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Humanities

Ethical Responsibilities of the Healthcare System to Pandemics

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Abstract

As most of the civilization witnessed during the COVID-19 pandemic, the healthcare system faced challenges that can affect how it will respond to future pandemics. It is the aim of this study to identify healthcare issues that will affect future pandemics such as the patient-healthcare worker ratio and inefficient medical documentation. In addition, data gathered from this paper are both from empirical studies and the author's works and observations in the healthcare industry. These bioethical responsibilities reflect the quality of the health systems in providing medical treatments to its patients. It has been shown that the lack of patient-medical worker ratio during the COVID-19 pandemic was an issue for patient safety. Inefficient medical documentation has also been shown to affect the quality of medical providers' interaction with their patients.

Keywords

healthcare, healthcare systems, bioethics, philosophy, COVID19, COVID, SARS-CoV-2

Introduction

Humans have been in a constant war against infectious diseases. As the medical field moves forward to counter these microorganisms, they also advance in their own way. This has contributed to the emergence of pandemics like COVID-19. As most of civilization witnessed during the COVID-19 pandemic, the healthcare system faced challenges that can

affect how it will respond to future pandemics. This paper will try to examine the effects of the patient-provider ratio and provider's administrative task and how this affects patient care in the difficulties posed by the COVID-19 pandemic.

Humanity has created wonders throughout the history of infectious diseases such as the discovery of vaccines and antibiotics. Immunization has been a central part of our healthcare system, internationally. Vaccines have eradicated diseases such as smallpox in the whole world, and polio in most westernized countries. Getting vaccinated is just one of the many examples of responsibilities we have as a civilization, but is immunization enough? The early phases of any pandemic have one common challenge, and that is to prevent its spread to the epidemic or pandemic level. Furthermore, this obstacle reflects the ethical responsibilities each one of us has in the prevention of a globally spread infection.

The Spanish-flu pandemic killed millions of people worldwide, the Ebola epidemic is still a problem to look out for, and many more infectious diseases happened that cost people their lives. The current COVID-19 pandemic has killed millions of people already in just two years and still counting, since it started in late 2019. This battle against infectious diseases has contributed to the difficulties of the healthcare system.

A Brief History of Infectious Diseases

From 1918 to 1920, Spanish flu had a world death toll of between 24.7 and 39.3 million. This Spanish influenza pandemic had three waves with a death rate of 5.2 per thousand people. This pandemic was not taken seriously by epidemiologists not until 1919, a year later the outbreak (Boianovsky & Erreygers, 2021). It took scientists some time to recognize that it was a virus and not a bacterium. In addition, the statistics gathered by the United States Public Health Services were poor in quality. However, the data collected was still able to make conclusions about how fast the virus was spreading during its outbreak. In the business sector during this pandemic, none of the journals of economists

took the Spanish flu seriously, which led to labor shortages and economic difficulties (Boianovsky & Erreygers, 2021).

Next, the HIV/AIDS epidemic started to circulate rumors about the virus. Rumors such as only gay people can get AIDS, or women are tricking men to have sex with them so they can transmit AIDS. At one point, the rumor shifted and claimed that the CIA developed a strategy to kill off African Americans and gays. This is a major problem in pandemics as rumors that lacks evidence and can circulate and cause fear to the whole population (Heller, 2015).

In December 2019, a virus that is later known as SARS-CoV-2 was first reported in Wuhan, China (CDC, 2022). In January 2020, the Centers for Diseases Control and Prevention heard about the outbreak and activated Center Level Response while Chinese authorities isolated the virus in their country (CDC, 2022). On the last day of January 2020, the World Health Organization declared a Public Health Emergency of International Concern. Two days after the World Health Organization declared it as a pandemic on March 11, 2020, the U.S declared it a nationwide emergency, followed by a shutdown for most U.S. states to prevent the spread (CDC, 2022).

The U.S. implemented lockdowns, social distancing, testing, tracing, and mask mandates. According to Haseltine (2021), some other countries like Australia had more restrictions such as additional hotel quarantine systems and highly monitored quarantine restrictions. For instance, citizens from international travel coming back to Australia would have to quarantine in their houses or hotel which are under surveillance by the police department. In addition, their cities' borders were closed from time to time such as during high alert situations, which enabled them to reopen in just two months (Haseltine, 2021). Australia had 5,000 deaths out of 3.3 million COVID-19 cases, while the U.S. has 953,000 deaths out of 79 million cases. (Haseltine, 2021).

This is not to downgrade the U.S. healthcare system, because after all there are more people in America. However, Australia's death rate is

much lower compared to the U.S. and this is probably what is happening to other countries as well who developed public health policies like Australia. In fact, many of the cases in Australia are from their hotel quarantine system patients (Haseltine, 2021). The consequence of Australia's rule-utilitarian decision against COVID-19 produced a better outcome for people in its country. The U.S. mostly initiated self-report quarantines once tested positive or showed symptoms common to COVID-19 with minimal restrictions such as not being able to go to work. The U.S. closed international borders but did not impose restrictions within borders so, even if an individual had the virus, they could still travel across states with SARS-CoV-2, furthering the spread of COVID-19.

