-action. We just do it and not to be trapped into “too-much planning”, keeping in mind that this is not our mission, but we are cooperating with God that His mission be fulfilled. We do our work with dedication and commitment but it is God who blesses it and make it continue if He wills it. I do believe doing mission work like this, it is important that I always anchor myself on God; that He will send us the right persons, after all, as I have said this is His mission. We might make plans, but we make them pliant and fluid, rather than be constrained only to what has been planned as if cast in stone. Innovations and creativity make the mission more interesting and inspiring because we participate in the creation of a God-reality. We also allow ourselves to commit mistakes, to fail, but we also make sure that we take responsibility on our actions and decisions, and learn to rise up again and move forward. And if it is the time to end... it is the time to end.

Engage the community into crucial conversation. We continue conversing with the key people to keep the activity on track or to add on to what has already been made without losing what is essential, and the essential is how to make God’s mission into fruition. We bring in more people to be part of the mission and let them feel that their stake was not wasted. Information dissemination is important for transparency, and consequently, for a deeper and wider support.

Be grateful. Always be grateful for everything is grace. We must not forget that we are not “the grace” but we are only channels of the grace of God. As I have already said it, we bring in more partakers of the mission, so it is a community that celebrates, not only I, me and myself... alone or our own elite group, for truthfully when one celebrates alone, he can easily be intoxicated by vane glory. By being grateful with the small successes or even with the learnings brought about by so called failures,

we can continue to be a positive energy to others, and this positive energy continues to radiate even without us knowing it. I am indeed grateful because through this mission we have made our conviction as Brothers of the Sacred Heart concrete, “to believe in God’s love, to live it and to spread it,” especially in this critical time. And, we are truly humbled by the people who believe in what we are doing and who have supported us in many different ways.

Conclusion

The spirit of *Bayanihan* in the Philippine setting is part of the Filipino culture. People from different walks of life especially the *Dabawenyos* helped one another because they are motivated by strong family values, sense of spirituality, and more so sense of empathy and gratitude. This noble deed spread through fellow *Dabawenyos* who are also companions in mission, some are proud student volunteers and others are ordinary citizens who have the heart to help in times of calamities, natural disasters and pandemics. This paper finds that despite the various challenges faced by the *Dabawenyos* in their desire to help such as lack of human and materials resources; difficulty in looking for supplies and information dissemination in terms of informing the donors on the proceeds of the cash and in kinds they donated, still our helping hands were able to find very good insights in their works of compassion in this Covid-19 pandemic.

Majority of the informants consider their noble endeavor simply as a way of life; they become cheerful givers and most importantly they make a difference to the lives of others with whom they helped. When we say works of compassion, it comes from the heart, it is in good faith. Crisis and disaster studies have acknowledged that citizen volunteers play a major role during crises (Drabek & McEntire, 2003; Helsloot & Ruitenbergh, 2004; Schmidt, Wolbers, Ferguson, & Boersma, 2017). While there are always good Samaritans in times of pandemic, the CSO and the government, as represented by the elected national and local officials, should work hand in hand to serve the general public. “The importance of citizen involvement can be seen when citizens converge to assist in damage assessment to provide general support to the GOs (Government Organizations)” (Kendra & Wachtendorf, 2003; Schmidt et al., 2017).

The ultimate goal of the “works of compassion”, of “help” in situations that the Covid-19 brought to all of us, is to be able to feel the need of our fellowmen who are greatly affected of the crisis. It is not the time for politicking. It is the time to cooperate, collaborate and coordinate with our national and local officials to create a strong platform to combat the Covid-19 pandemic. Pay compassion forward as stressed by Girod (2019). According to van Wessel, Hilhorst, Schulpen, & Biekart (2019), governments recognize the advocacies of the CSOs who are capable of organizing relief operations in partnership with private individuals. This initiative is very helpful in mobilizing government efforts to initially respond to peoples’ call for help in times of pandemic situation.

It is our hope that this force of compassion and charity indicated the people’s desire and willingness to walk an extra-mile to be able to share their blessings can

be the same strong force to challenge the different oppressive structures that put the poor to the margins of society and to emancipate them from these different forms of maladies and to restore their human dignity.

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Confidentiality of medical data and public safety and health

- Marlon Patrick P. Lofredo, PhD

Institutional Review Board Chair, St. Paul University Quezon City, Philippines

Professor in Bioethics and Ethics in Hospital Administration, SPUM Graduate School of Health Sciences, Philippines

Email: mpplofredo@spuqc.edu.ph

Abstract

The principle of confidentiality and privacy of medical data is an important patient safeguard, and it is rooted in fundamental human rights and ethics principles. The call for the voluntary waiving of confidentiality and privacy by COVID+ and suspected patients by involved healthcare and legal organizations in the Philippines has put into the debate table its ethical and legal permissibility. The common rule is confidentiality and privacy of information is not absolute, and there are laws delineating specific grounds for its permissible breaching. The basic ground for breaching is the primacy of public health and safety over individual right to privacy. The common good remains the primary consideration when conflict between principles occur in cases of pandemics like COVID-19. But care must be taken to ensure that patients are not discriminated and stigmatized as a result of the breach of confidentiality and privacy of medical data. The rule of thumb given by the Philippine National Privacy Commission is gather only what is necessary and disclose only to proper authorities. Breaching does not mean disclosed data is universally accessible. Governments must ensure that confidentiality remains protected even when such right is temporarily withheld as demanded by the principles of respect for persons, human dignity, autonomy, and justice.

Introduction

The rapid spread of COVID-19 and the difficulty of tracing contacts and travel history of patients is creating a conflict between the principle of confidentiality of medical data and the demands of public safety and health. With the rise of COVID-19 deaths and infection is the growing number of healthcare professionals getting infected and dying also. Practically, all are walking blind amidst the pandemic, and other people's health and well-being are also compromised when they go for simple treatment or check-up but they exhibit similar symptoms to COVID-19 and are immediately considered a suspect until it turns out negative for SARS-CoV 2 infection.

The reality that some patients lied about their travel history and contacts further strained the already exhausted healthcare workers, and their communities. The high-level communicability of COVID-19 and its lack of available specific treatment and vaccine makes it a formidable threat to public safety and health, and one of the solutions being proposed to curb its fast spread is for positive and suspected patients to waive confidentiality of their medical data to make tracing easier and to protect public safety and health. But will this be legal and ethical?

The issue of breaching confidentiality of medical data in COVID-19 cases was raised in the Philippines by the Philippine Medical Association (PMA), the Integrated Bar of the Philippines (IBP), and the Philippine College of Surgeons (PCS) when they issued a joint statement petitioning the COVID 19+ and suspected patients "to voluntarily waive the confidentiality of their medical condition and forthrightly inform those they have been in close contact with; and that the government, particularly the Department of Health, prudently uses and promptly shares medical information to enable all concerned authorities, institutions and persons to effectively take precautionary and remedial measures." This petition is the result of: the increasing number of COVID 19+ patients seeking treatment and admission but are lying about their true condition thereby compromising not only the health care workers but also of the whole health institution's ability to provide services; the difficulty of doing timely, adequate and complete contact tracing; the increasing number of unknowing virus carriers who are not tested, quarantined, isolated, or treated; the demand of fairness and right to precautionary or remedial measures of infected patients; and, the preeminence of the right to safe and healthy environment over individual right to confidentiality and privacy (Cepeda 2020; PMA 2020).

In response to the petition, the Philippine Inter-Agency Task Force, the one managing COVID-19 response in the country, approved on 8 April 2020 Resolution No. 22 directing the Department of Health and the Office of Civil Defense to enter into a data-sharing agreement in accordance with Republic Act No. 10173 or the Data Privacy Act. The Department of Justice affirmed the validity of the legal and ethical basis presented by the PMA and the Data privacy Commission for such action in times of public health emergency. As of this writing, COVID 19+ and suspected patients are now mandated to fully disclose all personal information to healthcare providers (Ropero 2020), and for health institution to prudently share that information among themselves to enhance contact tracing.

The principle of confidentiality and privacy of data

The principle of confidentiality is ingrained in the four pillars of medical ethics: autonomy, justice, beneficence, and nonmaleficence. Particularly, confidentiality and privacy of information are within the scope of autonomy, which is the capacity for self-determination. Being autonomous, however, is not the same as being respected as an autonomous person. To respect an autonomous person is to acknowledge his/her right to make choices and to act based on that person's own values and belief system.

Respect for autonomy involves not only desisting from meddling or intruding with someone's choices, but sometimes entails providing the person with the necessary conditions and opportunities for exercising autonomy. The principle of respect for autonomy implies that one should be free from coercion in deciding to act, and that others are obligated to protect confidentiality of information, respect privacy, and tell the truth.

The principle of respect for autonomy implies that autonomy has only prima facie standing, that is, it can be overridden by competing moral considerations. For

example, if an individual's choices endanger public health, potentially harm others, or require a scarce resource, that individual's autonomy may justifiably be restricted. Autonomy is limited by the principles of stewardship, respect for persons, justice and the common good. Respect for autonomy, then, should not be construed as an absolute and foundational value, but a "middle principle" that requires every individual to respect every other individual's self-determination to an appropriate extent within the context of community.

The same reasoning also applies to confidentiality and privacy of information. Confidentiality guarantees physician-patient trust and ensures that the patient will receive the best care from the information he/she confidently revealed to the healthcare providers, in effect the healthcare provider becomes the protector of the patient's information. The principle prohibits any health care provider from disclosing any information about the patient's condition and other data to others without prior consent or permission, and if such is provided, it requires that only authorized access occurs. Confidentiality and privacy are well protected in law and in hospital procedures and protocols.

Maintaining confidentiality is both a legal and ethical responsibility of healthcare professionals. But this is not an absolute principle – confidentiality can be breached ethically and legally, i.e., when patient confidentiality is likely to put human life at risk of harm, or when the patient has committed a crime punishable by law, a member of an illegal organization, has a standing warrant of arrest, and prison escapee, or, his condition put public safety at risk, like if the patient is suffering from contagious disease, like COVID-19. In such cases, the healthcare provider must seriously weight he pros and cons of breaking confidentiality.

The consent requirement of breach of confidentiality

A tricky aspect of breach of confidentiality is consent. The principle requires that patient must provide free consent. But what if the patient refuse to provide consent? Must consent be taken in all cases of possible breach of confidentiality?

The American Medical Association (AMA) has the opinion that medical doctors may disclose personal health information without the specific consent of the patient (or authorized surrogate when the patient lacks decision-making capacity) only to the following parties and reasons:

- a. other health care personnel for purposes of providing care or for health care operations; or
- b. appropriate authorities when disclosure is required by law.
- c. other third parties situated to mitigate the threat when in the physician's judgment there is a reasonable probability that the patient will seriously harm him/herself; or the patient will inflict serious physical harm on an identifiable individual or individuals.

All other reasons require the consent of the patient (AMA 2016).

The British Medical Association (BMA), on the other hand, allows breach of confidentiality where the law permits and "where necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of

disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others. The effect is similar to that of the common law: privacy is an important principle which must be respected but may be breached where other significant interests prevail. Any such breach must be proportionate to the benefits/harms it is intended to bring/avoid" (BMA 2020).

The World Medical Association (WMA) has this statement on the matter: "The duty of confidentiality must be paramount except in cases where the physician is legally or ethically obligated to disclose such information in order to protect the welfare of the individual patient, third parties or society. In such cases, the physician must make a reasonable effort to notify the patient of the obligation to breach confidentiality, and explain the reasons for doing so, unless this is clearly inadvisable (such as where telling the patient would exacerbate a threat). . . In all other cases, confidentiality may be breached only with the specific consent of the patient or his/her legal representative or where necessary for the treatment of the patient, such as in consultations between medical practitioners" (WMA 2016).

The three biggest medical associations all agree that confidentiality can be breached and that there are cases where consent may not necessarily be solicited.

Legality of breach of confidentiality in the Philippines

Although the right to privacy of information is a universally guaranteed human right, medical jurisprudence in the Philippines sees confidentiality of medical data and details as not absolute. While Civil Codes and Privacy Act duly protects confidentiality, certain conditions are identified that warrants reasonable breach of confidentiality. In particular, the Code of Ethics of the Medical Profession directs that "The physician shall hold as private and highly confidential whatever may be discovered or learned pertinent to the patient even after death, except when required by law, ordinance or administrative order in the promotion of justice, safety and public health. The commitment extends to discussion with persons acting on a patient's behalf. Safeguards shall be applied especially when using electronic information systems for compiling patient data, and when dealing with genetic information" (PMA 2016). This provision follows the right to privacy enshrined in Article III, Section 3(1) of the Bill of Rights of the 1987 Philippine Constitution (Republic of the Philippines 1987).

The right of the patient to privacy and confidentiality is well protected in the Magna Carta of Patient's Rights and Obligations obliging all those involved in the treatment of a patient to ensure that the privacy of the patients is respected and protected in all stages of his treatment. "The patient has the right to demand that all information, communication and records pertaining to his care be treated as confidential. Any health care provider or practitioner involved in the treatment of a patient and all those who have legitimate access to the patient's record is not authorized to divulge any information to a third party who has no concern with

the care and welfare of the patient without his consent" (Senate of the Philippines, 2017).

The Magna Carta allows breach of privacy and confidentiality when: such disclosure will benefit public health and safety; when it is in the interest of justice and upon the order of a competent court; when the patients waives in writing the confidential nature of such information; and, when it is needed for continued medical treatment or advancement of medical science subject to de-identification of patient and shared medical confidentiality for those who have access to the information (Senate of the Philippines, 2017).

In 2016, the Health Privacy Code of the Philippines or officially known as Administrative Order No. 2016-0002 titled "Privacy Guidelines for the Implementation of the Philippine Health Information Exchange" was promulgated. It is a joint administrative order by the Department of Health (DOH), the Department of Science and Technology (DOST) and Philippine Health Insurance Corporation (Philhealth) to promote information exchange in health care service while also protection and promoting the right to privacy of data subjects in a healthcare setup. On the Use and Disclosure of Health Information, Rule III-1 of the Code allows the use and disclosure of health information subject to the limitations covered by the consent given by the patient, or his or her authorized representative, and shall only be for the following purposes ". . . reporting of communicable, infectious and other notifiable diseases, including those that pose a serious health and safety threat to the public such as, but not limited to . . . Breakthrough epidemic of contagious disease." The Code (Rule III-1.3) also mandates that: "... in case of emergency, where time is of the essence, disclosure may be made even without court order." Confidentiality can be lifted "...b) when the public health and safety so demand; or c) when the patient waives this right."

In 2018, Republic Act No. 11332, An Act Providing Policies and Prescribing Procedures on Surveillance and Response to Notifiable Diseases, Epidemics, and Health Events of Public Health Concern, and Appropriating Funds Therefor, was enacted which required mandatory reporting of notifiable diseases and health events of public concern. Section 6g of the law enjoins all those involved in conducting disease surveillance and response activities to respect, to the fullest extent possible, the rights of people to liberty, bodily integrity, and privacy without prejudice to public health and security, and Section 9e warns the public that "non-cooperation" of the person or entities identified as having the notifiable disease, or affected by the health event of public concern is illegal.

Apprehensions on breaching confidentiality and privacy of medical data arose in the country as a result of the enactment of the Data Privacy Act in 2012 (DPA) which laid strict requirements designed to protect personal information in both government and private sector organizations. Section 13 of the said law, allows the processing (understood in the Act as any operation or any set of operations performed upon personal information including, but not limited to, the collection, recording, organization, storage, updating or modification, retrieval, consultation, use, consolidation, blocking, erasure or destruction of data) of sensitive

personal information and privileged information when: the data subject has given his or her consent; it is necessary to protect the life and health of the data subject or another person, and the data subject is not legally or physically able to express his or her consent prior to the processing; the processing is necessary for purposes of medical treatment, is carried out by a medical practitioner or a medical treatment institution, and an adequate level of protection of personal information is ensured.

The DPA still require the consent of the person before any disclosure or breach of confidentiality can happen. Previous laws and directives exclude conditions like danger to public safety and health from the requirement of consent. When this issue was referred to the National Privacy Commission (NPC) in light of the COVID 19 pandemic, it released Bulletin No. 3, on data protection in times of emergency, dated March 19, 2020, clarifying that "during this time, it is not only the 'misuse' of data that concerns us but also the 'missed' use that could have made a difference in containing the disease" and advised that the law allows the collection of what is necessary but disclosure must only be to the proper authority. The NPC further clarified that: "Data protection and privacy should not hinder the government from collecting, using, and sharing personal information during this time of public health emergency. Neither does the law limit public health authorities from using available technology and databases to stop the spread of the virus. The principles contained in the law allow the use of data to treat patients, prevent imminent threats, and protect the country's public health and still provide the level of protection the citizens expect. The Data Privacy Act of 2012 is an enabler in critical times like this."

Again, the NPC released Bulletin No. 7 on 6 April 2020, containing its official statement on calls for patients to waive privacy rights and publicly disclose health status. The NPC reiterated that the Data Privacy Act of 2012 is not a hindrance to the COVID 19 response. The NPC also clarified that Bulletin No. 3 was not meant "to support any request for the voluntary waiver by COVID-19 patients, PUIs (persons under investigation) and PUMs (persons under monitoring) of the confidentiality of their medical condition" but was released in connection with the Commission's appeal for the release only of "trusted and verified information," especially during an "unfamiliar global pandemic."

In response to the appeal of the PMA, IBP and PCS, the Commission provided the following guidelines: *On sharing with other authorized public authorities*, the DOH may do so subject to the limitations that the sharing is (a) pursuant to a public function or a public service, (b) based on the constitutional or statutory mandate of the DOH and/or the other public authorities, (c) strictly following set protocols and processes, (d) ensuring the security of such shared information, and (e) upholding data subjects' rights.

With respect to sharing medical information of individuals to private health institutions, the Health department would be in the best position to determine if such is consistent with the provisions of RA 11332 and other applicable protocols in a pandemic.

On the call for patients, PUIs and PUMs to share or consent to the sharing of personal data to the general

public for contact tracing, we affirm our stand that doing so may not be as helpful to contact tracing interventions as this can only induce fear among these individuals given the multiple reports now on physical assaults, harassments, and discrimination endured by patients, PUIs, PUMs, and even health workers. These threats to their safety and security may discourage them to report their symptoms to public authorities, take confirmatory tests, and submit to treatments.

If a patient, PUI, or PUM himself or herself would want to disclose such information, as what some public figures have done, that is their personal choice.

On seeking consent, the DPA requires consent to be freely given, specific, and an informed indication of will that they indeed agree to the public disclosure. Informed consent requires that these patients, PUIs, or PUMs have been made aware of the risks that may arise from the disclosure, including the risk of being subjected to violent physical attacks as some COVID positive patients and their family members have experienced according to news reports.

Although the legality of propriety of breach of confidentiality and privacy has been clarified by the NPC, it still reiterated that 'even in times of calamity or a state of a public health emergency, rules on patient privacy, the confidentiality of health records, medical ethics, and data subjects' rights remain in effect and upholding them equate to protecting lives.' This is why the NPC firmly advised that collect only what is necessary, disclose only to proper authority.

There is then a common permission in Philippine law for the reasonable, ethical, and legal breach of confidentiality and privacy of medical data, especially in times of national health emergency, such as COVID 19 pandemic, and for the protection of public health and safety. But such disclosure are not meant for public consumption. There are strict requirements as to who and to whom such disclosure can be made, and consent must be freely given by the patient before any disclosure is made, except when greater public safety and health requires it, or such right to consent is waived personally by the patient, or by lawful order from court.

The primacy of common good over individual good or right

Confidentiality and privacy of information is closely tied with the ethics principles of respect for human dignity, respect for persons, autonomy, justice, common good, double effect, nonmaleficence, and beneficence. Consequently, the principle is also checked and balanced by the same concomitant principles. The principle of common good serves as a regulating principle for confidentiality and privacy.

In general, the common good "consists of all the conditions of society and the goods secured by those conditions, which allow individuals to achieve human and spiritual flourishing" (O'Rourke and Boyle 2011, 19). It requires that all people and governments must be actively concerned in promoting the health and welfare of everyone so that each can contribute to the common good of all. It has three essential elements: respect for persons, social welfare, and peace and security. In so far as the common good assumes respect for persons, it compels public authorities to respect the fundamental

human rights of each person. Insofar as it assumes social welfare, the common good requires that the infrastructure of society is favorable to the social well-being and development of its members.

The concept of the primacy of common good over individual goods is prevalent in Thomistic philosophy, inspired by the Aristotelian maxim that the good of the whole is more divine than the good of the parts. Jacques Maritain, following Thomas Aquinas's line of thinking, explains that "because the common good is the human common good, it includes within its essence, as we shall see later, the service of the human person" (Maritain 1946, 421). It has long been held in Christian philosophy that the person is a totality in itself, that person is a part of a greater whole. While common good serves the totality of the human person, "the person still remains, as an individual or part, inferior and subordinated to the whole and must, as an organ of the whole, serve the common work" (Maritain 1946, 446). It must be understood from these suppositions that the individual must serve the common good since the common good, by its very nature, serves the individual in its totality. Working for the common good is "equally to everyone's advantage" (Rawls 1972).

But Maritain also argued that the common good is not simply a collection of private goods nor a good of a whole which sacrifices its parts. "It is common to the whole and to the parts and requires recognition of the fundamental rights of persons. To achieve the common good society needs a significant contribution from individuals" (Benestad 1983). While individual rights are respected, the individual must in turn make a significant contribution to the common good, or else such right may not be appropriately respected in the context of the community. This is to avoid the communist and totalitarian interpretation that individual rights can be duly sacrificed permanently and whimsically for the common good. We must be quick to remember that the principle of common good does not advocate the permanent surrender or sacrifice of individual rights, but rather the temporary suspension of such rights in such conditions that may endanger the good of the whole. Once risky and dangerous conditions passed, then all rights are restored. Again, the context of the such prioritizing of common good over individual good must be considered seriously, since the danger of abuse is always lurking in the dark crevices of uncertainty and knowledge gaps.

The observation of Robert J. Samuelson in his 1992 Newsweek article is still challenging each and every one of us today amidst the COVID 19 pandemic: "We face a choice between a society where people accept modest sacrifices for a common good or a more contentious society where groups selfishly protect their own benefits." Such observation is apparent in everyday news showing people disregarding policies and rules on social distancing and quarrelling with quarantine enforcers insisting on their rights and privileges over and above the community's good. Temporarily limiting the exercise of our right to free movement, right to engage in business and livelihood, and right to confidentiality and privacy are significant contributions to the common good in time of pandemic.

Moreover, common good makes democracy work since every citizen is expected to contribute something towards the common good and not just maximizing personal benefit. Political philosophies like those of Plato, Socrates, John Locke, John Rawls, Niccolo Machiavelli, David Hume, and Jean-Jacques Rousseau, believed that democracy will fall if people become more concerned with personal gains at the expense of the common good. In such condition, social cohesion and unity among citizens suffers, to the detriment of all. But despite the myriads of definitions of common good, “philosophers and other social scientists agree that when citizens no longer care about the common good and no longer take responsibility for ensuring a good life for all citizens, then the democracy at best becomes dysfunctional and at worse fails by transitioning into dictatorship or chaos” (Johnson 2018). Limiting the exercise of some of our rights may actually help in preserving a country’s democracy and for the proper functioning of our democratic systems during pandemics.

The dangers and effects of pandemic cannot be underestimated. It is not merely a health problem, but it also alters the way social structures and political systems operates. It necessitates change in lifestyle and paradigm and the way we see our rights and privileges. If we do not let go of our entitlements and voluntarily or willingly limit the exercise of some of our precious rights, then we may end up sharing a common fate – infection and worse, death and the utter failure of social and political structures and systems. Allowing breach of confidentiality and privacy of medical data in time of pandemic is for the common good, and that common good is public safety and health. Again, common good does not altogether nullify individual rights, in fact, in the long run, it may guarantee greater enjoyment of those rights after the pandemic.

The problem of Discrimination and Stigmatization

The disclosure of medical data of COVID-19+ and suspected patients may lead to discrimination and stigmatization. These are the primary reasons why some groups and policy makers are not amenable to breaching confidentiality and privacy for the sake of public safety and health. The requirement for prior consent is not only in compliance with the demands of the principles of respect of person and human dignity, autonomy and justice, but also a personal shield of the patient against unsolicited and unnecessary prying into his/her medical data. Due to the high degree of communicability of SARS-CoV 2 which causes COVID-19, the patients and his relatives and friends, especially those whom he/she had contact prior to testing positive of the disease, are at great risk of discrimination and stigmatization.

We have already seen people denying entry to COVID-19 suspected or positive individuals to their villages, and even when they are already declared cured of the disease, the stigma remains, and they are still avoided by others. The Universal Declaration on Bioethics and Human Rights, Article 11 provides that: “No individual or group should be discriminated against or stigmatized on any grounds in violation of human dignity, human rights and fundamental freedoms” (UNESCO, 2005).

The NPC is very clear in its directive to healthcare professionals that they only gather that which are necessary and disclose only to proper authorities. This means that data disclosed are not for public consumption, but primarily meant to hasten tracing, identification, quarantine, isolation, and treatment of COVID-19 patients, and to protect the healthcare professionals as well. Should village officials be informed of the medical data of the members of their community found or suspected to have the virus? Yes, since this will help healthcare workers identify those to whom the patient had contact with, but care should be taken that other members of the community do not have access to the information.

Although leakage of information is difficult to prevent, the DOH must promulgate guidelines that include protection of COVID-19 patients against discrimination and stigmatization. This may include community-based health education and mass media and online information campaigns.

Conclusion

While confidentiality and privacy of medical data is sacred in medical ethics, it is not an absolute principle. For the sake of common good, that is, public health and safety, this can be breached and disclosure of necessary data among healthcare providers and proper authorities is permissible ethically and legally. Some rights can be limited temporarily for the sake of greater good, and every act for the common good ultimately benefits even the person who willingly surrendered provisionally some rights. These are trying times and COVID-19 is changing our way of behaving, lifestyle, and shifting our paradigms. All must adjust to the new normal for the sake of the common good without compromising permanently individual rights. Government must ensure that confidentiality is still protected while taking all means to identify those who may have the virus. In this way those COVID-19 patients will be well protected against discrimination and stigmatization.

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Mobile contact tracing technology: way out or lock up?

- Maria Patrão Neves, PhD

Professor, Universidade dos Açores, Ponta Delgada, Portugal

Email: m.patrao.neves@gmail.com

www.mpatraoneves.pt

Abstract

Our present time is characterized by three crises: the health crisis that caused an economic crisis and degenerated into a social crisis. While biomedical technologies are not able to provide safe and efficient treatment or a vaccine, digital technologies stepped in proposing a fine-tuned mobile contact tracing to mitigate the pandemic effects. It was first used in Asia, and then expanded, following different models in the different countries, with regard both to technological systems and value systems. The first experiences tended to set up an effective system for the pursued objectives, seeking to adjust to the ethical concerns of the community; the recent European initiative starts by identifying the ethical requirements to be protected, and to which the digital system of contact tracing must respond.

The European Recommendation (8/4/2020) for a Pan-European Privacy-Preserving Proximity Tracing (PePP-PT), requires full compliance with the Charter of Fundamental Rights of the Union, and the technological option is shaped to acknowledge an opting-in system, the sole use of anonymized and aggregated data, and foreseeing expiration measures and deletion of person's data. Still, the Recommendation also acknowledges the eventual and temporary need to restrain the fundamental rights in the light of public interest, even beyond the crisis, pending adequate justification, thus establishing a quite permissive framework for possible action. De-confinement, or 'way out', is not for free: circulation will be as broad and free as extensive and precise the tracking of people in their interactions might be. The 'way out', will always imply a loss of rights, not always consented, for a time that can drag on. Meanwhile, the history of humanity shows that the social experiences have no return, therefore, it may always lead to a new form of 'lock up'.

Introduction

The present moment is characterized by 3 crises of enormous proportions. The first is the health crisis that broke out at the end of 2019, in China, and which, meanwhile, spread to the whole world, having determined the already very serious economic crisis which, in turn, is leading now to an evident social crisis which, like previous ones, threatens to be of unprecedented dimension for this generation.

The current health crisis can only be effectively and totally overcome with the production of a safe and efficient vaccine, which, despite frequent misleading information or advertising (by scientists seeking fame, by research centers seeking funding, and by countries seeking prestige) will not be possible to achieve in the coming long months. As such, national health authorities and governments in general were left with one single effective means of combating the epidemic: social

isolation, with leads to economic breakdown and social collapse.

In this context, all governments are trying to find the best solutions to mitigate the current state of a generalized crisis, aiming immediately not at the causes, but at the effects, that is, not acting directly on the health crisis (for lack of effective tools), but on economics and, consequently, on the social crisis.

Therefore, while biotechnologies fail to produce the necessary and desired responses – vaccines and drugs that are safe and effective –, digital technologies advance with some proposals, among which the mobile or smartphone contact tracing stands out, considered the most effective scientific-technological response, but also the most controversial ethically.

1. Mobile contact tracing: the first experiences

Contact tracing for contagious diseases is not a new and original idea of our times to control the spread of SARS-CoV-2. In ancient times, lepers were obliged to use a bell strapped to their ankles so that their presence could be announced at a distance, allowing others to stay away from any contact and thus reducing the risk of infection. In our time, when a person is diagnosed with an infectious disease, the physician and the health services in general try to identify all persons with whom the patient has been in contact and who may have become infected. The sooner all contacts are identified, for clinical evaluation, treatment and prevention, the more effectively the spread of the infectious diseases to family members, friends and acquaintances is controlled. It is obvious that this process depends heavily on the patient's recollections, depending also from numerous other variables that make it more or less time consuming and affecting its level of effectiveness. The novelty at the present time is the way used to implement an old idea: the application of digital technology to contact tracing for infectious diseases control, and specifically to SARS-CoV-2.

Digital technology has been used for the last past years to identify, locate and follow people, in different situations, and for different reasons, mostly within legal investigations and political reasons. It has also been used within healthcare, mostly to transmit clinical data of patients under monitoring to their doctors. But its application to infectious diseases, to identify and trace citizens, is more recent⁶. It was in 2014, during the last Ebola outbreak that digital technology was used and considered very successful in containing EVD transmission. Mobile contact tracing was then particularly used in urban Nigeria, due to robust surveillance systems and leveraging mobile applications for real-time monitoring (Swanson et al., 2018), and the World Health Organization (2014) presented it as *“an integral component of the overall strategy for controlling an outbreak of Ebola virus disease (EVD)”*, and as *“an important part of epidemiologic investigation and active surveillance”*

The application of digital technology to infectious diseases, exceeds the strict and exclusive domain of the patient-physician relationship, to which was restricted,

to begin involving a whole community and different authorities, which is even more true when considering a highly infectious disease such as SARS-CoV-2. In situations of epidemic outbreaks, the priority for action has always been public health, without a simultaneous consideration of other ethical concerns besides the protection of people's health and life. Issues such as medical confidentiality or citizens' privacy have been overlooked in the face of an emergency.

Today, however, in the current pandemic situation, and with the possibility of successive waves of infectious outbreaks, we find ourselves in an extended time frame in which, if it is true that health protection gains even more importance, ethical issues related to the integrity of procedures in respect of individual rights cannot remain suspended. Both concerns should apply to when considering digital contact tracing.

Asian experiences

Digital contact tracing, tuned as a strategy to fight Corona virus infection, started to be used in Asia, in China, and then also in South Korea and Singapore, following different models in these different countries (Huang et al., 2020).

China was the first country to implement a digital contact tracing as a strategy to control Corona virus infection. The country created the app Health Code, to be downloaded in all mobile phones, which gives users a colour-code (green, yellow and red) according to a combination of factors, namely their health status, travel history, and if they have been in contact with someone infected. Citizens access to public transportation, but also to shops, restaurants and other establishments depends on the color they receive from the authorities, green allowing access to all public spaces, and red requiring home confinement. It also provides the user with a QR code that can be scanned by authorities. Health Code was developed and it is managed by the government and runs in different platforms. It is not clear how the app works, which data are being stored, and for what purposes they can be used both, in the present and in the future.

South Korea, benefiting from its past experience with the Middle East Respiratory Syndrome (MERS) outbreak in 2015, namely the establishment of a legal basis for assessing citizen's information, was able to swiftly develop a robust contact tracing for the present pandemic. The Covid-19 Smart Management System (SMS) uses data from 28 organizations (national entities, smartphone companies, and credit companies, thus using GPS phone tracking, credit-card records, and surveillance camera footage) under the exclusive management of Centers for Disease Control and Prevention (KCDC), and follows the movement of all infected individuals, relying in massive testing of the population. Anonymised data showing Covid-19 patient's movements is published online. Those who come in contact with infected persons are tested again: if they test positive, they are hospitalized; if not, they should remain in quarantine for 14 days. Information gathered under this system is only accessible to epidemic investigators from KCDC, being purged from all personal information. This system is considered transparent and South Koreans have generally installed.

⁶ In 2011, Cambridge University proposed an app for the flu (the FluPhone), but the adoption rate was below 1%.

Nevertheless, there has been many complaints about the personal nature of the data made public by authorities, which can include age and gender, and also businesses visited or hotels and toilets visited.

Singapore developed the app TraceTogether⁷, a community-driven contact. Participating devices exchange proximity and duration of an encounter information whenever an app detects another device with the TraceTogether installed, using the Bluetooth Relative Signal Strength Indicator (RSSI) between nearby phones. Bluetooth signals are less intrusive than the mobile software applications. This system has been considered a paradigm for other countries: the download is voluntary; data (about interaction with other TraceTogether users) are stored in one's phone for 21 days, being then deleted; location data are not collected; if a TraceTogether user is tested positive for Covid-19, is required by law to work together with the Ministry of Health to trace all the patient's contacts for the past 14 days. By middle April, new cases began to grow rapidly in Singapore (mostly in migrant worker's dormitories), and the government immediately started to develop new apps, in addition to Trace Together, to overcome the limitations of different smartphone systems (android, IOS).

Other national experiences

The number of countries that are implementing digital contact tracing is increasing, also as the economic pressure to end the lockdown increases. Many countries, outside Asia, are currently planning strategies to implement it, taking into account the diversity of systems already in place. In fact, there are many other examples besides Asian ones.

Israeli created the app HaMagen, Hebrew for 'the shield', to identify and track people infected with COVID-19 also during their quarantine. It was developed using open-source tools. Therefore, it can be easily installed in other countries, at no cost, what is raising the interest of several countries looking for a quick and already tested solution.

Iran created the app AC19, to be installed by all Iranians before going to a hospital or health center. It is supposed to be a diagnosis app, capable to do the user's diagnose by asking a series of yes and no questions, at the same time that it locates them in real time.

These first experiences on mobile contact tracing show that it is generally considered effective to control the spread of an infection, such as the Coronavirus, insofar: population is widely tested; citizens have a mobile phone; and they are compelled (forcibly) or accept (voluntarily) the national tracing system.

These first experiences also show that, in a short period of time, many countries started using mobile contact tracing, considering it the most successful way to control the health crisis and to mitigate the economic and social crises. Although accurate information to quantify its effectiveness is not yet available, their use by some countries raised the eagerness of others to take the same step.

Thirdly, these first experiences show that digital contact tracing can be designed and implemented in

many different ways, with regard to technological systems and value systems. Regarding the latter, the systems can be more or less transparent in terms of procedures and more or less respectful of individual rights and of citizens' privacy. Overall, and while some ethical concerns are notorious, the value of public health and collective security clearly prevailed in these first experiences, other major ethical values fading away. It can be considered that beyond the case of authoritative governments, there were some factors that enhanced the willingness of the Asian population (as well as the Israeli), to accept and collaborate with digital contact tracing such as: former experiences dealing with epidemic outbreaks (in Asia); living in highly technologically advanced societies and countries (high-tech societies); nurturing a strong feeling of community and discipline.

Briefly, we can conclude that the effectiveness of mobile contact tracing does not depend only on technological progress, but also on the social, political, cultural and moral context in which it is implemented. For this reason, the adoption of mobile contact tracing in the European Union necessarily involves specific questions, more of an ethical than of a technical nature, and those of a technical nature derive from the need to answer the ethical questions.

2. Mobile contact-tracing: the European initiative

The European Union formally joined countries in favor of adopting digital contact tracing on 8 April, when the European Commission presented its Recommendation C (2020) 2296 to Member States *"on a common Union toolbox for the use of technology and data to combat and exit from the COVID-19 crisis, in particular concerning mobile applications and the use of anonymised mobility data"*.

The general objective is to develop *"a common approach to the use of digital technologies and data in response to the current crisis"* that overcomes the limitations and weaknesses of national, fragmented (closed groups or workplace contacts) and uncoordinated options, also preventing the *"proliferation of applications that are not compatible with the Union law"*⁸. This pan-European approach for the use of mobile applications, together with a common scheme for using anonymized and aggregated data, should leverage the effectiveness of the system due to the greater amount of accurate data and extensive collaboration, both important to better predict the evolution and spread of the infection (*"in providing information on the level of virus circulation, in assessing the effectiveness of physical distancing and confinement measures, and in informing de-escalation strategies"*), as well as sustaining the integrity of the Single Market.

In this Recommendation, the European Commission urged Member States to develop a COVID-19 mobile application by 15 April 2020, to be urgently adopted, working together with the Commission, and the European Data Protection supervisor. By 31 May, Member States should report to the Commission the

⁷ <https://tracetgether.zendesk.com/hc/en-sg>

⁸ European Commission, *Recommendation*, "Has adopted this recommendation", 13(2).

actions taken, pursuant this Recommendation. A potential pan-European application is not yet excluded.

Despite the very short period of time established to develop a European mobile contact tracing system, the European Union did not import technical solutions already implemented in other countries. Certainly benefiting from the knowledge of the existing systems, the European Commission's major concern was to identify the ethical concerns to be taken into account when designing the European system, especially in view of its socio-cultural context. The European Union's space is characterized by a strong democratic experience and a broad and rigorous implementation of human rights, from which a demanding awareness of the fundamental rights, freedoms and guarantees of all European citizens has developed. It is also in this context that the European Union has a *General Data Protection Regulation* (EU GDPR, 2016/679), in force since 2018, and which presents the most demanding legal framework in the world in terms of data protection.

Ethical concerns

The European Commission's Recommendation is clear and unambiguous in its demand for full compliance with the Charter of Fundamental Rights of the European Union (2000), with regard to individual rights and freedoms, with particular emphasis on the rights to privacy and protection of personal data. It also refers to: *transparency of the procedures, especially on the data processed and the people involved; prevention of surveillance and stigmatization; clear and regular comprehensive communication to the public, also providing opportunities for the public to interact and participate in discussions.*

Notwithstanding these safeguards, the Recommendation also includes some statements that go in the opposite direction, by admitting restrictions to the high ethical standards that the European citizens enjoy under the public interest. So, when the public interest is at stake, and *"in particular for monitoring and alert purposes, the prevention or control of communicable diseases and other serious threats to health"* (European Commission 2020; "Whereas", 7) data may be processed *inter alia* without explicit consent. Besides, Member States are allowed *"to adopt legislative measures to restrict the scope of certain rights and obligations established [...] when such restrictions constitute a necessary, appropriate and proportionate measure within a democratic society to achieve certain objectives."* (European Commission 2020; "Whereas", 10).

In fact, the European Commission recognizes that *"given the functions of smartphones applications [...], their use is capable of affecting the exercise of certain fundamental rights such as inter alia the right to respects for privacy and family life"*⁹, admitting that Member States' laws may have to set out or permit limitations to the exercise of certain fundamental rights, although these restrictions "must be justified and proportioned." ("Whereas", 23). Of particular concern is the statement that "any such restrictions should, in particular, be temporary, in that they remain strictly limited to what is necessary to combat the crisis and do not continue to

exist, without an adequate justification, after the crisis has passed." (European Commission, *Recommendation*, "Whereas", 23)

The acceptance of possible restrictions on fundamental rights when necessary, in the light of the public interest, and which can be extend beyond the crisis, through adequate justification, ultimately establishes a quite permissive framework for possible action by the authorities.

Technical solution

The European initiative is being designed to address the ethical concerns of its citizens. In this sense, we can say that there is an inversion of priorities in relation to the first experiences of contact tracing: instead of setting up an effective system for the pursued objectives, which seeks to adjust as far as possible to the ethical concerns of the community, the European Commission first identifies the ethical requirements to be protected to which the digital system of contact tracing must respond.

It is in this context that the European technological option, *The Pan-European Privacy-Preserving Proximity Tracing (PePP-PT)*, moves away from systems that rely on GPS, preferring less intrusive technologies, such as Bluetooth Low Energy based systems that do not collect personally identifiable information or user location data, with the list of contacts remaining on the user's device, and that require explicit user's consent. Still, the Commission's requirements for a mobile contact tracing system are tougher, more stringent, with specifications at various levels referring to

- nature: voluntary (opting-in system)
- data collected: anonymization of identity and confidentiality of communications(16(1)); avoidance of processing data on location movements, but setting a common approach for the use of anonymized and aggregated mobility data if these became necessary (for modelling of the virus spreads, and of the economic effects of the crisis); the solely use of anonymized and aggregated data where possible; data on the infected person remains anonymous; preventing de-anonymization and avoid re-identification (20(3)); immediate and irreversible deletion of all accidentally processed data capable of identifying individuals (20(4))
- data storage/access: on the mobile device, with possible access by health authorities and data storage (16(3))
- data processing: anonymized and aggregated where possible (16(2))
- data deletion: expiration measures and deletion of a person's data in principle after a period of 90 days or, at the latest, when the pandemic is declared under control (16(5), 20(5).)

The effectiveness of this system will depend heavily on a necessary parallel action of wider testing and also on the acceptance and collaboration of the general public, which will only be achieved if the system is reliable. In any case, it will leave out elderly citizens, and also the most disadvantaged, such as the homeless, who do not have a cell phone.

Meanwhile, the required general trust is already beginning to deteriorate, namely with the recent lack of transparency in the software operations, after having verified that the responsible consortium changed the

⁹ European Commission, *Recommendation*, "Whereas", 17.

option of using a decentralized protocol in the technology, considered as having higher privacy protections, for a centralized data storage, which can be prone to less security standards. Following this occurrence, some members of the consortium withdrew from the project, and about 300 academics, from more than 25 countries, published an open letter¹⁰, urging governments to distance themselves from the application of contact tracing software that stores data centrally.

Way out or lock up?

Digital contact tracing appears initially as a key to *de-confinement* and, in this sense, as an instrument to mitigate the economic and social crisis, that is, acting more on the effects than on the causes of the health crisis. After all, with regard to health, *de-confinement* will increase the number of infections, previously estimated to be acceptable according to the capacity of admissions of health services. Nevertheless, the Pan-European approach also foresees monitoring the evolution of the infection and predicting the diffusion of the disease and the impact on needs in the health systems, thus also acting, in the medium term, directly at the healthcare level.

The way out of *the coronavirus lockdown, to de-confinement*, made possible by digital technologies, is not, however, for free: circulation will be as broad and free as extensive and precise the tracking of people in their interactions might be. Despite the demanding ethical concerns, the 'way out' will always imply a loss of rights, not always consented, for a time that can drag on. We exchange personal privacy and freedom for social and economic sustainability.

Meanwhile, the history of humanity, shows that the social experiences have no return, therefore, it may always lead to a new form of 'lock up'.

Once the mobile contact tracing system is set up, it will remain available, because it will certainly be useful, for other reasons, for other purposes that may also be justified in terms of public interest. The fundamental ethical question, to which each and all of us ought to answer, is to what extent do we want to sacrifice our personal sphere, in which human identity was generated and nurtured, to the public space, in which we fulfill ourselves as persons.

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The application of artificial intelligence to the medical field: report of a qualitative investigation

-Taketoshi Okita

Department of Medical Ethics, Tohoku University Graduate School of Medicine, Sendai, Miyagi, Japan
Email: okita@med.tohoku.ac.jp

-Atsushi Asai

Department of Medical Ethics, Tohoku University Graduate School of Medicine, Sendai, Miyagi, Japan

-Tsuyoshi Horie

Department of Clinical Philosophy, Osaka University Graduate School of Letters, Toyonaka, Osaka, Japan

-Seiji Bito

Division of Clinical Epidemiology, National Tokyo Medical Center, National Hospital Organization, Tokyo, Japan

Abstract

Progress in artificial intelligence (AI) technological innovation raises questions about the role of medical staff and the meaning of medical specialization. This study involved a qualitative survey of medical professionals and ordinary citizens to expand knowledge of this topic. A combination of Neo-Socratic Dialogue (NSD) and Transfer Dialogue (TD) techniques, was used to acquire knowledge related to emerging forms of medical care and changing work demands after the implementation of AI, qualitatively analyzing the TD transcript only. Eleven subjects participated in two surveys (13-14 January, 2018 and 11-12 August, 2018). The main points raised during TD were classified into five categories: i) Functions which AI could perform/would find difficult to perform, ii) Changes in medicine caused by AI, iii) Necessary preparations for the application of AI to medicine, iv) Concerns about AI, and v) Others. The survey findings suggest that initiatives to promote the acceptance of each individual in society and appropriate technological development are essential to the process of preparing for the changes in medicine following the implementation of AI. These preparatory conditions cannot be limited to medical professionals, and must extend to workers across all disciplines and to society as a whole.

Introduction

In recent years, artificial intelligence (AI) innovation has proceeded at a dizzying pace, and its application to medicine is being promoted on a global scale. In relation to assessments and operations previously conducted by

¹⁰ <https://main.sec.uni-hannover.de/jointStatement.pdf>

doctors and other medical professionals only—such as diagnosis of diseases such as cancer, the selection of treatment, and surgical intervention—the development of AI has allowed for support in these areas; furthermore, a significant portion of procedures can be conducted independently by AI.

In addition, as AI technological innovation progresses, questions concerning the role of medical staff and the meaning of medical specialization have been raised. The clarification of the qualitative changes that AI will bring to medicine and the work of medical professionals is an urgent task that needs addressing before AI can be fully and effectively integrated into the medical field.

This study involved a qualitative survey of both medical professionals and ordinary citizens who had received medical care, concerning the forms of medical care that are likely to emerge and the new types of work to be carried out by medical professionals after the implementation of AI, with the goal of acquiring greater knowledge related to this topic.

Method

A method of philosophical discussion was used to acquire relevant knowledge related to emerging forms of medical care and changing work demands among medical professionals after the implementation of AI. This method involved a combination of Neo-Socratic Dialogue (NSD) and Transfer Dialogue (TD) techniques.

NSD is a philosophical discussion technique created by the German Kantian philosopher Leonard Nelson (1882–1927) in the early 20th century. It has seen widespread use in European countries such as Germany, the United Kingdom, and the Netherlands, and was first utilized in Japan in 1999 (Aizawa K. et al., 2010). Although NSD is a technique normally used for discussion in philosophy and ethics education, the fact that its methodology is based on having participants present their own personal cases related to a theme and conduct their own analyses of applicable cases has enabled its use both in Japan and elsewhere as part of qualitative surveys related to questions similar to the topic of this study, such as, for example, “What work do medical professionals perform related to patient decision-making?” (Horie T., 2008). TD is a discussion method that tests the kind of understanding and knowledge gained through application of general principles and decision-making processes acquired from NSD to real-world contexts. This method consists of a group discussion where participants can speak freely on an applicable theme based on their newly acquired knowledge and progress after NSD has been completed. The approach of combining TD with NSD was developed as a “Dialogue Complex” by the Department of Clinical Philosophy, Osaka University Graduate School of Letters (Horie T. & Homma N., 2003, Horie T., 2004, Homma N. & Horie T., 2010). Furthermore, a study similar to this one has been conducted in Austria, consisting of a survey of medical personnel and ordinary citizens on the theme of “genetic counseling and self-determination”. As with that study, the current study used a combination of NSD and TD. In addition, while only the participants and a facilitator participated in the discussion during the NSD phase, researchers in attendance also participated in the TD phase.

For this study, each survey consisted of 1.5 days of NSD and 0.5 days of TD, for a total of 2 days, and involved 5-6 participants. The participants were specialists in medicine and related fields, such as doctors, nurses, medical social workers, pharmacists, and psychological counselors, and ordinary citizens receiving medical care. The theme of the NSD session was “What are medical professionals doing for patient decision-making?”, while the theme of the TD session was “How should medical professionals approach their work after the introduction of AI?”.

Statements made during the NSD and TD sessions were recorded, and a transcript was created afterwards. This report qualitatively analyzed the TD transcript only.

In addition, this study was implemented based on an evaluation of the Tohoku University School of Medicine Ethics Committee and with the approval of the dean of the graduate school (2018-1-778).

Results

Two surveys were conducted in 2018 (13–14 January and 11–12 August). There were 11 participants in total, comprising doctors, nurses, a pharmacist, a speech-hearing therapist, a psychological counselor, and ordinary citizens. Tsuyoshi Horie served as the facilitator for both surveys. Information about the participants is recorded in Table 1, and Table 2 provides an overview of NSD.

The main points raised during TD were classified into 5 categories: i) Functions which AI could perform and those that would be difficult for AI to perform, ii) Changes in medicine caused by AI, iii) Preparations which need to be carried out for the application of AI to medicine, iv) Concerns about AI, and v) Other.

Category i) mostly involved discussion concerning the extent to which the medical care currently carried out by medical professionals could be performed using AI and the kind of functions that would be difficult for this technology to perform. Providing standard medical care and relevant medical field information, which can be readily converted to language or data, were identified as possible functions for AI, and many of the participants stated that running the process from diagnosis to proposing a course of standard care treatment was a possibility for AI. On the other hand, functions difficult to be converted into language or data, such as expert experience and judgment, insights, handling existential problems, consideration for individual patient conditions, and appropriateness in patient care were considered challenging for AI. In addition, concerns regarding excessive AI information collection and analysis leading to unwelcome medical intrusiveness were raised. In the debate on greater AI use, while some were of the strong opinion that there would always be areas where AI could not be applied effectively, others expressed the view that people’s expectations from medicine itself would change, and they would be accustomed to a new system in which AI could work more effectively. Although consideration for human-specific subtleties in medical care was identified as an area which would be challenging for AI, others also stated that the emotionless and fatigue-free nature of AI would make it better suited to some situations than human workers.

Concerning category ii), the participants identified possible changes in the relationship between patients and medical staff, structuring of medical experts' work, and overall approach to medicine itself. Regarding the relationship between patients and medical staff, the participants considered the role AI would likely play in the relationship between the two parties, with three contrasting viewpoints identified as follows: "Medical staff will have exclusive access to AI and interpret its analysis content," "Both patients and medical staff will have access to AI analysis content, but the medical staff will be expected to interpret, explain, and provide support," and "Patients and medical staff will have equal opportunity to interact with AI analysis." The participants were split relatively evenly across these viewpoints, and they further pointed out that there would likely be individual differences in the degree to which people were able to accept the technology, depending on the age groups involved and individual factors. In addition, many felt that applying AI within the medical care team could facilitate a more open dialogue. Concerning the structuring of medical care, some participants considered that specialist positions would remain subdivided into occupations such as doctors and nurses, while others saw the potential for unification into a single "medical staff" grouping. Further, participants pointed out that, through advances in the individual usage of AI and wearable technology, the process of gathering and analyzing medical data could itself change, possibly causing a shift in the overall approach to medicine itself, especially in relation to medical deduction and diagnosis.

Regarding category iii), the discussion focused on the responsibility for considering the information provided by AI for diagnosis and other functions as the application of AI within medicine progresses. The extent to which doctors need to be considered responsible for taking this information into account and the degree to which patients need support in this area from the medical staff were points of debate, and the necessity of patients themselves to be informed concerning their own advanced medical information as obtained through AI in relation to medical care was also discussed. Regarding future decision-making, given the remaining areas of uncertainty and with AI increasingly involved with the presentation of diagnoses and standard medical care, the participants discussed the extent to which patients would be able to understand the relevant information, the kind of literacy necessary for this purpose, and the kind of support required from relevant professionals. Some pointed out that relevant education, awareness of ethical considerations, and deeper engagement with issues of life and death will probably become more essential for a broader range of people in society than is presently the case. Participants also noted that, in terms of AI development, the developers need to have a greater understanding of medicine and medical ethics.

Regarding category iv), concerns were presented related to the black box aspect of AI deep learning. Participants raised concerns such as the possibility of AI moving out of control, perhaps even working against human interests like some form of Frankenstein's monster, or the distortion of learning and analysis orientation, regardless of the intentions of the AI

developers. Further, although human medical staff are likely to work to save the lives of patients, even if their return to society could be difficult, participants raised questions concerning the necessary steps to be taken if AI systems determined that care for these kinds of patients was illogical. In addition, they considered that, as AI continues to advance, pressure could mount to make wearable devices compulsory.

Regarding category v), many fascinating opinions were shared on other topics as well. For example, the participants reflected on whether AI might give patients advice like "you can give up on treatment, if you like" and pointed out that transferring medical care to AI might allow possibilities for mankind to discover new kinds of work and that the development of AI could be an opportunity to rediscover our humanity and opportunities for greater collaboration. Participants also contemplated whether AI could experience death and, in replicating the experiences of a dying person, could provide useful training material for human medical staff members in caring for critically ill patients.

Discussion

The knowledge acquired through the results of these two surveys can be divided into two categories related to the application of AI to medicine, namely, the changes that medicine and medical staff will likely face in future, and the preparations needed for these changes.

Regarding predictions for medicine after the implementation of AI, the fundamental perspective participants adopted was to consider those aspects that could be undertaken using AI, and they concluded that the current state of medicine will be dramatically changed, with the possibility that it could take on an entirely new form that goes beyond the question of whether AI can or cannot take over various functions. Whether a more limited or a more radical viewpoint on the possibilities of AI was adopted can be interpreted as occurring in relation to whether a short-term or long-term outlook was used. Even if a division of functions among AI and human workers was implemented within the current framework of medicine in the near future, the framework of medicine itself could still change more dramatically over a longer period. Furthermore, given the rate at which genome analysis technology has progressed in the past few decades, there could be technological changes that go beyond our imagination even in a very short period of time, and it is quite possible that both medicine and society itself could change along with their arrival. When considering medicine after the implementation of AI, an openminded and imaginative approach is likely to be of value in coping with the resulting process of change.

Table 1: Number of participants in NSD/TD and their occupation

Occupation	Number of participants
Doctor	2
Nurse	3
Pharmacist	1
Speech-hearing therapist	1
Psychological counselor	1
Ordinary citizen	3

Table 2 Overview of NSD

	First session (Jan. 13-	Second session
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	14)	(Aug. 11-12)
NSD questions	What work do medical professionals perform related to patient decision-making?	
Examples presented and shared by participants	A case related to examinations for mild chest pain and its handling by doctors: from the patient's perspective. At the first hospital, because the doctor immediately recommended a cardiac catheter test, the patient felt uneasy and canceled the examination. However, at the second hospital, the doctor listened carefully to what the patient had to say, and as a result, the patient felt confidence in the diagnosis given based on the follow-up observation results.	A case of refusing a blood sample to be taken for surgery preparation: from the patient's perspective. At the autologous blood donation stage in surgery preparations, the patient stated, "I want to go home," and refused to allow the taking of a blood sample. However, the blood was successfully collected when the nurse and doctor intervened.
Answers to questions after examining the cases	<ul style="list-style-type: none"> • Medical staff act as partners to work out patient concerns and expressing this attitude to the patient. • They identify the information patients need to make a decision for shared concerns with reference to medical knowledge and experience. • They clarify shared interests and comprehension through the interaction of the interests and understanding of the patient and the medical staff. (This represents a selection of the multiple answers received.) 	If medical personnel receive tentative consent from the patient based on a standard treatment plan, their final intention is to carry out this plan. Means of supporting decision-making in this process: 1) share information related to illness and treatment, 2) consider the best medical approach for the patient, 3) show consideration for each patient and each case, 4) show understanding and compassion related to patient concerns, 5) indicate information and choices bearing in mind the patient's everyday circumstances, lifestyle, and questions, and 6) for all categories of personnel to respond to patients in a consistent manner.

However, the perspectives and assumptions revealed in this study almost certainly involve some limitations,

and determining an effective approach in relation to the effects of AI in the medical domain requires a willingness to not be bound by rigid thinking. In another study, we have already considered what else may be required based on literary research (Asai A. et al., 2019). The findings of these surveys suggest that initiatives to promote the acceptance of each individual in society and appropriate technological development are essential to the process of preparing for the changes in medicine following the implementation of AI. These preparatory conditions for the application of AI technology to medicine cannot be limited to medical professionals, and must extend to workers across all disciplines and to society as a whole.

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The COVID-19 pandemic and social inequality

- Christopher Ryan Maboloc, PhD
 Ateneo de Davao University, the Philippines
 Email: ryanmaboloc75@yahoo.com
 -Carmelle Ayra Ferrer, MD
 Southern Philippines Medical Center

This paper addresses an important point with regard to the critical question of equality during a pandemic – are poor societies more vulnerable to public health emergencies? The available data with respect to the coronavirus crisis reveal that the majority of countries affected by the pandemic belong to the developed economies. This investigation determines the correlation between affluence and the spread of the contagion. It argues that the inequality among nations does not have any significant relation to disease movement, infection, and high mortality rate. However, addressing the problem of urbanization and investing in public health will be crucial in terms of confronting the socio-economic ramifications of the COVID-19 pandemic.

Introduction

Human societies have been devastated by wars in times past. The Second World War, the greatest conflict in the history of humankind, has killed more than 100 million lives. Societies have been destroyed by the whims of dictators. Famines have caused unimaginable misery and suffering to millions of human lives and death to countless people. Pandemics are no different. Such occurrences kill lives and at the same time also present themselves as hard challenges that humanity must reflect on if it must survive. Thomas Abraham (2011, 3) explains that questions about a pandemic are not just about health, but its political and social consequences as well.

Pandemics, by definition, refer to disease outbreaks that affect all people. The important features to consider to characterize any disease outbreak as a pandemic include “wide geographic extension, disease movement, novelty, severity, high attack rates and explosiveness, minimal population immunity, infectiousness and contagiousness.” (Qiu et al. 2016, 30) History reveals how pandemics have caused havoc to human lives. The death tolls number from thousands to tens of millions.

Some of the pandemics recorded in modern times include “smallpox, cholera, plague, dengue, AIDS, influenza, severe acute respiratory syndrome (SARS), West Nile disease and tuberculosis.” (Qiu et al., 4) The most difficult to predict among them and perhaps, the most dangerous considering the very high mortality rates are influenza pandemics that have been in existence since the 1500s. The Spanish Flu of 1919 has killed 50 to 100 million lives, for example.

The COVID-19 pandemic has killed 190,654 with a total confirmed cases of 2,718,699 cases as of April 23, 2020. The highest death toll is in the United States with 49,855 fatalities of 880,204 cases. Italy has 25,549 deaths of 158,183 cases. Spain has 22,157 deaths of 213,024 cases, higher than that of Italy. Outside Europe and Northern America, Iran recorded the highest number of deaths at 5,481 of 87,026 cases. (JHU 2020)

Disease movement

The coronavirus pandemic has spread rapidly. It began in Wuhan, China and entered the Western hemisphere immediately. As of the moment, China has eased restrictions while the United States is grappling with the right steps to make as some states are now eager to reopen their economies against the advice of top US health experts. According to Dr. Anthony Fauci, the only way to reopen the economy is to ramp up testing in order to protect the population.

The COVID-19 is a respiratory disease. Given that SARS-COV2, the virus that causes the disease, can spread from person to person, social or physical distancing is a must to protect the population. Overcrowded places such as transport hubs, malls, and office buildings, public parks and places where people converge act as a natural environment where individuals get the viral infection. Experts note that the coronavirus can live up to 48 hours in some surfaces and can remain suspended in the air for a longer period of time.

One of the contributory factors to the rapid movement of the outbreak is globalization. (Maboloc 2020, 77) The interconnected nature of our globalized economy means that the easy movement of peoples across the planet enabled the fast pace of human to human transmission. But it must be noted that while the disease has reached the African continent, the record shows that the infection is not as widespread as in Europe and Northern America.

For instance, South Africa recorded 75 deaths of 3,953 cases. Egypt has 287 fatalities of 3,891 confirmed cases. Ghana has nine (9) deaths of 1,154 cases. Nigeria has 31 deaths of 981 cases. Tunisia has 38 deaths of 918 confirmed cases. Senegal has recorded only 6 deaths of 479 cases. The Democratic Republic of Congo (DRC), which recently had an Ebola outbreak, recorded 25 deaths of 377 cases. (JHU 2020)

In Southeast Asia, Indonesia has the highest number of deaths at 647 of 7,775 confirmed cases; the Philippines recorded 462 deaths of 6,981 recorded cases while Malaysia has 95 fatalities of 5,603 cases. Singapore has the highest number of cases at 11,178 but has the lowest number of deaths at 4. Most cases recorded in the country come from its migrant labor force. Vietnam, it is worth mentioning, has zero deaths of 268 recorded cases. (JHU 2020)

It may be concluded from the above that the coronavirus infection affects more people in the Western hemisphere and especially, affluent societies. In contrast, the disease seem to be recording slow levels of infections in poorer regions such as Sub-Saharan Africa and Southeast Asia. Experts note that the South Korea has been efficient in containing the spread of the virus through testing, tracking, and tracing.

Infection and mortality rates

Diseases that have low infection rates are not classified as pandemics. The Ebola virus, in contrast, has been noted for its severity, infectiousness, and high mortality rate. (Qiu et al. 2016, 5) Severity is estimated by the case fatality ratio. (Donaldson et al., 2009) Wu Qiu, et.al writes that “the Ebola outbreak was an unprecedented public health emergency of international concern with 28,581 cases and 11,299 deaths in West African countries.”

The implication to human health “lies in the potential of the virus to mutate into a form capable of sustained person-to-person transmission.” (Qiu et al. 2016, 5) This is precisely the case for the SARS-COV2 virus. Leading science journal *Nature* reports that “although hopes for antibody-based immunity are high, there is currently little available data on whether human populations develop immunity to SARS-CoV-2.” (*Nature*, April 10, 2020)

In comparison, the dreaded Ebola virus has an estimated fatality rate of 40%. (Nabarro & Wannous, 2016) The Ebola emergency required international cooperation to contain its spread in Sierra Leone and the DRC. The disease first appeared in South Sudan and the DRC, near the Ebola River, where its name was taken from. According to the World Health Organization, “the current 2018-2019 outbreak in eastern DRC is highly complex, with insecurity adversely affecting public health response activities.” (WHO 2020) After reporting that the outbreak has been contained this year, a new case of the virus recently emerged in DRC.

WHO (2020) says that the death rate for COVID-19 is at 3% whereas the seasonal flu is at 1%. The WHO however is cautious as to this early estimate given that the total number of unreported cases remain unknown, especially in China. Thus, the international body has stated that “the only number currently known is *how many people have died out of those who have been reported to the WHO.*”

As of April 23, 2020, the death rate in the US is currently at 5.7% whereas it is 6.6% in the Philippines; the death rate in Italy is 13.4% while it is at 3.6% in Germany; in China, the death rate stands at 5.6% (figures already revised from the previously reported); in South Africa, the mortality rate is at 1.8% compared to 6.3% in Iran; Indonesia’s mortality rate for COVID-19 stands at 8.3% whereas it is at 1.7% in Malaysia. (JHU 2020)

Based on the above, it may be assumed that the persistent inequality among nations has no significant influence when it comes to the spread of the disease, its contagion or infectiousness and its mortality rate which shows a wide disparity between affluent states and countries in poor regions, although the Philippines and Indonesia show some variance.

It has been suggested that COVID-19 can spread rapidly in densely populated areas. This may be true in the case of the Philippines where the volume of cases have been concentrated in the National Capital Region, Cebu in Central Visayas, and Davao City in Mindanao. The said places have a high concentration of people who come to malls, transport hubs, and public areas.

While the whole Davao Region has 97 confirmed case, Davao Occidental which is 135 kms away from Davao City, has not recorded a single case of the coronavirus. (DOH 2020) By implication, the geographic configuration of the Philippines, lack of accessibility, and distance from airports and dense population have a significant correlation to disease movement. Cebu City, for instance, like Metro Manila, has an international airport with regular weekly flights coming from China, South Korea, and Japan.

Social inequality and pandemics

There appears to be no known reliable statistical data when it comes to the correlation between past pandemics and social inequality. The literature only suggests a few surviving anecdotal narratives which cannot be validated. It is widely known, for instance, that the plague that hit London in the 16th century decapitated a big part of the poor who lived in the slums while the affluent part of society were separated from the area where the plague emerged. Given the restriction, thousands of poor people died in their homes while being quarantined.

Chronic (non-communicable) diseases like cancer, heart or lung disease, offer some information as to the susceptibility of the population. Poor people lack access to quality health care and often do not have the means to procure medicine or available treatment. People do not just die from diseases. They die because of inefficiency and the lack of immediate care that is supposed to be provided by the state. The WHO (2020) explains:

The poor are more vulnerable to chronic diseases because of material deprivation and psychosocial stress, higher levels of risk behaviour, unhealthy living conditions and limited access to good-quality health care (see sidebar figure on the next page). Once disease is established, poor people are more likely to suffer adverse consequences than wealthier people. This is especially true of women, as they are often more vulnerable to the effects of social inequality and poverty, and less able to access resources.

The COVID-19 pandemic is feared to have a major health impact in impoverished nations. However, as the above show, that appears to be unfounded as of the moment. Social inequalities, it is suggested by some, give rise to pandemics. But such is not currently the case because as a matter of fact, COVID-19 is affecting developed countries more than the impoverished states. Internally, urban centers suffer the most in terms of a higher rate of infection compared to rural areas where people are spatially separated.

In the United States, data show that Black Americans have a higher death rate compared to Whites or Latinos. The disproportion can be examined by comparing the percentage of deaths to the population. (APM 2020) According to the APM Research Lab, “across the U.S., Black Americans are dying of COVID-19 at a rate of more than twice the population share.” The data shows that “collectively, they represent 11% of the population in states releasing data, but have suffered 28% of deaths.” (APM 2020)

The disproportion can be attributed to pre-existing conditions rather than race or a person’s economic states of affairs. The coronavirus, indeed, respects no economic or regional boundaries of borders. Battling the pandemic, policy-wise, should be about the epidemiological attributes or characteristics of the disease although it is without argument that the unequal or unfair conditions of human beings in society may contribute to the problem, as acknowledged by Dr. Fauci. Referring to the situation of African-Americans, he explains:

“And the reason I want to bring it up, because I couldn’t help sitting there reflecting on how sometimes when you’re in the middle of a crisis, like we are now with the coronavirus, it really does have, ultimately, shine a

very bright light on some of the real weaknesses and foibles in our society." (Business Insider, April 8, 2020)

The current statistics reveal that in New York City, 47.7% of coronavirus deaths belong to the 75 and above age bracket, 24.6% for (65 years old to 74 years old), 23.1 for (45 years old to 64 years old), and 4.5% for (18 years old to 44 years old). The sex ratio for deaths in New York City, which has become the new epicentre of the pandemic, is at 61.8% for males and 38.2% for females. (New York City Health Daily Data Summary 2020)

Globally, with respect to pre-existing conditions, the following are the co-morbidity rates for those infected with COVID-19: 13.2% for cardiovascular disease, 9.2% for diabetes, 8.0% for chronic respiratory disease, 8.4% for hypertension, and 7.6% for cancer. (Worldometer April 16, 2020) Doctors and experts are in agreement as to how pre-existing conditions may hugely contribute to mortality outcomes.

The conclusion based on the above data is that individuals with pre-existing conditions are more vulnerable to COVID-19. The basic point is that social inequality presuppose that the many members of poor communities are disproportionately served in terms of healthcare and for this reason, the unequal condition of people is a threat to their health which may result to death.

The coronavirus does not choose who becomes ill. But unjust structures and the uneven social conditions within the areas where the disease movement is prevalent may reveal who might succumb to the infection. On the other hand, people who are spatially separated from cities with density of people or places where economic activities require the convergence of large crowds might find themselves safe from the contagion for now.

On Non-Covid Cases: A Short Note

But health care professionals face other challenges. There are non-COVID 19 patients who cannot be discharged or easily transferred to another hospital due to health protocols imposed by the government, and we can see that in the Philippines. The Southern Philippines Medical Center (SPMC) is a case in point. The reason cited by public health and government officials is public safety and the need to contain the local transmission of the virus.

The social aspect of the problem has also made itself manifest. For example, health care workers such as nurses, attendants and others are discriminated by the community. Reports say that they are asked to leave their rented places and public transportation would drive past them as they are identifiable by way of their uniforms. Also, doctors at the government run hospital cannot do elective cases which are beneficial to patients because all services will only allow STAT or emergency procedures.

Some of the facilities inside the hospital complex at SPMC have been used for Persons under Investigation (PUI) and these cannot be used for non-COVID patients. Blood donations are suspended and blood banks or centers experience shortages. Other patients who suffer from a different condition in need of blood or require certain medications face risks and challenges. The

essence of holistic care is a bit compromised but doctors also feel that they cannot blame the institution. The public health situation at this time simply requires extra measures.

The services that hospitals can offer would require a greater form of sacrifice. It is the sentiment of frontline health care workers that they should not be left alone to carry the burden. Some questions linger: "How does one give care when patients in need of platelet concentrate cannot borrow blood?", "What if the donors are outside the local quarantine zone?", "These some questions that need to be asked inside during emergency cases for non-Covid patients."

Policy change in a post-pandemic scenario

The coronavirus has revealed harsh social pathologies. The unequal situation of people, the lack of access to quality healthcare for the treatment of chronic diseases, tend to exacerbate the condition of people in areas where the contagion is widespread. This means that some things should be done on the part of government and policy makers post-pandemic to improve the approach in combating a possible second wave.

From a global perspective, governments are witnessing the failure of systems to protect national and regional economies, with some countries in Europe expected to suffer from an 8% to 15% Gross Domestic Product (GDP) contraction. The United States has basically wiped out the 24 million jobs that it has created in the last ten years, with more than 26 million Americans filing for unemployment claims as of the moment. In the Philippines, 400,000 families expect hard times as the same number of overseas Filipino workers will lose their jobs.

It can be said that untamed growth due to rapid urbanization is one of the culprits in the fast spread of the virus. Prospectively, densely populated cities should be re-designed as a strategic measure to prepare the population for the possible second wave. Since people go where the jobs are available, government centers can be relocated to the provinces. In addition, small and medium enterprises must be set up away from urban centers to create more jobs and spur economic growth in rural areas.

To address inequities in health care, existing health care policies should consider the most vulnerable member of the population. Universal health care should be implemented. As what this pandemic reveals, if only governments invested more in public health, deaths could have been prevented or reduced. By improving the quality of health care services, people will be better equipped to combat the movement of the disease.

The University of Oxford is first to report on human trials for a potential coronavirus vaccine. At present, there are at least 80 undertakings on vaccine development. A vaccine is expected to be delivered between 18 months to two years. Mapping the coronavirus gene in January 2020 has helped accelerate the development of the vaccine. However, experts are cautious in terms of the timeframe, insisting that protocols should be followed to make the vaccine safe.

Vaccines should be developed as a collaborative effort of international bodies. In this way, access to the protection from the coronavirus can be made available

even to the poorest regions in the world. While substantial financial incentives await researchers, the fact of the matter is that pharmaceutical companies will be quick to jump on the occasion once a vaccine is found and profit from a potential windfall. This should be prevented through international pressure.

Politically, governments around the world must recognize the importance of health care as an integral component of human development. Doctors and other medical front liners should be duly recognized their sacrifices. Most states have invested billions of dollars in military upgrade but have neglected public health. And so, it is the case at of the moment that the grave threat to public health has shown itself as a real challenge.

The coronavirus pandemic reveals that everything in life is a symphony. In the absence of a part of a whole, the symphony of human life would collapse. In our modern times, people have poured a great part of themselves in pursuit of economic prosperity. Now, societies realize that all of that can fall into pieces if authorities neglect the total well-being of people. Above all else, human life is what matters in the end.

Conclusion

This study has sought to determine the correlation between social inequalities and the impact of pandemics to society. The correlation is not significant. The virus chooses and respects no economic or social boundaries. Given this, governments must guarantee the kind of environment in which people are safe and secure. By this, we do not only mean the protection of people with respect to the threat of the coronavirus disease, but their social and economic welfare as well. For that matter, preparing people in a post-pandemic world will require the bold re-channelling of resources. Government must invest more in public health. Prospectively, urban centers should be redesigned. The coronavirus teaches us that there is something greater than the economic aspect of life. And that is human life itself as primordial or fundamental value above all else.

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COVID-19 Age: Spirituality and Meaning Making in the Face of Trauma, Grief and Deaths

- Rogelio P. Bayod, Ph.D.

Cor Jesu College, the Philippines

Email: roger.bayod@gmail.com

Abstract

The COVID-19 outbreak is affecting not only the way people live but also the way people die, the way people handle their dead as well as their different "death" experiences. The different governments throughout the world have their own guidelines to follow in terms of management of dead bodies. But these guidelines are mostly focused on protecting the living from being contaminated with the virus. In many cases during emergency situations, dead bodies are no longer considered sacred and treated with utmost respect. On the contrary, they can even be a source of worry and fear for the government and also for some people. However, for the families and loved ones of the deceased, paying their last respect for the dead is an important part of the process of grieving, saying goodbye and accepting the fact that life here on earth is just temporary. This paper argues that in any corpse and "death" management even during emergency situations, a dialogue with culture, spirituality, faith and belief systems of the people as well as insights from psycho-therapists such as Joyce Rupp, Elizabeth Kubler-Ross, Victor Frankl and even the teachings of Jesus Himself, can be an important resource in helping the people cope with the loss of their loved ones and in dealing with their dead members of the family as well as their own "death" experiences during this pandemic.

Keywords: Finding Meaning, Spirituality, Corpse Management, Goodbyes, Grieving, Covid-19.

Introduction

The journey of life is always filled with stories of gains and losses, pains and joys, life and death. In normal

scales, they make our life colorful and beautiful. However, in emergency situations, too much pains and sufferings especially involving losses and deaths may lead a person to emotional despair and trauma. The purpose of this paper is to discuss how COVID-19 pandemic affects not only the way people live but also the way people die - be it physically, emotionally or spiritually, as well as the way they handle these different forms of death.

To be able to do this, first, we will try to explore how the governments (the most powerful actors) in different countries help their constituents in dealing with the psycho-spiritual impact of the Covid-19 especially to those people who have encountered physical death of their loved ones and family members and also their own "death" experiences. How are they coping up with this loss and its underlying emotions? How did the government help them? How are they saying goodbyes to their loved ones and family members during this pandemic situation? What could be the things that keep them to continue choosing "life" instead of "death" during this very challenging time? These are some of the questions that this paper tries to answer.

Lastly, this paper will try to offer a kind of psycho-spiritual insights gained from my personal experiences as a counselor and a spiritual director and also with the works of Joyce Rupp, Elizabeth Kubler-Ross, Victor Frankl and other psycho-spiritual therapists, and even the teachings of Jesus Himself on how to deal with our different experiences of goodbyes and letting go as we journey towards living a new life in the new environment brought about by Covid-19 pandemic.

Living, Death and Goodbyes

In her book, *"Praying our Goodbyes"*, Joyce Rupp reminds her readers that goodbyes are part of our life as the season of the year. She even puts theological or spiritual dimension in the human experiences of good byes. For Rupp, the word goodbye can be interpreted as "God-be-with-ye" or "Go-with God" (Rupp, 1988: 17). By taking God as a significant companion in the journey, Joyce Rupp wants the travelers and even the one sending them for that journey not to fear because even if the journey gets tough, there is hope and consolation in the thought that God is with them always. In other words, goodbye can be a blessing of love and also hope in the belief that since God journeys with you, you will never be alone.

How about those whose loved ones succumbed to death because of accidents and disasters? Did they have the same thinking about death? Were they able to say goodbye to their loved ones and ensure them that God is with them in journey?

While most people ensure that their loved ones will experience "good death" and provide best funeral services to prepare them for their journey to another life and to comfort themselves for the loss of their loved ones, that practice and its accompanying rituals in different cultures have not been followed during emergency situations. For example, during Typhoon Pablo that hit Mindanao in the first week of December 2012, I saw a lot of dead bodies wrapped in plastic bags being put along the roads in New Bataan, Compostela Valley Province (now, Davao de Oro Province). To avoid decomposition, they were buried immediately in mass

graves. The families who were still battling for survival and helping the responders to look for their other family members who are still missing, had no time to prepare a good funeral service for their loved ones. They did not even have the time to mourn for their death. Their immediate concern was to ensure that their other family members are still alive and they have a place to stay as their houses were ravaged by the raging waters and landslides.

This was also the experience of a lot of survivors during the Typhoon Haiyan, locally known as Yolanda that hit the Philippines most particularly, Leyte on November 8, 2013, causing the death of more or less ten thousand people. Sharing his experiences as a head of the Redemptorist Mission Team that responded to Yolanda disaster, Brother Karl Gaspar (2014) narrated how the government treated the dead bodies - they were buried together in different mass graves, other were unidentified and unclaimed. The most dramatic graveyard mentioned by Gaspar is that of Pedro Lacandoz' family whose 22 members of his extended family perished in that deluge (Gaspar, 2014: 44). The survivors of this Mega disaster were not able to provide best funeral service to their loved ones.

This awful event further traumatized the victims of disasters (Gaspar, 2014). There is no "good death" during disaster. In fact, the death that people experienced during disasters such as typhoon, landslides, earthquakes and wars can be considered a violent death. Gaspar (2014) even says that that this kind of death is no less violent than Jesus' death by crucifixion. During the psycho-social interventions what we conducted with the Typhoon Pablo survivors, they shared about their horrible experiences as they witnessed their loved ones struggled to live, asking for help but they could not help them. These heartbreaking stories of the Typhoon Pablo survivors were confirmed by the experiences of Gaspar during Typhoon Yolanda that these stories, are indeed heartbreaking and that even the most highly trained and experienced counselors and psychologists can reach saturation point after hearing one horrific story after another (2014: 46).

In the two scenarios mentioned above, although death was considered violent and the family members did not have the time to mourn for their dead, they were permitted to come closer, kiss and caress their loved ones whenever they were available. While many of them were not able to do these because of the situations, some were able to perform (albeit in such a hurry) the necessary rituals to say their goodbye and prayer to their dead and wish them luck in their next journey. But this is not the case now with Covid-19. In many parts of the world today, a lot of dead persons are cremated and buried without the presence of their family members and loved ones. This caused a lot of emotional distress to the members of the family who were not able to provide care and emotional support before their family members died and also their presence during their death (LaMotte, 2020).

Corpse Management in Different Countries During COVID-19 Pandemic

The Covid-19 pandemic exposes the unpreparedness of many countries (even the advanced ones) not only in

terms of managing the spread of the virus but also in terms of how to deal with the increasing number of deaths. Even those whose business is about managing corpses such as morgues, crematoria, cemeteries and funeral homes have been caught off guard with the situations. While funeral directors and others in the death care industry are changing the way they care for the dead, this pandemic reminds them of the challenges ahead (Kohn & Gould, 2020).

For example, in Italy, people with COVID-19 reportedly “face death alone” as funeral services suspended, and many dead unburied and uncremated, while in Iran, trenches are being excavated for mass burials (Kohn & Gould, 2020). On April 1, 2020, Italy observed a minute of silence to remember their dead due to Covid-19 (Independent Global News, April 1, 2020). In Australia, the latest guidelines advise families not to kiss the deceased but they can touch the body if they wash their hands or use alcohol-based hand sanitizer immediately afterwards (Kohn & Gould, 2020).

All the guidelines on handling the deceased due to Covid-19 crafted by different governments throughout the world are geared towards protecting the living from the possibility of getting infected with the virus. Although different countries have their own cultures and traditions on how to honor their dead, these cultures and traditions have not been followed during emergency situations. This is partly due to what Gaspar (2014) calls as the “age of secularism” that occupies the minds of modern and post-modern people most especially in the highly urban-based Americans and Europeans. This scenario poses lots of challenges among countries that have rich cultural practices, traditions and many rituals in dealing with their dead. For instance, in the Philippines, this challenge is very obvious not only during this Covid-19 pandemic but even during mega disaster such as in Typhoon Yolanda and other disasters that hit the country, causing the death of many people. Two Perspectives in Dealing with Dead Bodies in the Philippines

In the works of Gaspar (2014) among the Yolanda survivors, he found out that there are two layers of perspectives in dealing with the dead bodies. Gaspar said that these two perspectives followed two parallel lines and each with their own way of dealing with the extreme circumstances at hand. On the one hand, there is the perspective from the ordinary folks in terms of honoring the dead in the best way possible as dictated by their cultural traditions and belief system. On the other hand, there is the perspective from modernity which pushes the residue of the indigenous belief system and has made the people very rationale in dealing with their dead (Gaspar, 2014: 67-77).

In the first perspective we can see elaborate rites and rituals such as dances, community gatherings, and others among the different indigenous tribes in the country from North to South in honoring their dead. Although many of these tribes have been converted to Christianity during the Spanish colonization, these rituals are still alive. In fact, when the Spaniards brought the Catholic rituals of dealing with the dead, the Filipinos adopted them because these rituals juxtaposed easily with the legacy of their pre-conquest ancestors (Gaspar, 2014). Thus, today many Filipinos continue to practice their

indigenous cultures and traditions of honoring their dead which interfaced with Catholic liturgical rites and other elaborate rituals. Even in some elite and middle class families in the urban centers, we can observe in many funeral parlors that these rituals persist. Much more in rural areas, we can see that these rituals of honoring the dead are longer and more elaborate.

All these rituals have spiritual dimensions as the community prays for the dead and for the living to be able to have the grace to deal with their grief. Hence, for the Filipinos, the death of family members or loved ones is a community affair and everyone in the community, most especially the members of the immediate family and the relatives, would do everything they could, when given the chance, to provide and go through the different rites and rituals despite horrible circumstances such as disasters and pandemic. Thus, the different guidelines in dealing with dead bodies during this pandemic which prohibit them to come closer to express their emotions of gratitude and to say sorry as they pay their last respects to their dead brought them not only trauma and anger about but also guilt.

In the second perspective, Gaspar (2014) says that capitalism mindset and the secular way of dealing with the dead paved the way for business of corpse management in funeral parlors to thrive. To earn more profits, managers have to be engaged in systematic and strategic planning and management with clear defined objectives that are stretched to their optimum level (Gaspar, 2014; Kohn & Gould, 2020). It is also evident in this perspective that democracy would have the Church and the state separated and focused in their own business. Humanitarian agencies sprouted to make sure rights are respected and human material needs are responded in a global scale (Gaspar, 2014).

But what about the rights of the people to exercise their religious beliefs and rituals in dealing with their dead? Unfortunately, during Covid-19 pandemic, one of the rights violated was the religious rights of the citizens. The modern and post modern period put religion at the sideline as secular institutions asserted their prominence. These secular institutions coopted what was once the domain of religious and faith institutions trying to make the latter insignificant in the lives of people (Gaspar, 2014: 78). However, the values of the modern and postmodern era, while appealing and valid, cannot really provide answers to the deepest longings and yearnings of man. Since man is not only a body but also a spirit as asserted by Gabriel Marcel and some other philosophers and theologians, there is an existential ache or angst that permeates every human spirit. There is always kind of restlessness, anxiety, dread and sense of aloneness that accompany man in his sojourn here on earth towards his eternal destiny (Sartre, 1989; Rupp, 1988).

Dealing with Existential Aches and Moments of Loss during Covid-19 Pandemic

In one of our discussions with my students in my Theology courses we were dealing with the different inadequate images of God that many people embrace in their lives. One of the inadequate images of God that stirred debate among my students is the image that “God is a tester”. While a lot of theologians would assert that “God is a tester” image is inadequate and would even

provide good theological arguments against it, there are still people who cling to this image because this image has helped them in dealing with many adversities in life. In fact, one of my students shared her difficult struggles with her family and how she keeps her sanity by believing that she was like the modern Job who was tested by God during his time but still chose to trust in Him and in the end, all his blessing and fortunes were restored by God (See, The book of Job in the Christian Bible). One student also shared that by believing that God is just testing him through the many difficulties that they have encountered in life made him endure the pains and the trials thinking that at the end of the test, those who perform better will have the reward from God. These are examples of a culture and a belief system that helped the people cope up with the many difficulties they have encountered.

In my works as a counselor and spiritual director, I also encountered a lot of people who got angry with God, questioning his love and even power because of their difficult experiences, mostly involving death of family members and loved ones. While most of them would tell me how sorry they are for having that feeling and notion about God after our conversation, I assured them that their feelings and thinking about God are normal and even the “best” response that they could have given those terrible experiences.

Anger is one of the stages of grieving in Elizabeth Kubler-Ross’ “On Death and Dying”. According to Kubler-Ross (1969), anger is not only a normal feeling after an experience of loss but it is also a necessary stage of the healing process. While anger is a natural and normal feeling for a person who experiences abandonment and being deserted, our society fears and despises anger. Thus, even if it can be a strong anchor to give person temporary stability while he is in the abyss of nothingness and helplessness, it is not always welcome. Hence, most often, anger is being suppressed. Although people do not have to experience the five stages that Kubler-Ross outlined in her book such as Denial, Anger, Bargaining, Depression and Acceptance as these are not hierarchical or linear stages, those who experienced anger have the strength to bind themselves back to reality after being detached from it because of grief (Gregory, 2020).

Normally, their anger is directed towards God, other people and even themselves. Thus, their anger toward somebody may bring them once more to his social reality and connect them to people again. Sometimes, their questioning about God is an indicator of their strong faith in God. I reassured my students and those who come to me for counseling or spiritual direction that their feeling of anger is normal. I even reminded them of the importance of it in the process of healing.

For Joyce Rupp, this existential ache is within us because we are composed of both physical and spiritual dimensions (Rupp, 1988). Since we are not only composed of body but also of spirit, our final home is not here on earth but somewhere beyond this physical reality. Thus no matter how “good” and “comfortable” this earth maybe for us, there is always part of us that is yearning and longing for the true homeland where life is no longer difficult or unfair (Rupp, 1988:24). This

implies the importance of self-awareness to be able to get in touch with our deepest longing and yearning.

But what about those who are not gifted with the capacity for self-introspection? What about those who refuse to journey deep inside and instead choose to ignore and push away these feelings? People cannot endure ignoring their feelings and keep their sanity for longer periods of time. In fact, Rupp theorizes that our loneliness paradoxically connects us with others in their own aloneness (Rupp, 1988). Our awareness of our connectedness with other human beings even in our own moments of aloneness can be a source of deep realization that we have companions in our journey towards completion. This will in turn inspire us to love ourselves with all our imperfections and incompleteness. This is the true essence of our spirituality. According to Kenneth Leech,

“True self love means not trying to escape from ourselves, but listening to the voices within us...this involves the acceptance of our fundamental aloneness, not seeking to reduce it, not hoping that friendship, marriage, community, or group, will take it away. That aloneness is an integral part of being human, and an essential element of love. It is out of that aloneness that it becomes possible to respond rather than merely react to people and needs. Response has to grow and emerge out of the depths of myself: it is my response, born out of my inner struggle and inner self-knowledge, out of my spirit, my deepest core. This is what spirituality is about” (Leech, 1980:44).

The goal of our pilgrimage is simply to keep moving spiritually little by little everyday. In seeing life as a pilgrimage, the vision that is spirituality’s open-endedness recognizes that it is not how far one has come that is significant, but how far one has yet to go (Kurtz & Ketcham, 199: 138). Hence, despite the different aches that we have because of a tragic event that we encountered especially during this pandemic situation, we are challenged to go on even if the going may get rougher and rougher along the way.

Life is still uncertain. Even if lockdown and Enhanced Community Quarantine will be lifted, we cannot go back to what we have been used to before this pandemic. In fact, for those who had lost their family members, loved ones and friends because of the novel corona virus, their lives will never be as “normal” as before. We are confronted again and again with the truth that our world and our life is fragile. Frederick Buechner says, there is no doubt that the world is fragile and the return of chaos is a perpetual possibility (Buechner, 2003). Where do we go from here?

I think it is important that we will now fix our gaze on our God who also suffers but deeply cares for all of us. This is not saying that we will not do our part. Of course, we still need to look for solutions (vaccine and others) for this pandemic. We still need to work so hard to restore our economy. We will continue to enhance our knowledge in science and technology, development theories and economics. But let us not forget to also focus our attention to the God who cares.

When we experience lots of losses and goodbyes, we come face to face with the reality of suffering and pain. But we also come face to face with a God who suffers pains and hurts with us (Rupp, 1988). This suffering God

is personalized in the person of Jesus Christ who suffered a horrible death on the cross to show to the world how to live in love in the midst of pains, sufferings, betrayals and even hatreds. God allowed His Son, Jesus Christ to have a “full participation in the human condition just as all of us have to enter fully into it” (Rupp, 1988:39). But God does not orchestrate pains and sufferings in the world. He just allows sufferings to happen in order for us to experience the fullness of our humanity. As Kushner puts it succinctly, God allows suffering to happen because to block it would mean blocking also the growth of our human nature (Kushner, 1981).

As a caring God, He promised to be with us, to comfort us, to sustain us and to keep us from being shattered by our trauma, fear, guilt, sufferings and difficulties brought about by this pandemic (See, Is. 43: 1-5; 2 Cor 4: 7-18; Rom 8:35-39). God’s compassion and care is shown in His being a good shepherd to His flock (See, Is. 40:11). According to Joyce Rupp, God’s love is such a powerful companion for us that no matter how searing or how intense the hurt of our losses, He will help us to recover our hope, our courage and our direction in life (Rupp, 1988: 41). Believing in this beautiful promise of God, we will be more discerning to the will of God in our lives during and after this pandemic. Instead of declaring anything or everything to be the will of God, we are invited to be more willing to ask ourselves where in the midst of our pains and sufferings we can discern the loving presence of God (McNeill, Morrison, & Nouwen, 1982: 40).

Aside from understanding and believing that God is always with us in our moments of pains and sufferings especially during this pandemic, it is also important to get in touch with our own philosophies of life. Joyce Rupp calls these as our “one-liners” or the beliefs and sayings that we have which sum up our vision and philosophy of life (Rupp, 1988). Some examples of these common sayings and philosophies are: “Nothing is permanent including pains and sufferings”, “This, too, shall pass”, “God is above all these”, “God will provide”, “If it’s not yet our time, it won’t come to us”, “Life is beautiful”, “We are blessed and we can be a blessing too”, “There is beauty in the mess”, common among many Filipinos is “laban lang” (just continue the fight) and there are lots out there. You discover them when you talk to many people in your community especially those who experienced a lot in life.

These “one-liners” helped them cope up with their trauma, pains and sufferings. In my experience of journeying with people, I discovered that they have plenty of inner strengths to endure life’s trials and tribulations. These inner strengths gave them the many “whys” to go on living. These many “whys” to live are what Victor Frankl calls in his “Man’s Search for Meaning”, as the people’s constant search for life’s meaning and purpose especially in moments of pains and sufferings (Frankl, 1977). According to Victor Frankl,

“When a man finds that it is his destiny to suffer, he will have to accept that suffering as his task; the single unique task. He will have to acknowledge the fact that even in suffering he is unique and alone in the universe. No one can relieve him of the suffering or suffer in his

place. His unique opportunity lies in the way in which he bears his burden” (Frankl, 1977: 123-124).

Victor Frankl’s persistent search for meaning helped him to survive the difficult moments that he experienced in life being a prisoner in a concentration camp during World War II. Instead of succumbing to pain and depression, he searched for life’s meaning and purpose through his suffering. Not only was he able to survive the trials, he even developed a deeper understanding of the human spirit and was able to develop his philosophy, write a book about it which is still very much useful until today. For Frankl, this will to meaning is man’s vocation that must be fulfilled by him alone (Frankl, 1977). This will to meaning defies all dangers and all the despair that we face in life (Maboloc, 2012:119). This means that man if man has will to meaning, he has to rise above his pains, sufferings and circumstances. As counselors, we used his logotherapy (meaning making) to guide our clients find meaning in all their experiences and circumstances. This means that the person must hold on to his purpose in life since living a life without purpose is not living a truly human life (Maboloc, 2012). Thus, despite pains, sufferings and difficulties, man should continue to search for meaning and his purpose for living. Indeed, suffering and pains are part of man’s existence.

According to Joyce Rupp, sufferings and the “painful feelings that accompany our experiences of loss are on all levels of our being – physical, emotional, mental or spiritual” (Rupp, 1988: 33). We can expect to feel sad, shock, angry or guilty of something we have not done or not said. We might even have resentment and self-pity. We might lost our enthusiasm and energy to do our tasks. Indeed, it is hard to go on believing in a God who cares when something or someone that we hold so dearly is being taken away from us. Hence, we are also invited to learn from the examples of Jesus who embraced his suffering. It is what we do with our suffering and pains that matters. Jesus invites those who suffer to think of their suffering as a source of spiritual growth and blessing. In his teaching, Jesus says,

“I tell you solemnly, unless a grain of wheat falls into the ground and dies, it will remain a grain, but if it dies, it will bear much fruit.” (Jn. 12:24)

“Blessed are they who mourn for they will be comforted. Blessed are the meek for they inherit the land.” (Mt. 5:4-5)

Indeed, there is value in suffering, pain and grief. They remind us of our incompleteness but they can also lead us to discover our vast reservoirs of resiliency, vitality and endurance (Rupp, 1988:57). Suffering or pain can be a refining of purifying element. Suffering, pain and grief may refine not only our body but also our spirit. Taken into its proper context and purpose, suffering can bring us to new life.

In the first letter of James in the Christian Bible, it talks about the value of sufferings, trials and tribulations. “Consider it all joy, my brothers, when you encounter various trials for you know that the testing of your faith produces perseverance. And let perseverance be perfect, so that you may be perfect and complete, lacking in nothing. But if any of you lacks wisdom, he should ask God who gives all generously and ungrudgingly, and he will be given. But he should ask in faith, not doubting, for

the one who doubts is like a wave of the sea that is driven and tossed about by the wind." (James 1:2-7).

When our suffering transforms us positively we can be a source of positive transformation to others. We are can be like the bread that is broken, yet blessed and ready to be distributed to those in need. We are challenged to embrace an attitude of faithful surrender during time of losses and goodbyes especially in these moments of crisis brought about by Covid-19 pandemic. We are reminded to always have hope that what we suffer in this life (goodbyes, losses, pains, trauma and grief) cannot be compared to the eternal glory (hello) that awaits us. (See, Rom 1: 8-18).

Conclusion

In this difficult moment of our lives due to Covid-19 pandemic, our choices matter a lot. These will shape our lives not only in the present scenario but also in the future. We have a choice either to wallow in pain, grief and depression or we choose to go on living and loving despite hardships, loss and uncertainties in the future. We will probably experience many losses (life, properties, jobs, health, etc) but if we still have purpose and meaning in our lives, we will continue to face the many forms of deaths that this pandemic has brought and might still bring into our lives. Our culture, spirituality, philosophy, faith and belief systems have many things to offer to us to help us face and embrace different kinds of deaths. We can also learn from the different insights of philosophers, theologians, psychotherapists on how to manage trauma and grief. The teachings and examples of Jesus Christ who experienced lots of goodbyes and sufferings and how he faced all of them can also be an important source of inspiration for us in dealing our own experiences of pains, sufferings and goodbyes.

It is then important for the government and those working for the victims of this pandemic to dialogue with the culture, philosophy, faith and belief systems of the local people especially during moments of deaths and management of dead bodies because this will help them to say goodbye to their loss and to strengthen them in their journey with its own experiences of goodbyes and to prepare them to say hello to a "new life" after this pandemic.

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Nursing in Pakistan: issues and challenges

-Sumaira Khowaja-Punjwani, PhD (USA), CPB (USA), MBeth (Pak) & BScN (Pak)

Founding Principal & Associate Professor, Saifee Burhani School of Nursing, Saifee Hospital Trust, ST-1, Block F, North Nazimabad, Karachi-74700, Pakistan; Visiting Professor of Bioethics & Nursing, American Univ. Sovereign Nations, USA
Email: sumaira.khowaja@yahoo.com,
skpunjwani@sbson.edu.pk

Abstract

Nursing staff are considered as the backbone of contemporary, high quality healthcare systems around the globe, where standards of health care performance and provision are determined by the knowledge and skills of nurses.

This paper evolved out of a PhD Dissertation titled "Past, Present and Future Trends of Nursing Workforce Migration: Analysis and Policy Implications". This article provides an overview about nursing in healthcare delivery system of Pakistan and talks about Nursing in Pakistan. This article illustrates history of nursing in Pakistan, regulation of nursing in Pakistan including details regarding national regulatory bodies, provincial regulatory bodies and role of nursing federations and unions. It also discusses in detail nursing education system in Pakistan, status and image of nursing in Pakistan, the importance of nursing workforce in healthcare, nurse employment in healthcare hierarchy in Pakistan including power as nurse in current system and working conditions of nurses in Pakistan, shortage of nursing in Pakistan as a reason of demand and supply gap and migration of Pakistani educated nurses to foreign countries highlighting reasons for nurse migration.

History of nursing in Pakistan

The history of nursing in Pakistan is deep-rooted in the pre-partition period starting from 1931 to 1941. There is hardly any document that provides a comprehensive picture of History of Nursing in Pakistan except a master's thesis dissertation which was written by Ms. Hafiza Hemani in 1996. As per Hemani (1996), in 1860 Florence Nightingale established school of nursing in

London in association with St. Thomas's Hospital which offered first formal educational program to prepare students as nurses. In the same year an initiative was taken by Government of the Indian subcontinent for training of midwives.

Nursing in Indo-Pak region originated in 1884, when Anglo-Indian sisters came to India and promoted the profession of nursing. Also, the first school of nursing was opened at Mayo Hospital Lahore where mostly nurses were coming from England to work, because Muslim and Hindu girls were not joining nursing due to their cultural values. Even the ones who were joining the profession belonged to low socio-economic background and were converting from Hinduism to Christian. Mostly, schools were attached to Mission Hospitals and all the Matrons/ Nursing Superintendents were Anglo Nurses. In 1871, another school was opened in Northern India. From 1907 to 1941, great number of Nursing Superintendents were hired from Europe in India who developed rules, standards and curriculum outline for the first time for Indo-Pak Missionary Hospitals and also opened nursing schools in all provinces of India and Pakistan. Those rules, standards and curriculum were later adopted by civil hospitals.

In 1947 after partition, British nurses and non-Muslim nurses left Pakistan and there was a huge gap in nursing services as insignificant number of nurses were available to care for refugees wounded in riots. At that time, eminent political female leaders of West-Pakistan Ms. Fatima Jinnah and Rana Begum Liaquat Ali Khan who was a midwife called out women to come out of their homes to serve the refugees in camps. Those women's were working under supervision of few trained nurses available. Initially, 2 weeks training program was designed to prepare Nursing Assistants and entry into this program was after 8th grade. In 1948, two nursing schools were opened i.e. Ganga Ram Hospital in Lahore and Jinnah Postgraduate Medical College (JPMC) Karachi followed by development of nursing schools in Bahawalpur, Hyderabad, Multan, Lady Reading Hospital Peshawar, Civil Hospital Karachi and Mayo Clinic Lahore.

In 1949, the Central Council of Nursing (CCN) for Pakistan was established comprising 33 members including 9 nurses, 3 midwives and LHV and doctors and educators. The goal of CCN was to establish uniform standards for training and certificate throughout country. In 1950, CCN passed the rule to have two grades of nurses' i.e. General Nurse; training of 3 years and 3 months and Nursing Assistant. Girls with minimum 17 years of age were deemed admissible for nursing and preference was given to unmarried, widowed, divorced or childless women. For Females, Grade 8 education and ability to read and write English was the pre-requisite for admission as General Nurse and for Nursing Assistant ability to read and write Urdu was the only requisite. For Male, matriculation was must for entry into General Nursing however, they were not allowed to have enrollment in Nursing Assistant program. There were no fixed dates for admission rather intake was done round the year in order to minimize shortage of nurses and there were no separate classes for first, second and third year students respectively.

In 1952, the Pakistan Nursing Council (PNC) was established and admissions were opened biannually i.e.

April and November and Matric was must for females instead of grade 8 for General Nursing whereas, grade 8 was must for admission in to midwifery program instead of ability to read and write Urdu. These developments were later followed by establishment of examination boards and addition of courses in curriculum in 1973. It was made mandatory for a nursing institute to obtain recognition from PNC and follow prescribed curriculum and standards set by PNC. In 1973, National Assembly of Pakistan passed act to formulate Provincial Nursing Examination Board under Pakistan Nursing Council Act No. XXVI of 1973 after which four Provincial Nursing Examination Board were formulated i.e. Punjab Nurses Examination Board (PNEB), Khyber Pakhtunkhwa Nurses Examination Board (KPKNEB), Sindh Nurses Examination Board (SNEB) and Baluchistan Nurses Examination Board (BNEB) for the province of Punjab, Khyber Pakhtunkhwa, Sindh and Baluchistan respectively (Pakistan Nursing Council, n.d.; Sindh Nurses Examination Board, 2017). In 1988, 2 year Post Registered Nurse Bachelors of Science in Nursing (Post RN BScN) Program was introduced for nurses who had obtained Diploma in General Nursing and wanted to opt for degree program in Nursing. In 1997, four year Bachelors of Science in Nursing (BScN) degree program was initiated in which the pre-requisite for admission is Intermediate. In 2001, 2 year Masters of Science in Nursing (MScN) program was started and just recently i.e. in 2014, PhD in Nursing program has been commenced in Pakistan (The Aga Khan University, 2017).

Regulation of nursing in Pakistan

National regulatory bodies: Pakistan Nursing Council (PNC) is an autonomous regulatory body constituted under the Pakistan Nursing Council Act 1952 & 1973. PNC is the national regulatory body that is empowered to register and license nurses, midwives, lady health visitors and nursing auxiliaries; sets the curriculum for nurses; provides approval to nursing education institutions and programs; and works closely with four provincial nursing examination boards. PNC was established in 1948 (Pakistan Nursing Council, n.d.).

Provincial regulatory bodies: Under the umbrella of Pakistan Nursing Council (PNC), four Nursing Examination Board are working i.e. Punjab Nurses Examination Board (PNEB), Khyber Pakhtunkhwa Nurses Examination Board (KPKNEB), Sindh Nurses Examination Board (SNEB) and Baluchistan Nurses Examination Board (BNEB) for the province of Punjab, Khyber Pakhtunkhwa, Sindh and Baluchistan respectively (Pakistan Nursing Council, n.d.). The role of these examination boards is to conduct examinations and declare results for all categories of diploma program Nurses/Midwives/LHVs and organize workshops for examiners/teachers of nursing schools to update system of examination under the guidance of Pakistan Nursing Council and its reporting in the Pakistan Nursing Council meeting (Sindh Nurses Examination Board, 2017).

Role of nursing federations and unions: Competing unions focus on collective bargaining as they can exert significant influence in negotiation of working conditions, development of private nursing schools and

degree programs, and development of the profession (Aluwihare-Samaranayake, 2017). There are numerous Nursing Federations and Unions currently operating in Pakistan including, Pakistan Nursing Federation (PNF) which is an independent non-governmental professional association of nursing in Pakistan which was registered in 1972, Young Nurses Associations with respective provincial young nurses association like Sindh Young Nurses Association (SYNA) and etc.

Nursing education system in Pakistan: In Pakistan, Nursing education system can be categorized in to three cadres, i.e. general nursing, midwifery and public health nursing. Since the beginning of Nursing profession in Pakistan till today the predominant mode of nursing education in public as well as private sector is Diploma in General Nursing (RN) program which comprise three years of education after matriculation (Gul, 2008). However, as per the directives of Pakistan Nursing Council (PNC) and Higher Education Commission of Pakistan (HEC), in 2019 the transition from Diploma in General Nursing program to four years Bachelors of Science in Nursing (Generic BScN) program is in progress and many colleges are now phasing off RN program and instead are offering Generic BScN program in which the pre-requisite for entry is intermediate (FSc) premedical. Diploma in Midwifery was initially one year of training program after matriculation; however, currently three programs in Midwifery are offered i.e. 15 months Diploma in Pupil Midwifery and 18 months Diploma in Community Midwifery in which pre-requisite for admission is matriculation, and 1 year Diploma in Nurse Midwifery which is offered to candidates who have completed 3 years Diploma in General Nursing (RN). Few schools are planning to introduce 4 years Bachelors of Science in Midwifery (BScM) program in which a candidate can get enrollment after completion of intermediate. Public Health Nursing cadre includes 16 months Lady Health Visitor (LHV) program. For post-basic nursing education, 1 year specialization programs in almost 22 practice strands, 2 year Post Registered Nurse Bachelor of Science in Nursing (Post RN BScN) and two year Post Registered Nurse Bachelor of Science in Midwifery (Post RN BScM) program for which the pre-requisite is Diploma in General Nursing (RN) and Diploma in Midwifery (RM) with two years of clinical experience are being offered. Post RN BScN and Post RN BScM are equivalent to 16 years of education as per HEC. For post graduate education in Nursing, 2 year Masters of Science in Nursing (MScN) program is offered by few universities whereas, PhD program in Nursing has been recently started by one university only.

Nursing schools are usually working under the authority of hospital administration and some nursing schools have separate principal for the school with reporting relationship to hospital administrator who usually is a doctor by profession (Gul, 2008). Although, Pakistan Nursing Council (PNC) has repeatedly released notifications that only nursing professionals can head the school with most recent notification being issued in 2017 nevertheless, to date many schools are unable to fulfill this very essential requirement.

Referring to apprenticeship system of training, students gain experience by working in hospital clinical

settings, though many times unsupervised by qualified faculty and staff due to their scarcity; therefore, it is not unusual to find nursing students working independently without supervision especially during evening and night shift (Gul, 2008).

Curriculum is fundamental to nursing education for patient safety, cultural competence and evidenced based practice by use of technology and informatics, inter professional education, application of new pedagogies, critical thinking and simulation. The national curriculum for RM, RN and LHV program exists and is implemented widely. The national curriculum for BScN program was set by Higher Education Commission (HEC) with the cooperation of Pakistan Nursing Council (PNC) in 2006 for the first time which has later been revised in 2011 which includes all the essential elements and trends of modern education (Khan, Ghani, & Badsha, 2015). PNC is working for the development of a uniform Masters of Science in Nursing curriculum and revision of Post RN BScN curriculum. Nursing examination for diploma programs are conducted by respective provincial nursing examination boards whereas, medical universities conduct examinations for degree programs.

Status and image of nursing in Pakistan

Image is defined as the “character of a thing or person as perceived by public” and Kalisch and Kalisch as cited by Gul (2008) defined nursing image as “the sum of beliefs, ideas, and impressions that people have of nurses and nursing”. The image and status of nursing is a global problem that nurses face and literature suggests several reasons that has contributed in shaping poor image of nursing which includes; role of nurse is not clearly understood by general public, lack of recognition from other health professionals, low wages, compromised working conditions, unsafe work environment, and negative portrayal of nurses in media for instance as handmaidens to physicians, or sex objects (Gul, 2008). Several studies has been done to explore status and image of nursing in Pakistan and many studies has concluded that the image of nursing in Pakistan is generally poor since its inception and over the period of time this has remained unchanged. This poor image of nursing gives a setback for nursing to advance professionally and is also one of the contributing factor for shortage of nurses as the new generation does not choose the profession as priority (Gulzar, et al., 2016).

Importance of nursing workforce in healthcare

Nursing staff are considered as the backbone of contemporary, high quality healthcare systems around the globe, where standards of health care performance and provision are determined by the knowledge and skills of nurses. In today’s world, the role of nurses is not only confined to clinical care in hospital settings, rather their role has been extended to advanced practice arenas as they act as counselors, provides risk-manage challenging behaviors and promote healthy and safe living in community (Muhammad, 2015). Moreover, nurses with advance qualifications work as senior executives in hospitals, long term care facilities, community health centers, home care agencies, nursing colleges and professional associations (Bernard, 2014). Their role in administrative position includes managing

large number of staff and multi-million dollar budgets, establishing standards for care by developing Standard Operating Procedures and Policies (SOPs) at clinical and/or public health level. 'There is no denying in the fact that nurses play a major role in delivering health care services. Their round-the-clock presence, observation skills and vigilance allows doctors to make better diagnoses and propose better treatments. They provide care and assist in cure, participate in rehabilitation of the patients, and provide support to the healthcare providers' (Khan, Ghani, & Badsha, 2015) which no other healthcare professional can.

Literature has suggested improved patient outcomes and decrease morbidity and mortality where nurse to patient ratio is higher (Aiken, Sloane, Lake, Sochalski, & Weber, 1999; Aiken, Clarke, & Sloane, Hospital staffing, organization, and quality of care: Cross-national findings, 2002; Zhu, et al., 2012). In addition, adequate nurse patient ratio have positive impact on staff retention, increased job satisfaction and reduced staff burnout (Aiken, Sloane, Lake, Sochalski, & Weber, 1999). On the contrary, inadequate nurse patient ratio results in loss of important aspects of care and negative patient outcomes (Zhu, et al., 2012).

Nurse employment in healthcare hierarchy in Pakistan

Healthcare hierarchy

Likewise nursing education, nurse employment in healthcare hierarchy in Pakistan comprise of three cadre nursing professionals that are regulated by the Pakistan Nursing Council (PNC) as Registered Nurses (RNs), Registered Midwives (RMs) and Lady Health Visitors (LHVs). RNs mainly work in hospital settings, whereas LHVs and midwives have predominant role in community setting for maternal and child care. In general, midwives and LHVs are paid less than nurses however, they can have their private practice and can earn more money than nurses. As they are more autonomous in their practice therefore are well respected like doctors. Nurses having post-graduation qualification can work in administrative and teaching capacity in hospitals and nursing schools (Gul, 2008). Although, bedside nurses salaries are better than nurses working at academic positions yet bedside nursing is considered less attractive due to challenging work conditions.

Because the health system of Pakistan includes both the public and private sector therefore, nurses have employment opportunities in both sectors. In government hospitals, there is lack of appropriate service structure because of which a nurse employed on the 'Basic Pay Scale (BPS)' has to continue on the same grade for their entire tenure (Muhammad, 2015). Additionally, nurses encounters low wages and high workload, and lack of system for protection of nurses' right. However, the advantage of working in public sector hospitals include long-term employment benefit as there is less chance of the job being terminated. Private sector organizations pay better salaries and benefits to nurses though, mostly nurses are hired on contractual positions therefore job security is a great concern.

Power as nurse in current system

Nurses in Pakistan tend to be relatively powerless, perhaps because of social position, knowledge deficits, attitudinal beliefs and perceived burden of work (Gulzar, et al., 2016). Poor management and infrastructure, low wages, lack of recognition of the value of nursing as profession, scarce resources in education as well as clinical settings, medical dominance and limited opportunity for career progression and involvement in strategic planning for health development act as contributing factors for powerlessness and oppression amongst nurses working in Pakistan which is main reason that nurses perceive nursing as a job rather than a profession (Lee & Saeed, 2001).

Empowerment to nurses is essential if the status of nurses working in Pakistan needs raise as powerlessness leads to job dissatisfaction, burnout and depersonalization and contributes to poor patient outcomes (Gulzar, et al., 2016). Pakistan has a long history of severe leadership crises in nursing profession because of which nurses in Pakistan are rarely prepared to take on the role of decision-maker, risk-taker, teacher, or change-agent (Lee & Saeed, 2001).

Working conditions of nurses in Pakistan

Pakistan is one of the very few countries in the world that has an inverse ratio of nurses to doctors at 1:2 (Pakistan Bureau of Statistics, 2017), which greatly affects the role of nurse in healthcare settings. Due to severe shortage and medical dominance the role of nurses' remains very limited and many ordinary nursing tasks, such as monitoring vital signs and dressing wounds are performed by doctors, whereas, nurses are primarily responsible for medication administration, carrying out doctors' orders and clerical functions (Gul, 2008). For instance, arrangement of linen or soap and water, trouble shooting for patient complaints related to housekeeping or maintenance. The current working conditions of nursing workforce in Pakistan are challenging which is one of the major factor contributing to anxiety and depression amongst nurses due to low levels of job satisfaction (Khowaja et al., 2005). Bahalkani et al. (2011) conducted a study at one tertiary care hospital in Islamabad and found 86% of Pakistani nurses were not satisfied, and 26% were highly dissatisfied, with their working lives. Poor working environment, low salaries with no or poor fringe benefits, dignity, lack of training opportunities, inadequate supervision, responsibility given at workplace and time pressure were the major reasons of dissatisfaction (Bahalkani, et al., 2011). It is therefore, important to critically explore the context of living and working conditions for nurses in Pakistan.

Shortage of nursing in Pakistan

Poor management and planning: In Pakistan, government has paid little attention for development of a strategy for nursing workforce planning and management. This has resulted in a very low nurse to patient ratio. In this context, migration of Pakistani educated nurses to foreign countries has negative effect on an already weak healthcare system.

Table 1: PNC Recognized Institutes Summary					
Program	Province with sanctioned seats				Total with respect to program
	Punjab	Sindh	KPK	Balochistan	
Entry Program					
RN	58 (5237)	58 (3083)	14 (1355)	8 (275)	138 (9950)
RM	60 (1811)	29 (1070)	12 (255)	5 (60)	106 (3196)
CMW	50 (1734)	47 (1443)	15 (706)	17 (533)	129 (4416)
PM	20 (320)	11 (230)	-	-	31 (550)
LHV	14 (1291)	6 (245)	9 (365)	6 (185)	35 (2086)
LPN	12 (355)	4 (105)	2 (45)	-	18 (505)
FWW	3 (95)	2 (50)	2 (65)	1 (30)	8 (240)
Generic BScN	15 (535)	12 (605)	6 (210)	2 (45)	35 (1395)
Total with respect to province and sanctioned seats	232 (11378)	169 (6831)	60 (3001)	39 (1128)	500 (22338)
Advance Program					
Post Basic Specialty Courses	13	24	01	01	39
Post RN BScN	15 (500)	24 (1005)	6 (180)	1 (25)	46 (1710)
Fast Track BScN	3 (100)	1 (50)	1 (30)	-	5 (180)
MScN	1 (8)	3 (70)	-	-	4 (78)
Total with respect to province and sanctioned seats	32 (608)	52 (1125)	8 (210)	2 (25)	94 (1968)

Subsequently, the decision of Pakistani nurses to work abroad constitutes a 'double edged sword', where personal development abroad conflicts with the collective development of healthcare in home country (Gul, 2008). Numerous factors seems to contribute to regional and national shortage of nurses, such as decreasing trend amongst people to enter in nursing programs, demand and supply gap of nurses as comparative to market need, and internal and external migration of nurses from disadvantaged areas within countries or from low and middle income countries to high income countries (Aluwihare-Samaranayake, 2017).

The actual number of nurses in Pakistan is unknown and the estimated numbers usually differs from reality (Gul, 2008) as many nurses who are working in Pakistan are not registered with Pakistan Nursing Council. As per Pakistan Bureau of Statistics, Government of Pakistan in 2017 there are 103,777 Registered Nurses, 38,060 Registered Midwives and 18,400 Registered Lady Health Visitors (Pakistan Bureau of Statistics, 2017). As per Express Tribune 2018, a meeting was held in at the Ministry of National Health Services Regulations and Coordination (NHSRC) in which NHSRC Federal Minister Aamir Mehmood Kiyani informed only 5,000 of said

nurses hold Bachelor's degree in Nursing, 190 Master's degree and only 9 PhDs in Nursing.

Demand and supply gap

The total number of nursing institutes recognized by PNC for nursing entry level programs including, RN, RM, CMW, PM, LHV, LPN, FWW and Generic BScN are 500 with capacity to accommodate 22,338 nursing students and 94 institutes offer advance level program including 1 year post basic specialty diploma courses, Post RN BScN Program, Fast Track Post RN BScN Program and MScN program with sanctioned seats around 1,968 (Refer Table 1: PNC recognized Institutes Summary) (PNC, 2018). Whereas, as per Ministry of National Health Services Regulation and Coordination report for Human Resources for Health Vision 2018 – 30 published on April 2018 mentions that total number of approved nursing and midwifery institutions in the country are 215 by the end of 2017, out of which 145 are public sector institutes including Armed Forces institutes and 70 are private sector including missionary schools which altogether produce around 9,728 nurses annually as of 2017 (Pakistan Ministry of National Services: Regulations & Coordination, 2018).

Considering the population of Pakistan as per Pakistan Bureau of Statistics 2018, there is 93.41% of shortfall of nurses and referring to statistics provided in table 06 PNC recognized nursing institutes has capacity to produce only 22,338 nurses annually and currently is producing 9,728 nurses annually therefore, it can be concluded that there is huge gap between demand and supply of nurses which is one of the significant factor of shortage of nurses in Pakistan. Additionally, in 2019 PNC issued a notification as per the directives of HEC in which admission in Diploma in General Nursing (RN) program has been closed and now institutes need to develop capacity for Generic BScN program instead of RN which means that with the closure of RN program the gap is going to be more wide because out of 22,338 nurses, 44.5 % (9,950) opt for a RN program for entry in to nursing profession. Although, the initiative to stop RN program is worthy for future however, it would have been appropriate if the measures would have been taken to develop capacity amongst recognized nursing schools offering RN program to upgrade themselves for Generic BScN for smooth transition without inhibiting the number of nurses that these institutes prepare annually to maintain the trained workforce misbalance as far as the demand and supply of nurses is concerned.

Migration of Pakistani educated nurses to foreign countries: Migration of Pakistani educated nurses to foreign countries has been taking place since decades therefore, it is an established phenomenon. Advertisements regarding job vacancies in Saudi Arabia, Bahrain, Oman, Abu-Dhabi, Kuwait, United Kingdom and other countries appears in newspaper on weekly basis. There is no absolute data available which depicts the number of Pakistani educated nurses that migrate annually however, it is estimated that approximately 15% of nurses from the developing countries including Pakistan are moving to developed countries every year (Muhammad, 2015). Developing countries like Pakistan is the main victim of loss of trained health professionals because of increase in globalization which has resulted in severe shortage of nurses due to internal migration from rural to urban areas, and external migration from developing to developed countries. Significant loss of healthcare human resource due to increase migration trend has compromised the capacity of health systems to deliver care in areas where it is required the most (Muhammad, 2015)

Reasons for nurse migration: The causes of migration are numerous and multifaceted, and often are influenced by both sender and recipient country. As mentioned by Kingma (2007) most frequent causes of nurses migration are wage differences, political unrest, working conditions, lack of opportunities, possibility for professional development, active recruitment, better quality of life and personal safety (Nilsen, 2012). One of the significant factor that qualifies nurses to migrate from Pakistan to abroad is their image and status as nurses in society (Hussain & Afzal, 2015). The prodigious demand for nurses in most developed countries makes the migration process more efficient as thousands of nurses migrate each year to obtain labour abroad. Additionally, lack of incentives and information about

opportunities at home, non-probability of pensions hinders nurses to return to their country of origin. On the contrary, major reasons of nurses to stay and work in their home country are often based on commitment and moral, culture, linguistics and good governance (Nilsen, 2012).

Conclusion

Nursing in Pakistan is in its infancy and does not yet have the status of a mainstream profession. The public image of nursing is poor and the profession faces challenges on many facades. In Nursing, the ineffective educational system, stumpy wages and migration of healthcare workers to developed countries is tallying the workforce deficiency. Nurses struggle for their voices to hear and to achieve professional status. Lack of political and professional power, strategic planning, and human resource development and monitoring in the health sector have led to inadequate nurse recruitment and retention, varied educational preparation, and deficiencies in licensure of the nurse workforce. However, to meet health demands of the growing population, Pakistan needs to, both, train and retain more nurses for future workforce planning.

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on humanizing development and focusing on the actual freedom of the person as the main criteria for development, Sen's capability approach will be utilized as the moral framework in assessing the government's response measures to fight against COVID-19 pandemic. The global pandemic poses an immediate threat to both the poorest of the poor communities and to the health care sectors of society. Consequently, any response measure that the government should take must be directed towards sustaining both the socio-economic and healthcare objectives. It must help in enabling poor communities to sustain themselves during the entire pandemic; more so, it must likewise capacitate and strengthen the healthcare system in order to provide better services to the infected and to protect its healthcare front-liners. The crucial question of equality of capability among the poor and the front-liners will be examined by the paper using the capability approach theory in the context of the global pandemic.

What is equality of capability theory about?

Over the past decades the capability approach received substantial attention in the field of normative economics and political philosophy. Its remarkable contribution in the reconfiguration of developmental studies is expressed in its being the central paradigm for evaluating developmental projects in the Human development Report series (HDR) and in the United Nations Development Program. The capability approach was also influential in the World Bank's crafting of developmental policies during the Wolfensohn era. The 1990 Human Development Report emphatically asserts that, "Human development is a process of enlarging people's choices" (UNDP: Human Development Report, 1990). What this implies is that evaluating human development should be based on the actual capacity of the individual to choose from among life's best alternatives, and that any constraint that limits the person from choosing freely what she deemed as reasonable states of beings and doings is a latent manifestation of injustice and deprivation. Sen simplifies the point by asserting that "Development, in this view, is the process of expanding human freedoms, and the assessment of development has to be informed by this consideration" (Sen, 199:36). Des Gasper explains that The Human Development Report's reformulation of the 1970's development perspective of the United Nations Development Program (UNDP) from pure economic growth of development to expansion of human freedom suggests that human development, as well-being, is more than just building human capital to support the economic growth (Des Gasper, 2002). Sen argues that peoples are not just means for economic development but are likewise the necessary ends of development (Anand and Sen, 2000). "Economic growth must be seen as a means towards human development rather than human development as being for economic growth (Des Gasper, 2002: 442)." Although there is a necessary interrelation between the human capital and economic structure of development, nonetheless, such interrelation is aimed at humanizing development. The "human" in development is the object of every developmental project.

Empowering the poor and the front-liners; equality of capability in the time of COVID-19 pandemic

-Gerry Arambala

La Salle University-Ozamiz, the Philippines
Email: gerryarambala33@yahoo.com

Abstract

The advent of the equality of capability theory, as developed by Amartya Sen, has brought about the radicalization of the conventional theories of social justice and development. Sen's remarkable contribution in the field of developmental theories has paved the way for the reconfiguration and development of normative economics and political philosophy. With his insistence

Ingrid Robeyns in the paper “An Unworkable Idea or a Promising Alternative? Sen’s Capability Approach Re-examined” explained in full length the nature of Sen’s capability approach under three headings: “1. As a framework of thought; 2. As a critique on other approaches to welfare evaluation; 3. As a formula to make interpersonal comparisons of welfare (Robeyns, 2000: 3).” She argued that in order to better understand the direction and the structure of the capability approach it is imperative that it should be examined under the three aforementioned levels where it is operating. Equality of capability theory, in this regard, is conceived as a framework of thought that is directed towards assessing and evaluating social issues such as, poverty, social injustices, inequality, human well-being, freedom, liberty, gender biases and social ethics. It provides for a normative perspective that can be applied for efficiency evaluation of alternative approaches and consequently rejects those it considers normatively insufficient and inadequate (Robeyns, 2000: 4). The conceptual foundations of the capability approach is grounded in Sen’s critique to welfare economics, which conflates ideas of well-being with utility (utilitarianism), income with development (welfarism) and Rawls’s equal distribution of the primary social goods as justice and development. For Sen, all the aforementioned alternative approaches to development and justice are inefficient to account for the actual development and deprivation of persons. This is so because sheer acquisition and consumption of goods cannot translate to actual development owing to the realities of interpersonal differences. The capability approach argues that the proper space for evaluating individual development is the space of positive freedom “seen in the form of individual capabilities to do things that a person has reason to value (Sen, 1999: 56).” What this means is that for Sen, development should be conceived “in terms of the expansion of substantive human freedom (Drezel and Sen, 2002: 3).” This, however, does not mean that Sen is rejecting the necessary importance of opulence in the development of the individual; in fact he acknowledges that “Being “well-off” may help, other things given, to have “well-being”, but further adds that, “there is a personal quality in the latter absent in the former (Sen, 1984: 195).”

More so, for Sen commodities and social resources serve only as means for development and not as ends. What matters therefore, is that the individual is capacitated to project for the kinds of functioning (states of beings and doings) she finds reasonable to be or do. Being well-off is limited only to the “person’s command over things outside -including what Rawls calls “primary goods”. Having “well-being,” on the other hand, is not something outside her that she commands, but something in her that she achieves (Sen, 1984: 195).” For a poor ambulant vendor who is a father of 4 children and whose subsistence and the survival of his entire family depend solely on his everyday income from the goods he sells, 5 kilos of rice, two pieces of cup noodles, two pieces of canned sardines may not necessarily be enough to sustain his family’s well-being during the entire lockdown. The vendor needs more than just income and commodities in order for him to secure the life that is well for his entire family. Furthermore, Sen argues that

opulence in the form of possession and consumption of goods is undoubtedly important in enhancing the standard of living (Sen, 1985). However, he further asserts that “The standard of living is not a standard of opulence, even though it is *inter alia* influenced by opulence. It must be directly a matter of the life one leads rather than of the resources and means one has to lead a life (Sen, 1985: 16).” What that means is that development is a matter of capabilities and functionings and not directly on the possession and consumption of resources, which is presupposed in opulence and utility.

Human development in the time of a pandemic

It has been discussed in the above section that human development must not solely be conceived as purely economic; rather it must be centered on developing and expanding human capabilities and functionings. The need to extend our conventional ideas of development from purely economic to human well-being is founded in the presupposition that economic progressions are not ends in themselves but are means for human flourishing. That is, opulence in terms of acquiring and consuming resources serve as instrument for human development and cannot account for the totality of actual development and individual deprivation. Such is the case insofar as income and commodities cannot explain for the extent of the sufferings a human being has to hurdle owing to her actual state of disadvantage. A pregnant woman needs more than just income for her to flourish in her actual state of capability deprivation, as compare to a young lady who is free from any social responsibilities and is without impairments. What the pregnant woman needs is the freedom to choose freely from among life’s choices that she finds fitting for her actual state of special need; that opportunities for development be open to her, such as the most effective healthcare services be given to her during her pregnancy until her delivery, easy access to effective medicines that are vital for her state of delicate well-being and vaccines be available for her child to support its development, and so on. Many lamented about the news that for some poor Filipinos having 8000.00 pesos may not still be enough to sustain their individual well-being. Some of these people who lamented, may have good reasons to support their lamentations over the said statement, however, one must not set aside our individual and interpersonal differences that significantly affect the person’s capacity to transform income and resources to actual development. A poor and sickly old man lying in his bed inside his dilapidated shanty somewhere in the urban slums of Manila, is given the same amount (8000.00 pesos) may not achieve the same level of development satisfaction similar to a healthy man who lives in an apartment and is loved by everybody in the community. Sen argues that equal income to persons having unequal needs will not result to equal development.

Moreover, the question of human development is further made relevant when is confronted with the prevailing problem of a global pandemic. Over the past few months, the world is being afflicted by a highly infectious disease that has infected 3,073,603 in 210 countries all over the world and has caused the death of some 211,768 people. COVID-19 has become a global nightmare. It has afflicted most of the first world

countries in the north; USA with its 1.01M cases and 56,634 deaths followed by Spain with 209k cases and 23,521 deaths and so on, this suggests that the virus respects no borders and economic status in the global arena. Everyone can be a victim of the dreadful effects of the virus. Nonetheless, the truth remains that the most vulnerable communities during the time of a pandemic are the poorest of the poor communities and the developing countries.

According to the World Bank's latest global poverty report an estimated 10 percent of the world's population or 734 million people live below the international poverty threshold of USD 1.90 a day. However due to the ongoing crisis of the COVID-19 pandemic the World Bank fears that the five years progress in poverty eradication will be erased. And some 40 to 60 million people will be added to the 734 million who are living under the international poverty threshold of USD 1.90 a day. The World Bank reiterated that the pandemic will have a disproportionate effect to the poor, through job loss, rising prices, scarcity of food supplies, and disruptions of fundamental services such as education and health care service (The World Health Organization, 2020). The most devastating blow of the pandemic is more experienced by the struggling poorer societies than by the rich communities. The lack of basic resources to sustain the economic and social balance of poorer countries and the absence of well-established health care system during the global health crisis makes the situation of the poorer communities all the more deplorable. In addition, most of the poorer societies are often characterized by poor political governance, incoherent bureaucracy, corrupt and incompetent leaders, and are suffering from political violence, and from diseases related to poverty; all these unfortunate circumstances inevitably exacerbate the unimaginable impact of the pandemic to the lives of the global poor.

Reports from the World Vision affirmed that "In the Middle East and North Africa, the number of people living in extreme poverty nearly doubled in two years, from 9.5 million to 18.6 million, mainly due to the crises in Syria and Yemen (World Vision: Global Poverty Facts, 2020)." And further adds that "when looking beyond income to people experiencing deprivation in health, education, and living standards, 1.3 billion people in 104 developing countries are multidimensionally poor (World Vision: Global Poverty Facts, 2020)." Poverty is a multidimensional political phenomenon, so that attempts of eradicating it under one perspective may not necessarily lead to a positive result. Sen argues that human development is all about functioning and capabilities, rather than just goods and resources. It speaks ultimately of the freedom to achieve life's different functions. In a pandemic any government response measure must see to it that the overall development and capacity of the individual member is secured in order to ensure the balance of the economic and political objectives. Furthermore, inasmuch as ensuring the positive health of every member forms part of the overall positive freedom of every human being; health policies must be strengthened and must likewise be aimed at empowering the people who are in the frontline by providing them of the necessary facilities, equipment and technologies needed to properly battle

against the highly infectious disease, and thus provide quality health care to those stricken by the virus. More so, in securing the human capital (empowering the people and securing for them their necessary and fundamental entitlements) it should be emphasized that the people are not means for development alone but are its vital ends. So that, in crafting policies and social safety nets the well-being of the entire population must come first before anything else.

Equality of capability and government policies

As the virus continues to rapidly spread globally, afflicting more or less 3 million people across 210 countries and causing thousands of deaths, nations all over the world are imposing strict measures in the hope of containing and stopping the rapid increase of COVID-19 infection. While the imposition of strict social distancing and lock down measures have been proven efficient in containing the virus in most high-income societies, the same measure of strict social distancing may not necessary yield similar positive result to poorer societies. We have learned that strict social distancing measure has been a corner stone of most rich countries' response to COVID-19 pandemic. However, imposing the same strict draconian measure may not necessarily fit to the needs of poorer communities; and its unintended and inevitable consequences may even be as equally deadly as the virus.

A community whose state of living is utterly dependent on informal economy, and people needs to work every day to bring food to the table, a sudden halt of economic activities and the imposition of stay at home measure are proven to be disastrous. "When states have limited budgets and capacity to support their locked-down population, lockdowns can result in widespread starvation and rampant disobedience and unrest (Piper, 2020)." Almost immediately after the entire world placed itself in lockdown, narratives of unrest and the clamor of unfair treatment in poorer societies have grown each day. "In Kenya, police beat people for defying a stay-at-home order and shot to death a 13-year-old boy who was standing on his balcony. Human rights activists in Nigeria say that at least 18 people have been killed by security forces enforcing the lockdown. In India, reported cases of deaths caused by starvation due to strict social distancing measure surfaced in the daily news, and the news of an impending national lockdown sent millions of laborers fleeing for the rural areas where they hoped they could find food during the shutdown (Piper, 2020)."

In the Philippines, after the President imposed lock down policy in the country's capital and the entire island of Luzon, other provinces and municipalities followed the same protocol in the hope of containing possible contagion of COVID-19 and flattening the curve. But, since the implementation of strict social distancing measure there have been litanies of unrest and struggles on the part of the poor that surfaced on the daily news in the country. The meandering policy of lockdown in the country has caused the majority of the population to fear for their well-being. Hundreds of poor Filipinos are incarcerated due to the alleged -transgressions of the lockdown policy. Cases of excessive application of force, on the part of the law enforcers in apprehending

violators are almost ordinary as the “stay at home” policy continues in the country for another two weeks. Last week (April 22, 2020), a retired military man who was suffering from a post traumatic disorder was shot dead by a police officer in a checkpoint in Quezon city for allegedly attempting to pull a gun on the cops (CNN Philippines, 2020). Last Monday (April 28, 2020), an ambulant fish vendor who was allegedly violating the community lockdown order was mauled by barangay officials of South Triangle in Quezon City, he sustained several wounds and abrasion in different parts of his body caused by the beating. These and other lockdown incidences allow us to see the problem in the implementation of a “one-size-fits-all-approach” in dealing with the global pandemic. As many nations are encouraging the strict implementation of social distancing in order to contain the virus, for those people living in extreme poverty, this certainly is an additional burden. “For the Philippines, where it was reported that one in five people in the country live below the poverty line, impoverished communities in the densely populated city of Manila struggle to adhere to the practice (Nortajuddin, 2020).” Strict draconian measures in high income societies may have been effective in flattening the curve, for they have both: the economic capacity to sustain the well-being of their locked-down populations and a well-established and well-prepared health care system that assures the population of their positive health. However, in most developing countries all the aforementioned capabilities are mostly absent, so that any restrictive measure undertaken by the government that are empty of concrete plans, as in the case of social safety nets that will reassure the impoverished members of their subsistence during the period of lockdown, will only yield catastrophic results.

Any government response measure directed towards balancing the social and economic impact of the recent global pandemic must intricately take into account the positive freedom of the individual to achieve well-being expressed in at least the freedom to live well. Development as well-being freedom must be the ultimate criterion in grafting feasible policies that may sustain the well-being of the poor during a health crisis. To illustrate, consider the recent policy of putting everyone into lockdown. Although it has been proven that in most rich countries lockdowns wielded positive results. However, this may not necessarily be the case in most developing countries. One cannot just turn a blind eye to the inevitable dreadful effects of lockdowns to the poorest of the poor whose lives depend on their everyday struggle outside begging for their everyday subsistence. For the rich being in lockdown is a privilege, a peculiar immunity and a grace to be reunited with their love ones and to be safe under their often gated and well-guarded homes in their richly elaborated subdivisions. But for the poor living in the urban slums and in their dilapidated shanties wherein physical distancing is an impossibility and whose subsistence depends on their day to day income being landless laborers, such policy is experienced as a slow and agonizing chastisement that causes their everyday anxieties. The rich and the poor being in lockdown may have the same level of wellbeing, in terms of being under constraint to move freely and for some maybe in terms

of being undernourished, as in the case when a rich beautiful lady chooses to fast during the entire quarantine period for fear that she might gain weight in the end. Nonetheless, there remain a vital difference between the two; the rich with her affluence and political connections can easily choose otherwise, like when a certain senator attended a birthday party despite being under observation, while the poor, impoverished and undernourished, is forced to suffer owing to her state of absolute capability deficit. Sen points out that “in judging a person's advantage (the kind of deal that he or she has got), the importance of well-being freedom must be recognized (Sen, 1984: 201).”

It is noteworthy to emphasize that this is not to disregard the effectivity of lockdown in flattening the curve of the pandemic, for we have learned that it can save lives by cutting the chain of infection within the community. Rather, what is being argued here is that a “one-size-fit-all approach” in dealing with the pandemic may have unintended consequences that are catastrophic and deadly especially to countries that are struggling due to systemic deprivations and absolute poverty. Locking down an entire family, whose subsistence greatly depends on their ordinary lives outside looking for income and food being daily laborers, without immediate aid and feasible social safety nets that will guarantee their subsistence will inevitably result to catastrophic ends.

Moreover, aside from the aforementioned problems of individual subsistence and development during the pandemic, problems on the well-being and protection of health care professionals arise in most developing countries arise due to their often lax and inefficient health care system. The lack of a well-established and developed health care system further complicates the conditions of most of the impoverished countries infected with the virus. Accordingly, there has been “approximately 423 healthcare professionals (HCP) [who] have died of COVID-19 around the world, with Italy having the greatest number of HCP deaths, estimated at around 106 fatalities as of April 15 (Ichimura, 2020).” Furthermore, based on the report given by the Department of Health last Monday (April 27, 2020), the Philippines have recorded 1,245 cases of health care professionals infected with the COVID-19 virus and a death toll of 27, constituting of nurses and doctors who succumbed to the disease (CNN Philippines, 2020). The health department said that among the aforementioned cases of healthcare workers infected with the virus are 464 doctors, 471 nurses, 69 nursing assistants, 41 medical technologists, 25 radiologic technologists, and 10 midwives (CNN Philippines, 2020). The high incident of COVID-19 positive among the country's healthcare professionals has raised concern to the World Health Organization, Dr. Abdi Mahamud, WHO-Western Pacific Region COVID-19 incident manager said that the alarmingly high COVID-19 cases in the country among its health professionals may have been caused by “the lack of personal protective gears, its improper use, or the increasing number of cases overwhelming the healthcare system (CNN Philippines, 2020).” According to reports, the Philippines is one of the countries in the world that has high COVID-19 incidence and mortality rate among its healthcare professionals. One can expect that the

recorded number of COVID-19 cases in the country among healthcare professionals are expected to rise as the country is scrambling to reconfigure its system at the last minute; problems of limited test kits, lack of personal protective equipment and the need for proper facilities and technologies to care for the infected, and the subsequent rising of COVID-19 incidence will persist until the government will take feasible alternative response measures directed towards resolving the pressing problem.

Strengthening the Philippines' institutional framework:

The country's institutional framework for disaster risk and management is currently being strengthened with the creation of the new department for disaster risk and resilience. The new department is tasked to monitor the COVID-19 pandemic's impact to the socio-economic life of the country's population and the overall state of wellbeing of the country during the global outbreak. It is directed towards securing the balance of the economic and social objectives which are under constant threat by the pandemic. Facing the impacts of the global outbreak and in the hope of boosting its resilience and capacity to recover from the onslaught of COVID-19, the Philippines applied for its Third Risk Management Development Policy Loan of USD 500 million and was approved by the World Bank's Board of Executive Directors last April 9, 2020. The finance loan is directed towards boosting the country's capacity to address disaster risks, recover from natural calamities and support urgent needs brought about by COVID-19. The Department of Finance's report on COVID-19 socio-economic response last April 14, 2020 reiterated the government's "Four-Pillar Socio-Economic Strategy Against COVID-19". The framework consisted of: 1. emergency support for vulnerable groups; 2. marshalling resources to fight COVID-19; 3. fiscal and monetary actions to finance emergency initiatives and keep the economy afloat; 4. An economic recovery plan to create jobs and sustain growth (Department of Finance report on COVID-19 Socio-Economic Response, 2020). The first pillar is directed towards supporting the 18 million low-income families and the 1.2 million unemployed Filipinos due to the COVID-19 lockdown. It consists of credit guarantee, loans, wage subsidy intended to support the unemployed during the pandemic and the social amelioration program of 5000 to 8000 per month subsidy program. The estimated budget for this emergency support is USD 11.5 billion. The second pillar is aimed at providing support for the country's healthcare workers, through expansion of medical resources to fight COVID-19 and to ensure the safety of the frontliners, it has an estimated budget of USD 702.8 million. This includes the procurement of medical equipment and supplies, loans for COVID-19 facilities, the procurement of 1 million pieces of PPE (personal protective equipment), PhilHealth medical assistance and expenses of COVID-19 patients, and compensation of private facilities used for the purpose of fighting COVID-19. The third pillar is aimed at sustaining the economic welfare of the country during the pandemic with the estimated budget of USD 16.3 billion. The fourth pillar is intended to sustain small businesses during the health crisis. The government will provide

wage subsidy to some 3.4 million EQC-affected employees of small businesses; the estimated cost of the program for two months is from 38.1 to 51.0 billion pesos growth (Department of Finance report on COVID-19 Socio-Economic Response, 2020).

Conclusion

Although most of the countries that have been hit hard by the global outbreak, in terms of the number of cases and deaths recorded worldwide, are from high income societies, most of the developing countries and the poorest of poor communities remain to be the most vulnerable casualties of the devastating and dehumanizing effects of the pandemic. COVID-19 sees no borders, it does not choose who will be its next victims. The rich and the poor can be infected; and while the rich communities have the capability to deal with the disease and to sustain the well-being of their members, poorer societies are left on their own scrambling to defend themselves against the ravaging COVID-19 pandemic with their scarce resources and deplorable states of being. The deplorable state of existence among the global poor, the lack of sanitation, access to clean water, proper nutrition, education, proper housing, efficient and affordable healthcare services, makes most of the developing countries and the poorest of the poor communities more susceptible to the disease. Questions on development and well-being become significantly relevant when confronted with the prevailing threat of the global pandemic. Many nations across the globe have taken decisive and diversified measures to contain the virus in the hope of finally ending the global outbreak. As nations differ in economic statuses, the effectivity of the measures they undertake in battling against the virus likewise differs. Certainly, the rich communities are well-capacitated to sustain the well-being of their nations and their members. However, this might not be the case in most developing countries and poorer societies which are struggling from social inequalities and injustices. Left on their own during this difficult time, the poorest of the poor communities will helplessly succumb to the devastating effects of the virus. A one-size-fits-all approach may not necessarily yield the same result as to some who successfully applied the similar approach especially to most developing and impoverished nations. Any government response measure intended to resolve the pressing problem brought about by COVID-19 in developing countries in the south must sensitive to the development of everyone's positive freedom expressed in the freedom to live well and to be well protected and aided during the global outbreak. Living well entails being capacitated to project for the worthwhile life one has reason to value.

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Community quarantine in the Philippines

- Leandro S. Estadilla

St. Paul University Quezon City, the Philippines

Email: kurtlean@yahoo.com

Abstract

The Philippines current administration with the recommendation of the Inter-Agency Task Force on Emerging Infectious Diseases (IATF-EID) and in adherence with the World Health Organization Interim Guidelines implemented community quarantine measures to combat the continuous increase in the number of infected cases of COVID-19 in the country. This paper discusses the different community quarantines being implemented on the different parts of the country and how these measures helped in "flattening the curve" of COVID-19 infections. Recommendations in enhancing the fight against the virus is presented at the end of the paper.

Introduction

"The world is facing another battle. A war where the enemy is not seen nor heard, a war where health care professionals and not soldiers are in the forefront, and cooperation of everyone is needed." – Rodrigo Duterte, President of the Philippines.

The year 2020 has been very dramatic, an Australian wildfire had been felt, burning down thousands of houses and disrupting the ecosystem in that part of the world. There is also a spark of conflict between Iran and the United States of America and a recent exchange of

gun shots between the South and North Korea at their border. In the Philippines, phreatic eruption of the Taal Volcano is experienced, displacing more than 25,000 people from their home (CNN, 2020) and triggering the local government to declare state of calamity in the area. But of all these, the pandemic Novel Coronavirus, commonly called as COVID-19 is the worst and put every important aspect of life in a halt.

The virus, according to some experts first discovered in Wuhan, China started to spread in almost all countries in the world, infecting individuals in an enormous progression. Currently, COVID-19 affected more than three million people in the whole world (3,584,118) resulting to almost two hundred and thirty thousand deaths (251,562) as of May 5, 1:00 PM PhST (<https://coronavirus.jhu.edu/map.html>).

When World Health Organization (WHO) first announced an outbreak of the coronavirus on January 30, thru Public Health Emergency of International Concern, they also provided measures that every country should follow to prevent a human-to-human transmission of the virus (WHO, 2020). On their Interim Guidance in March, 2020, they mentioned that "*to achieve these goals* (prevention of transmission), *countries may include quarantine, which involves the restriction of movement, or separation from the rest of the population, of healthy persons who may have been exposed to the virus, with the objective of monitoring their symptoms and ensuring early detection of cases*". These measures will help the member nation to lessen the effect of infections among the population. They cited as well that a person who have had an exposure with an infected individual must do a quarantine for at least 14-days (WHO, 2020). The separation of a carrier of the virus for two (2) weeks from other people will safeguard that other people will not get infected.

Social Science in Humanitarian Action (2020) provided three (3) measures on how to restrict the movements of the populace at this time of COVID-19 pandemic. These measures are *quarantine, isolation, and social distancing* that can be implemented mandatory or voluntary in nature. *Quarantine* is defined as when: "individuals who have been exposed to a communicable disease are separated from others for the duration of the disease's incubation period; *isolation* is when individuals with a communicable disease are separated from others for as long as they are infectious; and *social distancing*, in which individuals or large groups of people are restricted from gathering".

Enhanced community quarantine (ECQ)

On March 15, President Rodrigo Duterte (PRRD) places Metro Manila, the capital of the Philippines in an Enhanced Community Quarantine (ECQ) and two days after, to the entire Luzon island, this measure is supposed to last until April 13. The decision in implementing the policy is recommended by the committee that the president himself created -- the Inter-Agency Task Force on Emerging Infectious Diseases (IATF-EID). The IATF-EID is composed of experts in different fields like health, public safety, policy makers, economists, among others. They are expected to resolve the issue that the country is facing in relation of the pandemic.

The recommendation of the IATF-EID is aligned with the objective of stopping the wide spread of the virus in the metropolis, and its neighboring provinces and to other parts of the country. However, on April 7, the spokesperson of IATF-EID confirmed that PRRD approved another recommendation of extending the lockdown until April 30. This extension is based on the following: cases of infections will rise when the lockdown is lifted, the Department of Health (DOH) of the country needs more time to ramp up its testing capabilities and test results turn around, and the government is targeting that once results were given, infected individuals will be immediately isolated from the public. These are to be done to prolong or “flatten the curve” of infections in the country while waiting for scientists to discover a vaccine to fight the virus.

As of May 4, 3:20 PM PhST, Philippines is third among ASEAN in terms of cases of infections of COVID-19, posting a total number of 9,485 cases while Singapore is on top with 18,778 cases and Indonesia ranks at second with 11,587 cases. However, in terms of deaths, Philippines is ranked second behind Indonesia with 623 and 864 deaths, respectively. Moreover, recoveries of patients in the Philippines cuts through half of ASEAN countries with a total recovery of 1,315 while the top two countries with most recoveries are Malaysia with 4,484 and Thailand with 2,740 patient recoveries.

Negative effects of ECQ

Though the lock down would help the country “flatten the curve”, many Filipinos expresses their negative sentiments. In the study of Pastor (2020), the food supply and support of the government is a problem experienced by many people in Luzon who expresses their opinions thru Twitter. He further claims that though some tweets show positive effects, *“it was miscredited to the coronavirus instead of crediting to the decision such as community quarantine, lockdown and social distancing.”* The negative sentiments emanated from the inabilities of the government, local and national to implement an efficient manner of policies in allowing the food transport from one place to another, issuing different statements from different checkpoints established in the capital. Another issue mentioned is the distribution of food packs that would have been a big help and support for people on their day-to-day living since they are no longer allowed to work not unless they are members of the health sector or necessity producing businesses.

Moreover, the lockdown policy would also have a psychological effect to the people. Quarantine according to Rubin and Wesseley (2020), would cause panic and anxiety in the community. They enumerated reasons on this *“Firstly, the measure shows that authorities believe the situation to be severe and liable to worsen. Secondly, the imposition of the measure primarily for the benefit of those outside the affected cities reduces trust—the belief that authorities are acting in my best interests—for those within. Thirdly, quarantine means a loss of control and a sense of being trapped, which will be heightened if families have become separated. Fourthly, the impact of the rumor mill must not be underestimated. The desire for facts will escalate and an absence of clear messages will increase fear and push people to seek information from less reliable*

sources.” These are manifested in the case of the Philippines during the early implementation of the lockdown. At the time of the announcement of ECQ, people were frightened on how serious and deadly the virus will be and almost everyone expresses their fear on their different social platforms. Many Filipinos, were trapped and caught off guard on the implementation of lockdown, several people were not able to return to their hometown (those who are working in the capital but originally living in neighboring provinces around Metro Manila) and forced to stay and find shelter in the city. Lastly, since there are quite a number of rumors emerging from the situation, people look for non-official source of information without verifying the truthfulness of the material, thus, “fake news” spread like fire and have been a big problem of the government as well. These triggers specialists to create an information drive to correct misinformation circulating in the country and some physicians even establishes online consultations for COVID-19 and mental health concerns, foreseeing the effect of ECQ to Filipinos.

Likewise, socio-economic aspect of the country is not safe from the effects of ECQ. National Economic Development Authority (NEDA) of the country expected an economic recession this year, with expected negative growth rate in the remainder of the year. Monetary speaking, the country is expecting to lose PHP298 billion to PHP1.1 trillion, equivalent to 1.5 to 5.3 percent of the country’s GDP and an unemployment of 61,000 to 1 million persons this year (NEDA, 2020). These contraction in the economy is primarily caused by the sharp decline in the tourism industry of the country since a big chunk of the economy depends greatly on the spending of foreign and local tourists. Manufacturing is also taking the blows of ECQ, many companies, especially small and medium enterprises (SME’s) can no longer operate since their workers are forbidden to transport from their homes to the companies and are expecting that no people are discouraged to spending their money on non-essential products. But the most compelling consequence is on the consumption of every households, many people are no longer receiving regular income and are forced to rely on the government’s amelioration. Each affected household, those poorest of the poor, is given an amelioration fund amounting to Php 5,000 to Php 8,000 to augment the lost income due to ECQ. Unfortunately, this amount is not enough for a family to sustain their day-to-day lives resulting to a weak consumption and spending in the economy.

ECQ in numbers

Although the effect of the quarantine and lockdown is imminent, this would have been worst if the IATF-EID did not implement such measure.

On her press briefing on March 18, DOH Undersecretary estimated that in two (2) to three (3) months, the number of infected cases will be around 75,000 and this will only be lessened if appropriate interventions and strict social distancing will be implemented by the government. This announcement is a way of assuring the public that the situation we are in is serious and the measure implemented by the IATF-EID is rightful and needed to combat the epidemic. This is

also supported by the different studies made by the different agencies and universities in the country.

In the study made by FASSSTER of Ateneo de Manila University in partnership with the Department of Science and Technology (DOST), using their modelling techniques in forecasting the number of infected persons, if no quarantine policy had been implemented on March, the country would have more or less two (2) million confirmed cases by today (using an assumption that an infected person can infect another person in another place in Metro Manila and people in NCR will go in and out the metro). They also claimed that number of infected persons will decline as strict and longer implementation of a lockdown and quarantine is put in place. In addition, if the Luzon lockdown will be lifted at the end of April, they computed that confirmed case of 6,800 persons by May 21 will be realized (<https://pchr.dost.gov.ph>).

Another prominent university in the country, the University of the Philippines (UP), forecasted that at the end of April, as the country adopted the extension of ECQ, the infected cases will be estimated between 9,000 to 44,000 persons (<https://www.up.edu.ph/modified-community-quarantine-beyond-april-30-analysis-and-recommendations/>) explaining further that instead of the cases doubling in three (3) days, the progression is now happening in every six (6) days. Thus, signifying that the extension of ECQ is helping flatten the curve.

These studies among others, helped the DOH to estimate the possible peak as well as the number of infections in the country in relation to the proposed ECQ of the IATF-EID. These figures also helped them create strategies that would mitigate the infections caused by COVID-19 among Filipinos.

General Community Quarantine (GCQ)

Due to the continuous increase in the number of cases of infections, the government extended the ECQ until May 15 in Metro Manila and introduced another quarantine measure to other parts of the country, named, General Community Quarantine or GCQ. The new measure is implemented to at least prevent the continuous decline in the economic situation of the country. Under GCQ, a new set of guidelines is to be followed, less strict than the ECQ.

On April 28, palace spokesman announces that “the GCQ will take effect May 1 to 15 and will be removed thereafter for “low-risk” areas and may be extended for “moderate-risk” areas.” (<https://pressone.ph/ecq-vs-gcq-palace-releases-new-guidelines/>). In this new measure, the following manufacturing sectors like beverages (alcoholic and non-alcoholic), steel, tobacco, and textiles industries to name a few are now allowed to do business. Further, malls catering to the personal and necessity goods together with establishments under personal care industries will be operating but in a strict health standard, social distancing and limited number of customers will only be accommodated. Other industries like real estate and other selected business activities offering services to people are also allowed. This new development in the new quarantine is hoped to help the economy rebound at least few percentage points for the rest of the year, aside from the fact that people are

longing for these products after depriving for almost one and a half month now.

Moreover, the palace announces that if the number of infected cases in the capital continue to decline, those under ECQ will be converted into GCQ on May 15, thus, encouraging everyone to observe how the new measure works in other places that already under GCQ.

Extreme Enhanced Community Quarantine (EECQ)

Though there are provinces in the country who experiences decline on the number of infected cases, there are also municipalities in the capital that experiences the worst. A spike on the number of cases in certain places is felt and led to the creation of the Extreme Enhanced Community Quarantine (EECQ), as some called it “hard lockdown”.

Under this measure, only residents who were issued a quarantine pass from the barangay or municipality can leave their homes to buy essential goods and in doing so, are always expected to wear masks. Further, businesses under EECQ is limited to selling only necessity goods at a limited time of operation. But there are also some local government units (LGU's) who implement a stricter EECQ measure. They are no longer allowing people to go outside their homes not unless in emergency cases, commerce is closed, and soldiers and policemen are tasked to monitor and implement more stringent sanctions to violators, paying heftier fee or placing violators behind bars. Food and other essential goods are provided by the LGU who makes use of the situation to further their mass testing for COVID-19 infections.

Conclusion

The implementation of Community Quarantine (CQ) greatly helps the country to at least slows down the effect of a widespread infection of the virus not only in the capital but also in neighboring provinces. Though some negative consequences are experienced, these are only small amounts of sacrifices the country and its people must do in order to lessen the further damage of COVID-19 in the future.

Many Filipinos are agreeable with the quarantine measures implemented by the authorities. People believe that these limits the transmission of the virus from one person to another and helps the government identify who among are infected and who are not. One way or another many are following the measures especially in the urban areas, maybe because they are the members of the population who have enough spaces in their homes to accommodate social distancing. Unfortunately, this measure is not applicable to those who do not have enough place in their homes and have insufficient funds to support their daily needs, these are citizens living in the slum areas. These people are made to choose between violating the guidelines set by the administration to finding extra income and disobeying the guidelines of the CQ.

In administering quarantine measures, effectivity will be realized if the citizenry is provided their needs to survive all throughout the lockdown, essential products for survival and health support. If the government fails to do its job, people will be forced to go out their homes, into the streets and look for ways to earn money to support their families.

Moreover, quarantine is only one of the steps to be undertaken by the government to combat the deadly virus. Mass testing of those suspected and are exposed to the virus must be implemented, and in a most efficient way possible. There had been news that only those who are well-off are privileged to be tested and this does not sit well with many people. Knowing who among the population are infected should be treated and provided with care in order to lessen the spread of the virus to others, especially the vulnerable members of the society. The virus is causing lots of deaths of people who are 60 years old and above and those people who have comorbid cases. Lastly, availability of hospitals for patients' care must be provided to the infected and should be treated with utmost care. Though resources of the government are scarce, an efficient manner of allocating and using the budget for the pandemics will certainly go a long way and save many lives.

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Enhancing spiritual palliative care of Muslim patients: a perspective from Islamic theology

-Mohammad Manzoor Malik

Lecturer, Department of Philosophy and Religion, Graduate School of Human Sciences, Assumption University of Thailand
E-mail: philomalik@gmail.com; mmalik@au.edu

Abstract

An Islamic approach from its theological sources to address the spiritual pain related to palliative care of terminally ill patients can be established on attaining a spiritual stage of soul or spirit termed as reassured soul.

The attainment of such stage is based on hope of the patient to receive mercy and forgiveness of God. And the way of attainment of hope is possible by doing the repentance, praying, and patience. In combating the pain and suffering, the patient is supposed to understand that the life in its reality is a test and facing such a test is possible by two ways, one is patient centric by building patience within to endure the suffering and second is seeking help from God by praying. For the spiritual well-being, the patient should understand that his suffering is in fact expiation for his sins. On the other hand, the visitors and caregivers of patients have certain responsibilities that contribute to enhancing of the spiritual well-being of the patient, including comforting them by giving hope to the patients and at the same time praying for their recovery. These all elements enhance the spiritual well-being of patients and help in prevention of suffering by spiritual means.

Introduction

World Health Organization (WHO) defines palliative care as "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (World Health Organization, 2012). Furthermore, it says that palliative care beside other elements "integrates the psychological and spiritual aspects of patient care" (World Health Organization, 2012). This article is about spiritual care of such Muslim patients who are terminally ill or face life-threatening illness. The spiritual well-being of the patients has two-fold benefits and aspects: the first one is providing a spiritual relief to patients to cope with the illness and its associated problems such as anxiety, discomfort, and despair, and the second one is helping patients to be spiritually at peace in case there is high certainty that their illness is life-threatening or they are terminally ill.

An Islamic approach from its theological sources to address the spiritual issues concerning the palliative care of the patients with life-threatening illness could be established on a *spiritual construct* that is attaining a stage of self or soul (*nafas*) called as reassured soul (*nafs-e-mutmainna*). The initial state of self (*nafas*) should be between the fear (*khawf*) of God and hope (*rajja*) from God. And to overcome and minimize the element of fear (*khawf*), the patient should perform repentance (*tawbah*). On the other hand, the patient while coping with sickness should realize that the reality of life is a test (*ibtillah*) from God, and facing such test is possible by two ways. The first is the patient centric by building patience (*sabar*) within to face the sickness and the second is seeking help from God by praying (*salat*) to him. The test leads to the concept of expiation (*kafarah*) of the sins and misdeeds. In other words, suffering has a positive meaning in Islam as expiation of sins. On the other hand, there are certain spiritually meaningful responsibilities of caregivers and visitors of patients such as to pray for their healing and giving them hope by saying positive and optimistic words.

In the subsequent parts of this paper, the above arrangement and scheme of the concepts are followed accordingly.

Reassured Soul (*nafs-e-mutmainna*)

Attaining reassured soul, the secure self, or the soul at peace (*nafs-e-mutmainna*) by the end of life is a goal and wish of every Muslim. It is a state of attaining peace with and pleasure (*rida*) of God. The purity of soul and perfection is desired because Muslims believe that they come from God and to him they will return, as The Quran states "Indeed *we belong to Allah*, and indeed to *Him we will return*" (The Quran, 2: 156). Furthermore, the life according to the Quran is impermanent therefore a person should be prepare for the hereafter and the "... hereafter is better ..." (The Quran, 87: 16-17) for the believer.

According to The Quran it is the purification of soul that leads to success and it is its corruption that leads to failure as it states "...Truly he succeeds that purifies it (self or soul), and he fails that corrupts it!" (The Quran, 91: 7-10). The Quran describes three stages or types of self (*nafas*): the soul which commands and encourages doing sin, (*nafs-e-ammara*), as it is stated in the Quran that this soul "... overwhelmingly commands a person to do sin." (The Quran, 12:53). The second type of soul is blaming, or regretting (*nafs-e-lawwama*). The Quran states that "And I (God) swear by the reproaching soul." (The Quran, 75:2). It is a guilty soul that eventually leads to shunning the sinful life. The third is reassured soul (*nafs-e-mutmainna*).

The reassured soul or self (*nafs-e-mutmainna*) is what a Muslim wishes to attain before death. Regarding this soul, the Quran states that to the righteous it will be said at the time of death, "Oh reassured soul, return to your Lord well pleased, and pleasing to Him." (The Quran, 89:27-28). Al-Tabari explains *nafs-e-mutmainna* as reassuring, as it is reassured of the promise of God, which he promised the people of faith with of dignity in this world and in the afterlife, and thus the soul ratified it. Ibn Abas says reassured soul means ratifying self, Qatadah says reassured soul means the believer who reassured himself of the promise of God. (Al-Tabari, v. 24, P. 393). This soul is peaceful. At the time of death the angle of death sitting by the side of dying person addresses him by saying, "O pure soul, come out to the forgiveness and pleasure of Allah'. Then his soul comes flowing out like a drop of water flowing from a cup..." (Musnad Ahmad ibn Hanbal, h. 17803).

Therefore, it is the perfection of soul or in other words attaining reassured soul that concerns a Muslim patient. And attaining such stage of soul is what matters most in fulfilling spiritual need of a patient in providing relief as the crucial element of the palliative care of a Muslim patient. Muslims believe that after death the body decays but the soul remains and the soul either receives the pleasure and tidings of God or it receives torment and displeasure of God. A righteous soul receives the glad tidings of mercy then it is taken up to heaven and it is said to him "welcome to the good soul that was in a good body. Enter praiseworthy and receive the glad tidings of mercy and fragrance ..." (Ibn Maajah, v. 5, h. 4262). The state of reassured soul or self (*nafas*)

should be in between the fear (*khawf*) of God and hope (*rajja*) from God.

Hope (*rajja*) and Fear (*khawf*)

The best condition and a state of life of a believer in Islam is that he should be living between the fear (*khawf*) and hope (*rajja*). He should have fear of God and at the same time he should not be hopeless of his mercy even if one is convinced that he /she has attained the state of reassured soul (*nafs-e-mutmainna*). There should be balance between fear and hope and this balance keeps a person mindful of his duties and striving for the pleasure of God. The Quran states that "...they call on their Lord, in Fear and Hope..." (The Quran, 32:16). Therefore, for the reassured soul with which God is pleased is the one that is fearful of God as the Quran states, "... Allah is well pleased with them and they are well pleased with Him; that is for him who fears his Lord". (The Quran, 98:8).

Though a believer is supposed to be between fear and hope, yet the teachings from the theological sources give higher importance for being hopeful of God's mercy. There is a message of hope in the Quran, not to be despairing as The Quran states that "O my Servants who have transgressed against their souls! Do not despair of the Mercy of Allah ... (The Quran, 39:53). Furthermore, *God is with you and will never deprive you of your (good) deeds.* (The Quran, 47:35). The Messenger of Allah said, "Allah the Exalted says: 'I am as my slave expects me to be...". (Sahih al-Bukhari, v.9, h. 502). Therefore, a patient should expect the mercy and forgiveness of God.

To minimize the element of fear and maximize the element of hope, there are certain acts a patient can follow. Among those acts is repentance (*taubah*) and asking forgiveness (*maaf*) from people who the patient may have wronged in the past.

Repentance (*taubah*) and Forgiveness (*maaf*)

There is an essential aspect of human beings and that is human imperfection. Just like ordinary human beings, a patient under the palliative care is assumed to have lived with human experience that is imperfect in the sense that such experience may have been comprised of mistakes and sometimes of misdeeds. To gain the spiritual strength, it becomes necessary that such a patient should cleanse himself and feel a spiritual state of purity. Among those acts that can help the patient to cleanse himself is repentance (*taubah*) and asking forgiveness (*maaf*) from people who the patient may have wronged in his past.

Repentance (*taubah*) means that one feels regret for his or her sins and turns to God without any intercession with the intention to obey him. And it is only God who can forgive, The Quran states "Will they not, then, turn towards God in repentance, and ask His forgiveness? For God is much-forgiving, a dispenser of grace" (The Quran, 5:74) and "Hence, ask your Sustainer to forgive you your sins, and then turn towards Him in repentance ..." (The Quran, 11:9). Sheikh Saleh Al - Karbasi explains repentance as the return to the path of God after deviating from it. And repentance can only be achieved by regretting the acts of evil, and by the determination to leave sins and not to return to them, with the seriousness in restoring the rift in the life of human

moral because of those sins and by amending the lost rights of people and the rights of God. After all this, if a person sincerely asks forgiveness, God will accept his repentance (<https://www.islam4u.com>). The Quran states, "But as for those who do bad deeds and afterwards repent and [truly] believe- verily, after such repentance thy Sustainer is indeed much forgiving, a dispenser of grace!" (The Quran, 7:153).

Therefore, a patient should perform repentance and seek God's forgiveness without any delay before the time of death or while facing a serious illness. Because, "whereas repentance shall not be accepted from those who do evil deeds until their dying hour ..." (The Quran, 4:18). "But as for him who repents after having thus done wrong, and makes amends, behold, God will accept his repentance: ..." (The Quran, 5:39) "...Verily, God loves those who turn unto Him in repentance and He loves those who keep themselves pure" (The Quran, 2:222). The above mentioned concept of repentance is comprehensive of repenting the misdeeds a person may have committed by violating the commandments of God and other beings.

However, if a patient has wronged any fellow human being such a patient should ask the person to forgive him. This concept could be called as forgiveness (*maaf*). The Prophet Muhammad says, "The poor of my Ummah would be he who would come on the Day of Resurrection with prayers and fasts and Zakah but (he would find himself bankrupt on that day as he would have exhausted his funds of virtues) since he hurled abuses upon others, brought calumny against others and unlawfully consumed the wealth of others and shed the blood of others and beat others, and his virtues would be credited to the account of one (who suffered at his hand). .." (*Sahih Muslim* , b. 32, h. 6251). By performing repentance (*taubah*) and seeking forgiveness of persons a patient may have wronged in some way, the patient will gain a spiritual peace. Being at peace with God and fellow human beings.

Test (*Ibtillah*)

The concept of test (*ibtillah*) is connected with worldly life. In Islam, there are tests and trials that a person may face in living his life. Prophet Muhammad said, "If God wants to do good to somebody, He afflicts him with trials." (Saheeh Al-Bukhari, v. 7, h. 548) These tests can be in the form of disease, loss of property, danger, hunger etc. In face of these tests, a Muslim whether sick or healthy is supposed to be the best in his conduct and show patience. The Quran states, "And most certainly shall We try you by means of danger, and hunger, and loss of worldly goods, of lives and of [labour's] fruits. But give glad tidings unto those who are patient in adversity" (The Quran, 2:155). "Every soul shall have a taste of death: and We test you by evil and by good, by way of trial. To Us must you return." (The Quran, 21:35).

The concept of *ibtillah* (test) shows that a Muslim patient in face of losses, diseases, should have will to live in patience. Thinking that by the best conduct in his adversities he will get reward from God. The Prophet says, "Strange are the ways of a believer for there is good in every affair of his and this is not the case with anyone else except in the case of a believer for if he has an occasion to feel delight, he thanks (God), thus there is a

good for him in it, and if he gets into trouble and shows resignation (and endures it patiently), there is a good for him in it." (Muslim, b.42, h. 7138).

Patience (*sabar*) and Prayer (*salat*)

In facing adversities, A Muslim patient is supposed to be patient and at the same time, the patient should seek help from God by praying to him. Being patient and at the same time praying enhances the spirituality of the patient and gives him will to live peacefully.

In face of the adversities, a Muslim is supposed to adhere to patience (*sabar*) and seek help by praying (*salat*). The Quran states "And seek aid in steadfast patience and prayer: and this, indeed, is a hard thing for all but the humble in spirit" (The Quran, 2:45). In other place God repeats, "O you who have attained to faith! Seek aid in steadfast patience and prayer: for, behold, God is with those who are patient in adversity" (The Quran, 2:153) "...and bear in patience whatever [ill] may befall thee..." (The Quran, 31:17). This patience is going to be fruitful in the hereafter as the Quran states "... reward them for all their patience in adversity" (The Quran, 76:12). Muslims are supposed to advise each other abiding to patience and mostly when any adversity befalls them and the Quran states "and being, withal, of those who have attained to faith, and who enjoin upon one another patience in adversity, and enjoin upon one another compassion" (The Quran, 90:17). Besides praying, a Muslim patient should keep repeating the beautiful names of God (*zikrullah*) "And (all) the Most Beautiful Names belong to God so call on Him by them." (The Quran, 7:80) because such remembrance of God leads to the peace of heart as the Quran states, "...Verily in the remembrance of Allah do hearts find rest!" (The Quran, 13:28).

Expiation (*Kafarah*)

Kafarah means expiation of sins. According to Islam people will receive reward or punishment according to their deeds either in this world or in hereafter. The punishment is not mechanical that it will necessarily follow by committing a misdeed because God is merciful (*Raheem*) so he can forgive and his forgiveness can be sought by seeking and asking for forgiveness (*istigfar*) by supplications (*dua*). Furthermore, any harm or sickness that may befall a Muslim is expiation for his sins. And this concept is called as *Kafarah*. It is reported in the Prophetic traditions that whenever the Prophet went to a patient, he used to say to him, "Don't worry, if Allah will, it will be expiation (for your sins....)" (Sahih al-Bukhari, v. 7, h. 560). Furthermore, the Prophet said: "No calamity befalls a Muslim but that Allah expiates some of his sins because of it, even though it were the prick he receives from a thorn." (Sahih al-Bukhari, v. 7, h.544). Similarly, "No fatigue, nor disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were the prick he receives from a thorn, but that Allah expiates some of his sins for that." (Sahih al-Bukhari, v. 7, h. 545).

Therefore, the above concept of *kafrarah* is also important to remind a patient that his illness and pain is in fact a spiritual growth for himself so it can make the patient feel better spiritually.

On the other hand, there are certain spiritually meaningful responsibilities of caregivers and visitors of patients such as to pray for their healing and giving them hope by saying positive and optimistic words.

Visiting Sick Person (*iyadah al-marid*)

Some of the scholars are of the view that it is an obligatory duty (*Sunnah muakkadah*) of every person to visit a sick person. However, Ibn Taymiyah favored the view that it is a communal obligation (*fard kifaayah*). Not everybody, but at least some should visit the patient. Ibn Taymiya in *al-Ikhtiyaaraat* holds that it is the correct view (<https://islamqa.info/en/answers/71968/visiting-the-sick-some-etiquettes>). The Prophet said: "Free the captives, feed the hungry and pay a visit to the sick." (Sahih al-Bukhari, v. 4, h. 282). There are many Prophetic traditions or narrations (*ahaadeeth*) which speak of its virtue, such as the words of the Prophet (peace and blessings of Allaah be upon him): "When the Muslim visits his (sick) Muslim brother, he is harvesting the fruits of Paradise until he returns." (Riyad as-Salihin, b. 7, h. 898). The visitors of the patients are supposed to pray (*Duaa*) for the sick in the manner as narrated regarding the practice of the Prophet by saying "Don't worry, if Allah will, it will be expiation (for your sins)" (Sahih al-Bukhari, v. 7, h. 560). It is also narrated that whenever Allah's Messenger paid a visit to a patient, or a patient was brought to him, he used to invoke Allah, saying, "Take away the disease, O the Lord of the people! Cure him as You are the One Who cures. There is no cure but Yours, a cure that leaves no disease" (Sahih al-Bukhari, v. 7, h. 579). So the visitors of sick persons are supposed to cheer them up and give them glad tidings of healing, for that will comfort the sick person spiritually. The Prophet is reported to have said "When you enter upon one who is sick, cheer him up and give him hope of a long life, for that does not change anything (of the Divine Decree), but it will cheer the heart of the one who is sick." (*Sunan Ibn Majah*, v. 1, h. 1438).

Conclusion

Handling spiritual pain of Muslim patients in palliative care has necessarily roots in religion. And these roots can be explored only by right understanding of the relevant subject matter from the theological sources. The theological sources lead to a spiritual construct and that is attaining a stage of soul called as reassured soul. The reassured soul as a spiritual construct as explained in the abovementioned discourse consisting of many elements. It includes the concept of hope, repentance, test, expiation of the sins, patience, and prayer. These all aspects of the construct are patient centered. On the other hand, there are responsibilities of care givers and visitors to pray and encourage a patient. The practitioners such as doctors and nurses can and should be part of such spiritual care. They could do so by reminding the patient time to time about how they can be spiritually peaceful. They can enlighten the patient with the wisdom either by themselves or by inviting any Muslim religious person to advise the patient. On the other hand the staff can also advise the visitors before they meet the patient to take the spiritual needs of the patient in consideration.

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The ethical dilemma among healthcare professionals in the midst of COVID-19 pandemic

-Randy A. Tudy

Cor Jesu College, Philippines
randytudy@cjc.edu.ph

Abstract

The COVID-19 pandemic has stretched the limits of human safety wherein individuals are not sure if they have already contracted the virus making them always fearful and anxious. Frontliners, like the health care professionals (HCPs), are most vulnerable since they are handling patients who could possibly contaminate them. Many are terrified and are put in a difficult situation, especially when reports are coming out as regards the alarming number of HCPs who became COVID-19 positive. These HCPs are facing an ethical dilemma. Should they continue to work or not? Some of them left their jobs for fear of their safety and the safety of their families. In this paper, I will argue from the lens of rational egoism and Christian Ethics the ethical dilemma the HCPs are facing during this recent pandemic. On the one hand, those who are on the verge of surrendering and those who resigned consider their self-interest above others'. On the other hand, not continuing their job is compromising the principle of the common good. The decision of HCPs in this time of crisis depends on their philosophical stance and/or their religious faith. However, I further argue that the real equalizer is the assurance of their safety brought about by the provision of personal protective equipment and other supporting mechanisms.

Introduction

The COVID-19 pandemic traumatized the people around world. The health sector is trying to cope with the growing demands of responding to the containment of the virus. According to the World Health Organization (WHO), as of April 8, 2020, there were 22,073 HCPs who got infected with the virus across 52 countries (Business Standard, 2020). Unfortunately, the number of casualties continues and all the more worrisome. Based on the updated list of Medscape, 578 HCPs died around the world with US, Italy, and Iran topping the list, as of April 22, 2020 (See Table 1). In Southeast Asia, the Philippines has the highest number of casualties, followed by Indonesia. Aside from these data, Filipinos were shocked to learn about a large number of doctors, and other health workers tested positive of COVID-19 in the country. At the end of April 2020 based on the update from the Department of Health (DOH), a total of 1,619 Filipino health workers were infected (See Table 2). There was also a report about 20 Filipino healthcare workers who died in the United Kingdom (Ramos, 2020). The World Health Organization noticed this disturbing data. WHO-Western Pacific Region COVID-19 manager Dr. Abdi Mahamud sounded the alarm as the Philippines recorded 13% of the positive COVID-19 cases came from the health workers, as compared to 2-3% among the region's 37 member states (CNN Philippines, 2020a). He even called this percentage as an outlier due to its significant difference, although it is one percent lower as compared to 14% in Spain recorded in the month of March (Minder & Peltier, 2020). The statistics painted a picture of the severity of the problem in the Philippines and throughout the world.

If the number of positive cases increases day by day, people will become terrified. How much more for the frontliners like doctors, nurses, and other health professionals? In my previous article, I argued that the motivation of the HCPs is driven not just by their professional oath, but more on their contribution to the common good (Tudy, 2020). In this paper, I will shed light on the ethical dilemma among HCPs from the lens of rational egoism and Christian ethics. This paper contributes to the debate on whether it is ethical or not for HCPs to refuse going to work during a pandemic.

The dilemma among healthcare professionals

A pandemic causes a lot of pressure not only to the general public but all the more to the frontliners, the HCPs. It is not surprising why many of them are hesitant to report to work for fear of acquiring the virus. In two surveys conducted, only around 50% of the respondent HCPs said they would report to work in the event of a pandemic (Gershon, et al., 2010; Irvin, Cindrich, Patterson, & Southall, 2008). Among the many reasons, the well-being of family members remained a top barrier that influence their attitude to work during a pandemic (Ives et al., 2009). In December of 2019 and the first quarter of 2020, the world grappled with the devastating effect of COVID-19. Many died around the world, including the HCPs. Moreover, it was sad to note that during this time of crisis, when their services were badly needed, some of the HCPs had no recourse but to resign from their jobs. There were reports of HCPs leaving their jobs, such as in Australia (Cush, 2020), UK (Boswell,

2020), Bulgaria (Petkova, 2020), and other countries. They were called the "deserters" (Pahlman, Thomo, & Gylling, 2010) for abandoning their duty. Others were on the verge of surrendering (Boswell, 2020). Among the major reasons were the lack of protective equipment (Boswell, 2020; Cush, 2020; Freitas, Napinoga, & Donalisio, 2020; Lancet, 2020; Skorzevska, 2020), extended work schedules (Boswell, 2020), and the fear of passing the virus to their families (Lancet, 2020). All of these were valid reasons, which are expected, especially during a crisis like a pandemic.

Table 1: Top 10 countries with the largest number of HCPs' fatality

HCPs	N	% of the total 578 fatalities
US	120	20.76
Italy	106	18.34
Iran	79	13.67
UK	67	11.59
Philippines	25	4.32
Indonesia	22	3.81
Spain	21	3.63
Brazil	21	3.63
Mexico	18	3.11
China	9	1.56

Source: Medscape (www.medscape.com/viewarticle/927976)

Table 2: Number of HCPs infected with COVID-19 in the Philippines

HCPs	N	%
Nurses	604	37.31
Doctors	557	34.40
Nursing Assistants	99	6.11
Medical Technologists	63	3.90
Radiologic Technologists	31	1.91
Midwives	18	1.11
Respiratory Therapists	17	1.05
Pharmacists	13	0.80
Barangay health workers, administrative aids and utility workers	217	13.40
Total	1,619	100.0

Source: DOH Televised Briefing (as of April 30, 2020); CNN Philippines (2020b)

The COVID-19 pandemic, however, is not the first time when HCPs are put in a situation where they have to make a tough decision. For example, when a report was published about health workers being infected with AIDS due to exposure to patients' blood, several health professionals expressed apprehension of having contacts with their patients. Dr. Terence M. Schmah, a heart surgeon in Milwaukee, said in an interview, "I've got to be selfish. It is an incurable disease that is uniformly fatal, and I'm certainly at a high risk of getting it" (Gruson, 1987). The COVID-19 pandemic opened up a new threat to the HCPs. They were afraid of getting the virus while in the hospital treating the COVID-19 positive patients. They also suffered from psychological stress (Simione & Gnagnarella, 2020; Wu, Styra, & Gold, 2020; Zhang, et al., 2020; Zhu et al., 2020) due to the enormous demands because of the huge number of patients, discrimination from society, and the thought of contracting the virus. Some of them are in a dilemma if they have to stop working or not. Are they concerned

about their safety and their families? What about the patients who are helpless without their services?

Rational egoism

Is the decision of HCPs to leave their jobs or their refusal to report to work ethically wrong? With the number of HCPs infected of the virus and the fear that engulfed other HCPs, how do we explain the ethical elucidation of such a dilemma? Or, how can we explain the decision of those who eventually resigned from their job? In *Wealth of the Nations*, Adam Smith wrote, “It is not from the benevolence of the butcher, the brewer, or the baker that we expect our dinner, but from their regard to their interest. We address ourselves, not to their humanity but their self-love, and never talk to them of your necessities but their advantages” (Smith, 2010, p. 8). The actions of individuals are intended for self-gain. Though the intention is of self-interest, Smith, in describing it as an invisible hand, argues that by pursuing one’s interest, it has an eventual effect on society. However, the main contention here is the concern for oneself.

The concept of self-interest can be traced to rational egoism, which can be attributed to a Russian philosopher Nikolay Chernyshevsky. In his novel *What is to Be Done*, Chernyshevsky described Lopukhov’s act to save Vera Rozalsky from a marriage pre-decided by her tyrant mother as a selfish act because he was in love with her. His book became an inspiration for revolutionaries and was credited to inspire the creation of the Soviet Union. An English philosopher Henry Sidgwick was also credited for rational egoism, as explained in his book *The Methods of Ethics*. Agreeing to Hobbes’ concept of “Seek peace and follow it”, Sidgwick (2017) described the precept of rational egoism as self-preservation. He further said, “In Spinoza’s view, the (egoistic) principle of rational action is, as Hobbes thought, the impulse of self-preservation” (Sidgwick, 2017, p. 41). In explaining what is reasonable conduct, he further argued that “the ultimate end of each individual’s actions is his own greatest happiness” (p. 55). However, towards the end of his book, Sidgwick is stuck with the problem- conflict between rational egoism and universal benevolent. This gray area did not escape the criticisms from other scholars (Sverdlik, 1985). In the concluding chapter, he pointed out a conflict between self-interest and duty. He wrote, “But in the rarer cases where we find a conflict between self-interest and duty, practical reason, is being divided against itself, would cease to be a motive on either side. The conflict would have to be decided by which of two groups of non-rational impulses had more force” (p.248). The dilemma among HCPS is the tug-of-war between personal sacrifice or duty. It can be noted that Sidgwick, throughout his book, described rational egoism. However, he still considered finding a harmony between the two (self-interest and duty) as problematic and is subject to more debates.

Another Russian born writer, Ayn Rand, rose to fame through her works inspired by her objectivist philosophy. Her philosophy is expressed in her novels, particularly in *The Fountainhead* and *Atlas Shrugged*. *Atlas Shrugged*, first published in 1957, continued to sell well. For example, it sold 200,000 copies in 2008, 500,000 copies in 2009, and around seven million copies sold all in all dating back a decade ago (Jackson, 2011).

In an article *The Guardian* written by Freedland (2017), US President Trump, some key republicans, and popular US entrepreneurs were mentioned as some politicians influenced by the philosophy of Rand. Alan Greenspan, Federal Reserve chair, used Rand’s objectivism as an inspiration in his work (Weiner, 2016). However, Rand’s philosophy became the subject of criticisms and ridicules. Critics to Rand were quick to caution on the negative connotation of her idea. According to Presley (1999), the critics of Rand, such as Lasch, Kohn, and Sampson, were concerned about the consequences of unbridled individualism (p. 256). According to Burns (2009), Rand’s biographer, it was only Aristotle that Rand acknowledged having an influence on her and she was asked for an opinion she would refer to a character in her novels, although in her childhood years she was reading the works of Walter Scott and Victor Hugo. Rand criticized altruism (renouncing oneself for the sake of others) as against egoism, or what he called as rational selfishness. Hicks (2009), in discussing egoism by Nietzsche and Rand, created a matrix showing the differences among altruism, selfishness, and egoism as to intent, consequence to self, and consequence to others. It is clear that the intent of the three is different, but for the consequence to others both Altruism and egoism connote benefits. However, altruism and egoism disagree on the consequence to self.

	<i>Altruism</i>	<i>“Selfishness”</i>	<i>Egoism</i>
<i>Intent</i>	Selfless	Self-interest	Self-interest
<i>Consequence to self</i>	Sacrifice	Benefit	Benefit
<i>Consequence to other(s)</i>	Benefit	Sacrifice	Benefit or neutral

Source: Hicks (2009). Egoism in Nietzsche and Rand, p. 256.

Aside from her novels, Rand had written a book entitled “Selfishness as a Virtue: A New Concept of Egoism”. The book is a collection of her essays. In the introduction, Rand already warned readers that the title itself may evoke questions about the irony from the accepted concept of selfishness. To this, Rand immediately provided the answer- “For the reason that makes you afraid of it.” She recognized that the word “selfishness” is popularly synonymous with evil or anything referring to pure self-gratification. Explaining the social principle of objectivist ethics, Rand argues that “the achievement of his own happiness is man’s highest moral purpose” (Rand, 1964, p. 9). The starting argument of Rand is the definition of selfishness from the dictionary, which is about the concern with one’s interests. He added that “to be selfish is to be motivated by concern of one’s self-interest” (Rand, 1964, p. 40). In the case of the HCPs who left their jobs, they chose the higher value of protecting their own lives and the lives of their families. Rand describes selfishness that includes (a.) “a hierarchy of values set by the standard of self-interest, and (b.) the refusal to sacrifice a higher value to a lower one or to a nonvalue” (p. 40). From the patients and their families, and even from the public, the act of surrender while others need their services is cowardice and pure neglect of one’s oath. However, for the HCPs,

their decision is based on their moral judgment, values, and convictions. Are they selfish or simply expressing what Rand calls as genuine selfishness? Rand defines genuine selfishness as “a genuine concern with discovering what is to one’s self-interest, an acceptance of the responsibility of achieving it, a refusal ever to betray it by acting on the blind whim, mood, impulse or feeling of the moment, an uncompromising loyalty to one’s judgment, convictions, and values- represents a profound moral achievement” (p. 42). Thus, is the decision to leave the medical practice an act of genuine selfishness? Rand’s definition justifies such a decision.

Self-interest and Christian Ethics

Concern and love for others are the core of Christian ethics. Fr. Bud Grant, a professor of theology at St. Ambrose University, said that Catholics follow certain legal, moral and ritual maxims of the Christian faith because of their desire of heaven (Grant, 2011). Supporting this notion is equivalent to doing something to gain something, which is heaven. However, more than the personal gain, the Church remains committed to proclaiming the gospel values and the commandment of loving God and loving one’s neighbor. Jesus Christ gave the example of sacrificing His life for the sake of others. Similarly, the Church is consistent in its catechism with a common theme on the common good, particularly in her social teachings.

Pope John Paul II, in his apostolic letter entitled *Centesimus Annus*, said: “*All human activity takes place within a culture and interacts with culture. For an adequate formation of a culture, the involvement of the whole man is required, whereby he exercises his creativity, intelligence, and knowledge of the world and of people. Furthermore, he displays his capacity for self-control, personal sacrifice, solidarity and readiness to promote the common good. Thus, the first and most important task is accomplished within man’s heart*” (Paul II, 51).

The concept of self-sacrifice for the common good explains why selfishness has no place in the Christian faith. A genuine Christian is willing to forget oneself for the sake of others. Hence, martyrdom is considered as the supreme form of witnessing to the faith. Pope Francis (2016) re-affirmed the meaning of the common good “as a central and unifying principle of social ethics” (p. 156). The pope reiterated the teachings of the Church about the common good, that is “the sum of those conditions of social life which allow social groups and their individual members relatively thorough and ready access to their own fulfilment” (Paul II, 1994; Paul VI, 1965). The essence of Christianity is the common good- the concern for others above one’s self-interest. In the gospels, Jesus explains the greatest sacrifice, which is to die for one’s friend.

In a practical sense, the HCPs during this COVID-19 pandemic face the threat of their lives, but they are also caught in between the decision to save themselves and to save others. The ethical dilemma on their decision to continue or not in exercising their duties is dependent on their philosophy in life or their faith. As Christians, the greater good is the common good. To sacrifice for the sake of others is the ultimate vocation for each follower of Christ. In this pandemic time, the faith of the HCPs is tested with fire. After all, this is about life and death.

The equalizer: lessons of the past

I have pointed out that the ethical dilemma among HCPs during a pandemic is influenced by their philosophy in life or faith. However, I referred to the literature to discover what had been learned from the past pandemics and even the lessons of the recent one. One important lesson of the past was to look at the factors that influence the decision of health workers during a pandemic. The most common factor is the safety of HCPs through the strict observance of the precautionary principle (Balicer et al., 2010; Garrett, Park, & Redlener, 2009; Gershon et al., 2010; Possami, 2007). For example, Balicer et al. (2010) found that ensuring adequate supplies of personal protective equipment and establishing a subjective norm of awareness and preparedness are among the things that influence HCPs’ willingness to report to work during a pandemic. Moreover, Gershon et al. (2010) pointed out organizational preparedness with an emphasis on worker protection. And, recognizing the hassle of travels, Ives et al. (2009) suggested to the UK health care sector to provide accommodation and provision of information and guidance to ensure the safety of HCPs.

On a macro level, Upshur et al. (2005) called for the governments and the health sector to implement a comprehensive and transparent protocol to ensure the safety of health workers. At present with the still ongoing fight against COVID-19, there are lessons worth mentioning. For example, Taiwan, using the lesson from SARS, implemented a modified form of traffic control bundling to protect its health workers (Schwartz, King, & Yen, 2020). And, based on the experience, in Wuhan, China, there was also a suggestion for a provision of periodic professional development among HCPs in the protection from occupational hazards (Zhang et al., 2020). Also, Adams and Walls (2020) recommended letting the workers feel that they get enough rest as part of the supporting mechanisms. Moreover, healthcare managers need to address the mental health of HCPs (Greenberg, Docherty, Gnanapragasam, & Wessely, 2020). The question is, have we learned from the past lessons? According to Dr. David S. Jones, in his article entitled *History in a Crisis- Lessons for Covid-19*, “the history of epidemics offers considerable advice, but only if people know the history and respond with wisdom” (Jones, 2020). What is clear from the past and present lessons is ensuring the safety of HCPs. Their decision during a pandemic largely depends on how the government and the institutions they are working can provide protection. I argue that, regardless of beliefs and faith, HCPs are faithful to their calling, but they should be accorded with respect and protection for them not to be placed in a situation where they are confronted with the ethical dilemma as to their decision to serve or not.

Conclusion

From the philosophical point of rational egoism, the dilemma about the decision of HCPs is justified by their self-interest, whom Rand calls it as rational egoism. When their decision is well-thought influenced by sound judgment, their convictions, and values, it is genuine selfishness, as Rand’s describes it. However, if the decision is based on one’s Christian faith, the notion of

the common good surpasses one's self-interest. In other words, the ethical dilemma among HCPs can be gleaned from two lenses- rational egoism and Christian ethics. For those who are confused but are leaning towards surrendering or those who take the crucial decision of leaving the profession, they decide based on the philosophy of rational egoism. For those who remain and continue their mission as health workers, they decide based on their faith, particularly on the principle of the common good. However, before any philosophical and faith-related justifications, HCPs, by virtue of their oath, are willing to serve as long as the government or health institutions provide an assurance of their safety. It is not worth risking one's life when protective equipment and other supporting mechanisms are not provided. Thus, hospitals and any other healthcare institutions need to prepare and to implement precautionary measures to ensure the safety of their HCPs.

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Axel Honneth on social justice and the environment as a moral-practical concern

-Victor John M. Loquias

Graduate School, University of Santo Tomas Manila, Philippines
Philosophy Department, Ateneo de Naga University
Email: vloquias@gbox.adnu.edu.ph

"The earth," he said, "has a skin; and his skin has diseases. One of these diseases for example is called: "Human being." – Friedrich Nietzsche (2006)

Abstract

An environmental ethics grounded on a theory of recognition assumes social justice as incomplete without the due recognition of persons' relationship with the environment from the standpoint of well-being as an integral part of human flourishing. The state in which this recognition is found missing in intersubjective relations is called reification or the loss of the empathetic engagement of persons with the environment. In Axel Honneth's social theory, the historical moment in which this reification began can be traced from the emergence of the capitalist economic system. Economic inequalities and environmental crises are simultaneous effects of capitalism symptomatic of the severed empathetic engagement with the environment. The ethical significance of the environment is derived therefore on the first place from its role in the moral integrity of persons. The environment becomes a critical concern for social critique in the advent of this reification. Ethical action towards the environment in a recognitive framework demands reparation of this empathetic engagement in the practical level of human affairs where the environment is always already integrated.

Introduction

This paper answers the basic question whether an environmental ethics can be drawn from the normativity

of social relations where recognition stands as a theoretical framework.¹¹ An affirmative standpoint is taken and the basis for this assertion is articulated through an explanation of what social (in)justice consists in based on the theory of recognition where man's relation with the environment is re-appraised from the viewpoint of intersubjectivity. Within this viewpoint the environment is described as always already integrated in the everyday zones of practical human affairs which make it therefore a concern of social theory. Reconstructing Axel Honneth's social theory, recognition is presented here as the holistic and fundamental condition for the flourishing of persons' full integrity in which the environment forms an integral part of their well-being. Any response that deviates from this would constitute reification described more fully, in the second part of the paper, as the loss of the empathetic engagement with the environment. This loss is the particular forgetfulness of recognition in the dimension of man's relation with nature which is traced, via normative reconstruction, from the emergence of the

¹¹ Arne Johan Vetlesen remarks that "the environment is not among the topics with which critical theory is commonly associated." Arne Johan Vetlesen, "Critical Theory and the Environment," In *Routledge Companion to the Frankfurt School* (New York: Routledge, 2019), 471. Vetlesen ascribes to the three generations of critical theorists the increasing disappearance of the place of nature in their theory. He claims that from Theodor Adorno to Axel Honneth, critical theory suffers from a "nature deficit" in their lack of a direct treatment of the relation between man and his environment. See Arne Johan Vetlesen, *The Denial of Nature: Environmental Philosophy in the Era of Global Capitalism* (London: Routledge, 2015). An eloquent and incisive critique of Honneth's early social theory follows this same line of criticism by Jean Philippe Deranty. He argues that "the model of interaction that has gradually emerged as the fundamental structure upon which the ethics of recognition is built, is *restricted* to intersubjectivity narrowly interpreted as interhuman interpersonality" (Italics mine). Jean-Philippe Deranty, "The Loss of Nature in Axel Honneth's Theory of Recognition. Rereading Mead with Merleau-Ponty," *Critical Horizons* 6 (2005): 164. The ramifications of this loss of nature according to him is that the ethics of recognition puts the duty towards nature indirectly and is featured relevant only within the context of its value to the fulfilment of socialized individuals. The implied premise for this observation is that recognition, reduced to intersubjective interaction cannot account for a critical articulation of man's relation with nature and his environment. As Deranty bemoans "it seems difficult to use the ethics of recognition to account for the feelings of wrong and even injustice that human beings feel on the part of desecrated natural sites, tortured, massacred or industrially exploited animals." *Ibid.*, 168. But despite the perspicacity of Deranty's critique, it would be excessive to claim that Honneth's social theory excludes the relation between persons and the world of nature though, Honneth himself admits that nature recedes into the background of the social which is primarily the object of his study. For nature, as Honneth conceived, is supposed to be *integrated* already rather than lost in the everyday practical aspects of social life. What arises, in fact, are anomies in the harmonious relation between man and his environment—social pathologies which then could be diagnosed via critique. From the theoretical standpoint of recognition therefore, the environment is a social and moral concern which demands a responsive practical action. This paper counters therefore both Vetlesen and Deranty's standpoint.

capitalist economic system. Capitalism described as misdevelopment of the institution of the market economy is identified likewise as the historical moment in which the environment assumed a critical concern for social critique. Ethical action towards the environment assumed its significance on the first place because it is integral to the moral integrity of persons. Global environmental crises however is symptomatic of this severed empathetic engagement with the environment, the reparation of which calls for practical action. The third part therefore where the environment is framed as a moral-practical concern joins together how the environment takes on significance within a recognitive stance. It is moral because personal integrity is dependent on the recognition of the relation with the environment as an integral part of a flourishing life, and practical because social critique elevates the environment to a demand for ethical action against disrespect or reification situated in the spheres of recognition or the institutions of social freedom. Ethical action towards the environment must therefore be localized in these institutions for more efficiency and particularity where engagement with the environment is found in varied human affairs. The features of an environmental ethics within the framework of social recognition is outlined afterwards.

What is social (in)justice?

Social injustice is foremost the normative basis for social critique. In Axel Honneth's theory this is consistently maintained from his early works¹² where the theory of recognition takes centre stage up to his later focus on the historicity of forms of recognition into the social institutions of freedom.¹³ As in the composite description of Heikki Ikaheimo, recognition in the context of the social dimension of existence serves both as an ontological and ethical foundation. Ontological because the coming to be of subjects as persons happen via mutual recognition. It is ethical as well because the extent of recognition rendered and received by persons determines how close they come to the good life which ought to be reached by them as persons.¹⁴ Honneth's proximity to Aristotelian ethics is obvious here in the teleology of human act to a flourishing life. The Kantian principle is also manifest in that, a flourishing life is deemed universally achievable by all rational beings.¹⁵

¹² See Axel Honneth, *The Struggle for Recognition: The Moral Grammar of Social Conflicts*, Translated by Joel Anderson (Cambridge: Polity Press, 1995); and Axel Honneth, *Disrespect: The Normative Foundation of Critical Theory*, Translated by John Farell (Cambridge: Polity Press, 2007).

¹³ See Axel Honneth, *Freedom's Right: The Social Foundations of Democratic Life*, Translated by Joseph Ganahl (Cambridge: Polity Press, 2014).

¹⁴ Heikki Ikaheimo, "Making the Best of what We Are: Recognition as an Ontological and Ethical Concept" in *The Philosophy of Social Recognition: Historical and Contemporary Perspectives*, Edited by HansCristoph Schmidt am Busch and Christopher F. Zurn (Plymouth, Lexington Books: 2010), 346.

¹⁵ A similar mix of this Aristotelian and Kantian principles is articulated by Daryl Macer which he applies to ground bioethics. He writes: "An Asia-Pacific perspective of bioethics would say that the pursuit of a good life is a goal that all

But beyond Aristotle and Kant, Honneth takes a Hegelian inspired rendition of the development of persons grounded on intersubjectivity. The ethical life (*Sittlichkeit*) for Hegel is achieved through a series of struggles for recognition that progressively integrates individuals into the social spheres of the family, civil society and the state which are formed out of the agonistic process itself. The subject therefore is no longer conceived as an atomistic entity that could achieve self-realisation alone or determined blindly by factors external to his will because the individual and the social come together, in the original language of Hegel's philosophy, as objectification of the spirit.¹⁶

Taking a naturalistic turn via Georg Herbert Mead's social psychology, Honneth revises Hegel's ethical life into the spheres of recognition that contribute to the psychological development of the identity of persons. This identity formation is a life-long process of socialization where subjects progressively gain positive modes of relating-to- self through recognition accorded to each other. The progress made is gauged according to the proximity that individuation reaches greater integration, the deficit of which indicates moving away from its course. The struggle for recognition is the ontological condition for this becoming social of individual subjects that Honneth arranges into three general spheres.

Foremost is the recognition received in the sphere of love and care that caters to the basic need for emotional development necessary for an individual to grow in independence. Having the initial experience of being affirmed singularly as an individual subject, a person learns self-confidence which enables him to carry out the greater struggles ahead in life. This sphere however is quite limited only to persons within the range of intimacy from whom love and care could be expected for mutual reciprocation. The second sphere in contrast demands recognition of persons as entitled to rights, a feature that one shares with the rest of his fellowman as a bearer of dignity. This is the sphere of equality which must be accorded to every individual through legislation and execution of laws having wider, universal reach. So endowed, the individual gains self-respect which enables him to view himself as a citizen equally entitled to rights that should be promoted. In the third sphere a person is recognized in his particularity as part of a community who could contribute to its development. Such recognition naturally elicits self-esteem in persons for their unique capabilities that could render service in various ways to the society. It also empowers them such that it allows them to take an agentive role to work in solidarity with the rest of the members of the society.¹⁷

These spheres constitute the normative conditions for the moral development of persons and the psychological progress of a well-rounded personality. A recognition grounded morality takes socialization as the

persons can hope for." Daryl Macer, PHILIPPINIANA SACRA 47/140 (Special Issue, 2012): 455.

¹⁶ See Georg Wilhelm Friedrich Hegel, *Lectures on Natural Right and Political Science The First Philosophy of Right*, Translated by J.M. Stewart & P. C. Hodgson. (Berkeley: University of California Press, 1995).

¹⁷ Honneth, *The Struggle for Recognition*, 92-130.

condition for practical action that approximates the good life. What this take on morality immediately implies is that the good life, being intersubjective in nature, always entails having to respond to what is due to the other, of justice in other words. In this context, what is due refers to the recognition that *ought* to be rendered to the other. For Honneth, justice cannot be determined beforehand as a normative universal principle which could later be applied in particular circumstances. Justice takes various forms according to the normative demands of recognition that shape culture specific values and norms in the society. The three spheres of recognition identified by Honneth therefore presuppose as well three forms of justice that respectively contribute to the moral development of the individual.

To determine what is just implies then an antecedent knowledge of justice which becomes crystal clear especially when one experiences having been denied or deprived of them. Injustice occurs when recognition is withheld from persons and wounds up the personality, disabling the ascent of the individual to greater social integration. Rape and torture are concrete examples of injustices in the sphere of care; unjust wages would be instances of disrespect in the second sphere where the right for just compensation of one's labour and achievement is disregarded for profit making; humiliation and social denigration on the other hand are clear acts in the third sphere which disempower individuals and their capability to contribute to social development and change. Elsewhere,¹⁸ these acts of misrecognition are also categorized by Honneth under the concept of "pathologies," a medical term that refers to illnesses but also implies the procedural course for its remedy—diagnosis. While pathology metaphorically captures the experiences of social misrecognition, diagnosis illustrates on the other hand the role of social critique in disclosing these aberrations so as to identify the right social therapeutic measures in regaining psychological and social health.

While Honneth tackles recognition in the context of identity formation, he later admits shifting the emphasis on its institutionality so that the spheres may be taken to mean already as "social goods."¹⁹ This shift is premised on Honneth's insight that recognition takes on different forms in different historical conditions. Overtime they are institutionalized in relative social environments. In as much as recognition allows for self-realization, we could also say that it is the course through which one becomes free—in the society where one is socialized. Socialization in this case would be the condition of freedom. While the progress of identity formation follows the ascent towards greater degrees of recognition, freedom in turn is fulfilled in greater participation with social institutions. These institutions normatively at work today are (1) personal relationships which include the family, friendship and intimate relationships, (2) the institution of market economy, and

(3) democratic political will-formation. Social freedom consequently is the individual's being integrated into these social institutions. The society on the other hand, zoomed in, illustrates an organically comprised whole through the confluence of these institutions which Honneth describes as the substance of a democratic ethical life—an obviously reworked Hegelian notion of the ethical life in the present.²⁰

Participation in these social institutions presuppose self-realization in each respective domains. Justice therefore is served already in these institutions for, as Honneth states, "what we can reasonably call 'justice' today is largely contained in the normative principles that underlie and lend legitimacy to the constitutive spheres of action in our societies." (Willig 2012, p.147). Injustices on the other hand would take form in the misdevelopments, earlier described also as pathologies, of these institutions. Hence, the need for social critique. The task of social critique is also at the same time the work which justice performs as "analysis."²¹ For Honneth, this means internal critique or normative reconstruction²² of norms and values originally bent towards emancipation. Justice as analysis refers to the task of judging questions of legitimacy of these values.²³ Zurn (2015, p.14) attributes this method to a Nietzschean influence in Honneth so that we could also call it as revaluation of "meanings, interpretations, and values in order to change institutions and practices."

Honneth's focus on the social gives the impression of taking for granted the concern with nature and the environment, that it lies outside the scope of social critique. Honneth (1991, p. xxi) admits letting "*the aspect of the social relation to the natural world remain too far in the background*" of his work of "*establishing the suppressed dimension of conflictual interaction within the tradition of critical theory.*" But whether it is of social critique to address, Honneth has very early affirmed it in the positive. The following statement of Honneth provides an early support for the claim in this paper that the environment takes on a moral-practical concern:

A social theory whose central concern is to treat the practical relationship to inner and outer nature as a basic fact of forms of social life, however, must inquire about the access to precisely these everyday zones of social action. That is, the cultural models that are decisive within a society for organizing and regulating as a whole the exchange with the natural world are presented not within the sphere of aesthetic production, which has in the meantime become autonomous, but within the specific spheres of institutionalized everyday action. Practices concerning the preparation of food and the rearing of children, the cultivation of nature, and

¹⁸ Honneth, *Disrespect: The Normative Foundation of Critical Theory*.

¹⁹ See Morten Raffnsøe-Møller, "Freedom, Solidarity, and Democracy: An Interview with Axel Honneth," In *Recognition and Freedom. Axel Honneth's Political Thought*, Edited by Odin Lysaker & Jonas Jakobsen (Leiden: Brill, 2015).

²⁰ See Honneth, *Freedom's Right: The Social Foundations of Democratic Life*

²¹ Honneth, *Freedom's Right: The Social Foundations of Democratic Life*, 1-11.

²² Honneth describes this as disclosure of the institutionalized normative ideas and principles informing our practices though they may not be immediately transparent to us. Gonçalo Marcelo. "Recognition and Critical Theory Today: An Interview with Axel Honneth." *Philosophy and Social Criticism* 39:2 (January 2013), 216, DOI: 10.1177/0191453712470361.

²³ Honneth, *Freedom's Right: The Social Foundations of Democratic Life*, 58.

one's relationship to one's own body present domains of action of this sort in which the social relationship to nature is daily reproduced. The normative practical rules that in turn guide these cultural activities can then be distinguished according to the question of whether they are more "mimetically" compliant or "instrumentally" controlling in their relation to the natural environment.²⁴

Here, Honneth is advancing his critique of Theodor Adorno's relocation of the "mimetic"²⁵ relation to the natural world within aesthetic production. Honneth apparently sides with the non-instrumental mode of relating with nature that Adorno and Horkheimer advances against the enlightenment's rationality of the domination of nature. But Honneth does not see it fruitful for a critical social theory within the redemption offered by Adorno in art and aesthetic production. It should be found rather in the critique of everyday practical social life that forms the society's cultural habits. This means that for Honneth, nature is *integrated* already, and not lost, in the everyday life of man. Yet he was quick to acknowledge that the Frankfurt School tradition offers less elaboration in this matter than French social anthropology mentioning specifically the works of Claude Levi-Strauss.²⁶

Honneth identifies that in relation to nature "the danger of a social pathology emerges when nature is dominated to such an extent that the very possibility of a nonviolent integration of nature into the practice of social life is inhibited."²⁷ In Honneth's reading, Levi-Strauss' ethnographic works shares an affinity with Jean Jacques Rousseau in the latter's diagnosis of modernity. "Ethnography is justified as an empirical science of archaic cultures by the experience of estrangement from nature characteristic of modern societies." (p. 140) In its reconstruction of theoretical models from archaic societies, where it could still find intact the "feeling of solidarity and primordial accord with every natural life form as the fundamental 'principle' of all social life," (p. 148) ethnography could offer an empirically grounded corrective guidance for rebuilding society. This time a society based on an expanded view of freedom reconciled with the ecological ethics of the "integration of all social life with the natural world."²⁸

What Strauss' enterprise represents is a diagnosis in one of the three regions of possible failure in social development, these three regions being: with regard to an individual's relation to self, with regard to the relations of social life and with regard to the relation to nature.²⁹ While the domination of nature accounts for

the pathology in the third aspect, the disintegration of identity in the first and second region results from either the dominance of individuality or collective identity to the exclusion of each other. Honneth takes up again more thematically this dimension of man's pathological relation with nature in his reconstruction of Georg Lukacs' concept of reification. Honneth (2008, p.66) states that likewise, there are three forms of reification: "*reification in our relationship to other people, in our relation to nature, and in our relation to ourselves.*" If the three forms of a positive relating-to-self are to be understood as "normative or ethical ideals" which reification is able to penetrate, reification can be judged therefore as a "problematic deviation" from each respectively. In the next part, the relation to nature will be shown as an integral aspect of a positive relation to self which is nonetheless withheld in the process of reification described by Honneth as forgetfulness of the fundamental act of recognition. This will eventually show that social (in)justice as described above is linked with man's relation with the natural world and social emancipation is unattainable without the recognition of the environment as an integral part of human flourishing.

Reification as the loss of empathetic engagement

Honneth's distinction of the three forms of reification presupposes the holistic status of recognition interweaving the relation that the self has with himself, others and nature, so that a fully realized existence cannot not be deficient in any of these three aspects. For Honneth reification indicates "the process by which we lose the consciousness of the degree to which we owe our knowledge and cognition of other persons to an antecedent stance of *empathetic engagement* and recognition" (Italics mine, p. 56). Put differently, it is the loss of this empathetic engagement which is "the primordial form of relating with the world. (p.37)." In this state individuals tend to perceive others as mere things, which means that the observable behavioural expressions of others are not perceived with that claim for recognition and demand for appropriate response. Honneth likens this further to "the autistic child's world of perception, as a totality of merely observable objects lacking all psychic impulse or emotion."³⁰ Here, not only that a fundamental connection is missing between persons, but objects as well which are accorded values by individuals are neutralized in the sense that they are treated as mere things devoid of values and meanings attached. But the antecedent recognition of persons which Honneth refers to demands that objects should not be perceived apart from the contexts that persons respectively attach to it.³¹ What Honneth is saying here obviously is that in recognition, the social and the objective natural world converge integrally that a rupture between can only result into reification.

Honneth's turn to Adorno in advancing the non-instrumental treatment of nature as the non-reified form of relating with nature shows only the holistic character of intersubjective recognition. This is even more audible in Honneth's words:

²⁴ Ibid.

²⁵ Mimesis refers to the human cognitive activity in which "thought makes the world resemble itself." Theodor Adorno and Max Horkheimer, *Dialectic of Enlightenment*, Translated by Edmund Jephcott (California: Stanford University Press, 2002), 19.

²⁶ He also mentioned Johann P. Arnason and Klaus Eder to belong to the same category of interweaving the social with the relationship with the natural.

²⁷ Axel Honneth, "Author's Introduction," In *The Fragmented World of the Social: Essays in Social and Political Philosophy*, Edited by Charles W. Wright (Albany: State University of New York, 1995), xxi.

²⁸ Ibid.

²⁹ Axel Honneth, "Author's Introduction," xxi

³⁰ Ibid., 58.

³¹ Ibid., 63.

With Adorno, we could add that this antecedent recognition also means respecting those aspects of meaning in an object that human beings accord that object. If it is indeed the case that in recognizing other persons we must at the same time recognize their subjective conceptions and feelings about nonhuman objects, then we could also speak without hesitation of a potential “reification” of nature. It would consist in our failing to be attentive in the course of our cognition of objects to all the additional aspects of meaning accorded to them by other persons. Just as is the case with the reification of other persons, a “certain blindness” is here at hand. We then perceive animals, plants, or things in a merely objectively identifying way, without being aware that these objects possess a multiplicity of existential meanings for the people around us.³²

The meanings and values that persons attach to things indicate their capacity to live a life where the world becomes integrated into a certain view of a flourishing life or well-being. The term “environmental identity” which Figueroa defines as “the amalgamation of cultural identities, ways of life, and self-perceptions that are connected to a given group’s physical environment”³³ aptly describes man’s inseparability with his environment. This entails that disrespect, consisting of actions that wound up the personality in the spheres of care, rights and solidarity, implicates as well how an individual is treated in his fundamental way of living in the world from the standpoint of well-being. Whatever counteracts this fundamental orientation to life may be categorized under reification. And it is interesting that Adorno’s interfacing description of “the wrong state of things” (Adorno, 2004, p.11) and “damaged life” (Adorno, 2005, p. 120, 193-4) all lead to that one historical phenomenon which may be identified as the prime reason for having the environment take on such a critical concern today to be addressed—capitalism. Adorno (2005)’s analysis, for Honneth (2005) is “*not an explanatory theory but a hermeneutic of a failed form of life*,” a genealogical interpretation of “the rise of our second nature in the reified, frozen life conditions established by capitalism.” Damaged life includes reification of nature which is most exemplified today by disrespected indigenous modes of life and the indigenous peoples’ deterritorialization from their habitat through massive environmental destruction to the interest of life indifferent capitalists.

Once the notion of reification is understood to include forgetfulness of man’s self-determination in his mode of relating with his environment from the context of well-being, the environment appears now more prominently as a political and cultural concern. Andre Gorz’s framing of the environment as ecology is particularly helpful in reinforcing this claim. Gorz corroborates the fact that reification of the capitalist system is that which puts forth the *critical* concern between man and nature. He dispels the pretence that

ecology is apolitically self-sufficient, and that it is especially concerned with man’s “return” to nature reconceived as sacred. “The ecological movement is not an end in itself,” he says “*but a stage in the larger struggle*.” (Gorz, 1980, p.3). He was referring to the monolithic struggle against capitalism confronting the society in a global scale. Capitalism is propelled by the ideology of growth which, it insists, is inexhaustible in nature thus justifying the endless consumption mediated by labour. Yet on the contrary, science and technology according to Gorz (1980) has already established that “*all productive activity depends on borrowing from the finite resources of the planet and on organizing a set of exchanges within a fragile system of multiple equilibriums*.” Ecology, or what he terms as “ecological realism,” is a critique of this growth-oriented capitalism by unveiling this suppressed fact of the external limits to human activity in the natural world. The effects of the utter disregard of this limits has long manifested already in the globally experienced catastrophes, diseases of civilization and reduced quality of life despite the high levels of material consumption.

Gorz, in other words, diagnoses the social genesis of environmental reification where it becomes an object of social critique. For Andre Gorz, ecology stands in relation with the emergence of political economy. It is the anti-thesis immediately confronted with “economic rationality” that essentially stems from *human social activity*. Writing in reference to Marx, he explains that “political economy begins only where free cooperation and reciprocity cease. It begins only with *social production*, i.e. production founded upon a social division of labor and regulated by mechanisms external to the will and consciousness of individuals—by market processes or by central planning (or by both).” (p. 14). On the other hand, “ecology does not appear as a separate discipline until economic activity destroys or permanently disturbs the environment and, in so doing, compromises the pursuit of economic activity itself, or significantly changes its conditions. Ecology is concerned with the external limits which economic activity must respect so as to avoid producing effects contrary to its aims or incompatible with its continuation.” (p. 15)”. Left to themselves, individuals within a small community who organize themselves autonomously and exchange their goods and mutual services in the spirit of free cooperation needs no external intervention (for the management of their resources) by political economy. In so far as communities and its mode of production do not pose destructive effects to the environment, Gorz insists, ecology as a separate science does not apply to them.

Gorz’s description of the genesis of political economy and ecology as a science strongly corroborates Honneth’s diagnosis of the de-socialization of the market in the advent of capitalism: “the historical moment in which the capitalist economic system emerged was when the processes of production and consumption required for the material reproduction of society could become so exclusively determined by supply and demand—with the help of the universal means of exchange, i.e. money—that these processes could take place independent of all normative expectations and moral consideration,

³² Ibid.

³³ Robert Melchior Figueroa, “Indigenous Peoples and Cultural Losses,” In *The Oxford Handbook of Climate Change and Society*, Edited by John S. Dryzek, Richard B. Norgaard, and David Schlosberg (New York: Oxford University Press, 2012.), 2, DOI:10.101093/oxfordhb/9780199566600.003.0016.

without any ethical embedding.”³⁴ Capitalism is a misdevelopment that led to the disappearance of the moral content of the market as a system of cooperation. It has inculcated that since the economy is anonymously propelled by blind forces, anyone can compete for individual prosperity and grow their interest with sky as the limit through the use of “ingenuity.”³⁵ In other words, the market in the capitalist system has ensured the promise of individual freedom for private concerns. What Honneth calls empathetic engagement with the world was lost in this channelling of market mediated labour to mere individual success. Not only was cold indifference practiced to fellow human beings’ labour in favour of profit in entrepreneurial decision making but more so to the environment from where the resources for production are mined. It is now manifest that the reification of the institution of market economy is simultaneous with the reification of nature.

Today, ideas of justice that revolve around the principle of distribution appears to draw its legitimacy from the experience of inequality that was brought about by capitalism. However, it can be seen now that economic inequalities that distribution seeks to address could still be traced from a prior fundamental act of a withheld recognition in which capitalism is both an offshoot and the prime obstacle for its coming into the consciousness of subjects. Capitalism as a reified condition is a forgetfulness of the fact that the market economy is supposed to be a social institution that should advance freedom in the aspect of material reproduction through social cooperation. The rationality it has inculcated—that the market economy is a private enterprise—has been deeply imbedded as an economic culture thus making it resistant to change. But the grave consequence of this enculturation is the sustained reduction to invisibility of diverse environmental identities through massive and limitless exploitation of environmental resources in order to keep the one dimensional system of capitalism running. “Invisibility” is another of Honneth’s concept which he uses in order to describe the intentional act of not ascribing “worth” to others as being able “to lead their lives in rational self-determination.”³⁶ Capitalism as reification is not only the cause of cultural invisibility but worse, it is the cause of the destruction of the environment and “environmental heritage.”³⁷

³⁴ Honneth, *Freedom’s Right: The Social Foundations of Democratic Life*, 178.

³⁵ “To be a master of the economy takes the instincts of genius.” Max Horkheimer, “Authority and the Family,” In *Critical Theory: Selected Essays* (New York: Continuum, 2002), 79. Horkheimer was describing here the invaluable characteristics of an entrepreneur regarded in a free-trade economy to stay on top of the heap. This includes the knowledge of market forces and human needs in order to identify what to produce, create an efficient combination of human labor and machinery to maximize results with low expenditures and the capacity to carry out difficult and cold decisions to increase profit.

³⁶ Axel Honneth and Avishai Margalit, “Invisibility: On the Epistemology of Recognition,” *Proceedings of the Aristotelian Society* 75 (2001), 122.

³⁷ “Environmental heritage pertains to the meanings and symbols of the past that frame values, practices, and places peoples wish to preserve as members of a community.

What is done in this part is a normative reconstruction of the emergence of the environment as a critical concern. Capitalism is a socio-economic and historical pathology that has caused world-wide environmental crises. Making sense of Nietzsche’s description of man as a disease, today’s environmental crises is brought about by man through a socio-economic system which deviated from the promise of social freedom, a pathological system now autonomously operating and rapidly manifesting as turning against man himself in the impending world catastrophes caused by environmental destruction. While it is possible that nature might just cleanse itself of the disease that is man, the prevention of total annihilation is just as well a responsibility that man must carry out through the reparation of damage which he has incurred upon himself. The demand for social justice is a demand for “environmental justice.”³⁸ What is happening in our environment is largely attributable to man’s doing so that “we can no longer look out at nature without looking back at ourselves.” (Dryzek, 2003, p. 114). The environment which has now become a critical issue is for man a moral-practical concern.

The environment as a moral-practical concern

Shannon Brincat (2015) articulates certain questions that pose the urgency of recognition as a theoretical resource, structuring the environment as a moral-practical concern. He asks: “how can communities maintain their unique identities in the context of climate change? How can individuals flourish amid the projected crises of rising sea levels, ocean acidification, declining food production, changes to the water cycle, among others?” (p. 278). Climate change is a global environmental concern that demands action also in a global scale but Brincat explains that it “cannot be addressed without, at the same time, addressing the global issues of inequality and uneven development that has underpinned the crises—that is, without bringing in cultural, symbolic, and social forces that are equally responsible for, and causative of, climate change.” Brincat’s identification of climate change as “part of a multifaceted crises of human intersubjectivity”³⁹ is a specific instance where the environment emerges as a matter for social critique.

Morality in Honneth (1997, p. 28)’s definition is “the quintessence of the attitudes we are mutually obligated to adopt in order to secure jointly the conditions of our personal integrity.” Furthermore, “the various attitudes,

Environmental heritage is the expression of an environmental identity in relation to the community viewed over time.” Figueroa, “Indigenous Peoples and Cultural Losses,” 2.

³⁸ “Environmental justice is broadly construed as the conceptual connections, causal relationships, and strong correlations that exist between environmental issues and social justice. Environmental justice frames social issues (including cultural contexts and political economies) as environmental issues. Social and environmental issues are inseparable, co-causally related, and always in a context that requires a political interpretation; in particular, such a consideration of justice accounts for power dynamics and socio-environmental practices that maintain historical relations, as well as the remedies for injustices.” Ibid.

³⁹ Ibid., 279.

which taken together take up the moral point of view, are introduced with reference to a state that is considered desirable because it serves human well-being." This time personal integrity has now been established to be inseparable from man's mode of living and relating with his environment. Man's relation with the environment is meshed with the various fields of human action. The environment as a moral-practical concern demands that we recognize others as making claims on us in their pursuit of a flourishing life and that we respond in affirmation of it through our actions in different levels. In the case of personal relationships for example, love becomes more concrete when we provide for nourishment of our loved ones, spend quality time with them through vacation in the beach or by nature tripping. Love and care for our beloved if placed in a long term deal would take into consideration the means of preserving the environmental conditions that would ensure their physical well-being.

In the aspect of labour and market economy, it has been more evidently shown that capitalism as a social pathology has caused environmental crises affecting the lives of people around the world especially those in developing countries who are not equipped with the sophistications to deal with imminent environmental catastrophes. Action in this sphere does not necessarily ask for the immediate radical abolition of capitalism as it is in fact an unrealistic project to pursue at the moment. But the consciousness of the negative impact of capitalism to the environment should make us initiate alternatives for a more "socialized"⁴⁰ economic market system where social cooperation, inclusion and participation replace the rationality of profit accumulation and monopoly. A more socialized market cannot but recognize the rights of every person for physical well-being and thus respect what Gorz earlier stated as "the external limits" of economic activity mediated by labour. In other words not only will the dignity of human labour be accorded with respect but that labour itself will also have to be respectful of the environment from where it gets the material for production in order to be truly faithful to the welfare of man in the long run which human labour serves on the first place. In retrospect Honneth's agreement with Adorno of the non-instrumental mode of relating with nature is contextualized in the latter's critique of the functionalist-instrumentalist rationality of capitalism which is a reified condition. A non-reified state, in Honneth's revision, would then be a reintegration of the environment into the context of personal integrity and well-being. This entails a total reorientation of how we relate with each other in a more respectful manner in the different areas wherein the environment is always already involved—in personal relationships, work, and political relations.

In democratic will formation, care for the environment can be better integrated when we take into consideration the "wisdom of strangers" as Sheila Jasanof rightly puts it. What she meant was that "others' judgement, not our own, lays the groundwork for any collective decisions in the modern world." (Jasanoff,

2012). Earlier the sphere of solidarity was discussed as the recognition of persons in their capability to contribute to the development of the society. Elsewhere, Honneth (2017.p.62) likewise affirmed that "wherever barriers to communication are removed, the ability of the community to perceive as many of the currently hidden potentials for solving a problem productively will grow." This entails reintegrating those who have previously been rendered invisible in the society to be recognized as part of decision making. Political decision making in matters of environmental concern, as further explained by Jasanoff (2012), needs to take into consideration diverse perspectives. "Public reasoning, a process that all democratic societies are committed to in avoidance of arbitrary power, depends on prior criteria of what counts as valid reason." This validity springs from the culturally specific norms and values which varies from one culture to another. This "deep-seated ways of knowing and acting" is also called by Jasanoff as "civic epistemologies." Jasanoff (2012).

Scientific truths are valuable for the grounding of policies on facts. But interestingly, even scientific facts established by the concerted efforts of scientists, scientists who arrive at a convergence of understanding of the facts, do not immediately reach public assent, posing therefore an even greater challenge to reach consensus. Jasanof (2012) points out that "factors conditioning the reception and uptake of scientific claims by lay publics operate to some extent independently of the dynamics of knowledge production within scientific communities." The tendency of people when faced with such facts which do not "speak" in their "language" is collective resistance or "cultural denial." (Norgaard, 2015). One reason for this is that "trust and credibility, as social achievements, are necessarily inflected by culture, markers of trustworthiness depend on contexts of interpretation." (Jasanof, 2012, p.2) The tendency in certain cultures to resist change is due to the norms and values which preserve the cohesion of their communities. An example is the denial of climate change despite having it long been factually identified by science. In Norgaard's description this cultural denial of climate change happen when "people collectively hold information about global warming at arm's length by following established cultural norms about what to pay attention to, feel, talk, and think about in different contexts."⁴¹ In a way the culture serves as a haven for the thought that everything is fine within their boundaries. Collective action is therefore crippled and a wider participation for political deliberation and praxis is suspended.

Cultural denial presupposes that man's relationship with nature and the environment has always been cultural. As already described by Honneth in the long quote in the first part of this paper, the relation with the natural world is presented in the institutionalized spheres of everyday social action. There is a need therefore to mediate and translate scientific truths into these diverse civic epistemologies not merely to win their allegiance to policies but to truly pave the way for their active engagement and inclusion in decision

⁴⁰ Honneth, *Freedom's Right: The Social Foundations of Democratic Life*.

⁴¹ Norgaard, "Climate Denial: Emotion, Psychology, Culture, and Political Economy," 7.

making processes. But persons also need to assess their cultural backgrounds in the face of critical issues and their exposure to other thought systems to effect transformation from within and perhaps devise cultural means for greater participation in political will-formation. The way is through internal critique of the cultural relationship with the environment upon exposure to otherness.

In a nutshell, the environment is a moral concern because personal integrity is dependent on the recognition of it as an integral part of a flourishing life which persons are entitled to have. It is practical as well because social critique elevates the environment to a demand for ethical action in the various spheres of recognition or institutions of social freedom. Ethical action towards the environment is demonstrated to have greater normative bite when the institutions are reoriented to physical well-being and respectful aims. Deviations from these result to what has been discussed herein as reification which is the straying away from an empathetic engagement with the environment. Capitalism was identified as a socio-economic misdevelopment which had a far-reaching effect on the environment precisely because of the loss of the moral content immanent in the principle of social cooperation and mutual concern for well-being. This diagnosis is a showcasing of social critique on which an environmental ethics, based on a recognitive framework, is set. From the preceding considerations, the visage of an environmental ethics from the perspective of a social philosophy of recognition may then be articulated to have the following features:

(1) *The recognition of the fact that personal integrity and flourishing always includes recognition of man's relation with the environment as integral for physical well-being.* Social recognition in other words includes respecting different modes of relating with the environment that reflect their society from where it derives its normative legitimacy. Disregard of this fundamental recognition amounts to disrespect and the emergence social pathologies that manifest in environmental predicaments.

(2) *The recognition of the ways nature and the environment is integrated in the multifaceted dimension of human life—domestic, social, cultural, economic, political, and religious—the intersubjective frameworks of meaning on which nature finds articulation in human experience.* An environmental ethics based on social recognition is a multifaceted human concern for praxis in different levels from which social pathologies could take form. Thus, in order to identify these pathologies it is imperative to have the third.

(3) *The removal of the barriers of articulation and communication.* This is important in a two-fold manner: first, various experiences of disrespect against the environment can be articulated free from coercion, and second it paves the way for greater democratic participation and inclusion to decision making processes in the identification of potential solutions to environmental concerns from previously excluded groups or communities. In this way cultural values become transparent to itself and to others.

(4) *The reflective analysis and internal critique of cultural values upon exposure to "other" values.* This

imperative arises out of one culture's encounter with another set of norms and values outside of its epistemological boundaries. This is fruitful likewise in two ways: while it effects transformation from within it through the reevaluation of the legitimacy of cultural claims, it prepares itself as well for a more engaged participation in problem solving and decision making processes in matters of environmental concerns through its widening and further enrichment.

(5) *The reorientation of the institutions of freedom to the enhancement of physical well-being of persons and a healthy environmental identity.* To have greater normativity, ethical action towards the environment must be incorporated into the different institutions of freedom—in personal relationships, market economy and political will-formation. This allows for different levels of praxis in which the environment could be reintegrated to the promotion of the well-being of persons.

Conclusion

The distinctive feature of an environmental ethics drawn from Honneth's recognition theory is the joint identification of the clear place that persons' relationship with nature takes within a moral purview and of the fields of practical action in which ethical actions towards the environment could be reoriented. This paper extended the coverage of personal integrity to include persons' relationship with nature and the environment from the standpoint of physical well-being—that a full recognition of persons that contribute to the formation of their individual identity must be congruent to the recognition of their "environmental identity." The failure or the withholding of this complete recognition reverts to what Honneth calls as reification—the forgetfulness of the fundamental and antecedent recognition that behavioural expressions of persons asks from us. It was also shown that the simultaneous effect of reification is the reduction of peoples' cultural modes of relating with nature to invisibility. Environmental ethics defined within the contours of the theory of recognition puts premium on the task of social critique in order for experiences of reification to be diagnosed and articulated, then identify measures for emancipative action. The identified social pathology in the sphere of market economy that has contributed to a global reification of peoples' relationship with the environment, undermining their well-being is capitalism. Capitalism has crept into the various spheres of human activity. Its imperturbable instrumental rationality and indifference to the environment for the maintenance of cash flow has caused environmental crises in a global scale. But while capitalism as a system cannot be radically abolished, a recognition-based ethics shows us the multifaceted means for practical action in the same way that capitalism's mechanism has infiltrated the different institutions of social life. The environment as a moral-practical concern demands a re-orientation of our personal relationships, market economy and democratic political will-formation—the institutions of social freedom—to one which recognizes the integral place of caring for the environment in a flourishing life that everyone deserves.

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Editorial address, and all correspondence to:

Prof. Darryl Macer, Ph.D., Hon.D.

President, American University of Sovereign Nations (AUSN), <https://www.ausovereignnations.org>

Email: darryl@eubios.info

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