There is one thing in common about all these pandemics, and that is the lack of integration of health policies regarding infectious diseases. For instance, policies from America might not be fully integrated into a state-by-state response. This lack of integration in the public health system reflects the healthcare system discrepancies observed during the COVID-19 pandemic, such as healthcare worker and hospital bed shortages. What are the obligations of the healthcare system in pandemics like COVID-19? As individuals, what can we do to assist public health in the community? This paper aims to understand some of the challenges in the healthcare field that might affect its response to pandemics like COVID-19.

Patient-provider Ratio & Documentation

I currently work at the Veterans Affairs Medical Center in Indianapolis where the main population are the military veteran's population. Based on my observations and research, the issues of patient-provider ratio and time-consuming administrative documentation has been a hurdle for many healthcare workers. Patient-healthcare worker ratio is a policy to promote patient safety for the majority of the patients. In Immanuel Kant's consequentialist theory rule-utilitarianism claims that for any situation, one must choose the action that will utilize the greatest good for everyone involved (DeGeazia, Mappes & Brand-Ballard, 2011). Since this is a consequentialist theory, it is important to examine how an action

will benefit everyone in that specific situation, such as in the COVID-19 pandemic. The mask mandates, quarantines, and vaccinations surely benefited the majority of people, but there are some unnoticeable problems most people are not aware of such as the patient-staff ratio.

The healthcare system has policies dedicated to the best outcome of patient care. However, in the wake of SARS-CoV-2, the healthcare system was already short-staffed with healthcare workers. For instance, the nurse-patient ratio even before COVID-19 was already not efficient for the proper implementation of patient safety. If a nurse has 8 to 10 patients to take care of in a day, many possible errors can happen like medication errors, fall risk, etc. According to the Faculty of Intensive Care Medicine (FICM), the standard nurse-patient ratio must be based on the level of the patient's needs. For instance, a ventilated and critically ill patient is considered level 3, a state that must be provided by a 1:1 nurse-patient ratio. In the COVID-10 pandemic, however, this ratio was not properly implemented as some nurses take care of up to 6 critically ill patients (Hill, 2020).

The nurse-patient ratio is one of many policies the healthcare system values for the best of the majority. However, the patient-ratio policy is still a big issue in healthcare today and many medical workers cannot attain the needs of all their patients. Thus, the policy was not utilized for the benefit of critically ill patients. The consequence for the goodness of the majority was probably insufficient in tackling the patient-provider problem for most hospitals during the height of the COVID-19 pandemic.

Furthermore, documentation in the healthcare system is another struggle medical workers face in their daily patient interactions. Documentation is important to keep records of daily medical procedures in the hospital to communicate with other healthcare workers. For instance, notes, medication, lab tests, etc. are all documented every day by many medical workers to fully integrate information into the whole medical team. A common healthcare provider saying in the hospital I work at is "If it's

not documented, it never happened," which implies the strict implementation of patient documentation. However, documentation is also taking too much time in exchange for the quality of patient-care interaction. According to a study by the National Institute of Health (NIH), two-thirds of internal medicine residents spent four hours of their day on administrative tasks, and for every three minutes spent with a patient, one min was dedicated to documentation (Siegler, Patel, & Dine, 2015).

This is not to say that documentation is not important, but are healthcare workers documenting efficiently while sparing adequate quality time for their patients? To elaborate more, if an internal medicine doctor has 12 COVID patients in a 10-hour day and 4 hours of this is spent documenting, that means each patient only gets 30 minutes of patient-physician interaction per day. In this case, the benefit of the majority according to rule-utilitarianism was not maintained from the inefficient administrative task and patient-physician interaction. Are 30 minutes enough to help someone in a critical stage in their life? Arguably, patient documentation must be updated to provide quality care for patients without sacrificing too much time for patient-provider interaction.

Policies such as medical documentation are arguably important, especially in imposing goals that will contribute to the greater good of all the patients. However, humanity is not all about following the greatest good for the majority because in that sense it is disregarding other people who did not benefit from that action. The patient documentation or the health record system is a good utility to keep records of patient daily procedures, but disregards other duties that healthcare providers must provide to their patients. The outcome for the majority might hurt other people in the process, especially when other people's needs are forgotten for the sake of the goodness of the majority.

Healthcare Worker Duties

The COVID-19 pandemic was difficult for every country and for the majority of the world's population. Even though it was the same disease, people had different struggles in their lives. For instance, the health-

care system and healthcare workers faced a conflict of duties during the COVID-19 pandemic. SARS-CoV-2 created new challenges at the VA Medical Center, and I can see this by the time I park my car in the parking lot until going inside the hospital. The entry was stricter allowing only a couple of visitors, and sometimes family members could not visit their loved ones who were infected with COVID. There were times hospital beds were running out because patient capacity was almost full, mostly due to SARS-CoV-2. Surgeries were being canceled due to high COVID risk as most patients in the VA Medical Center are in their old age. Only emergency surgeries were optimized, prioritizing the most needed ones. During the heights of COVID-19, fluctuations of decisions were a struggle in deciding to prioritize what is needed in difficult and unexpected situations.

In W.D. Ross non-consequentialist, prima facie duty, which claims that people face the unavoidable conflict of duties in their daily lives, and they must prioritize the decision that is needed the most in that situation, even if they must override other duties (DeGeazia, Mappes & Brand-Ballard, 2011). At the individual level, rules cannot be absolute because each people have different circumstances in their life. A surgeon canceling surgery after a patient tested positive for SARS-CoV-2 is a tough decision that must be made. The risk of performing surgery while having a positive COVID result is still higher than the result of the surgery. Physicians usually do not cancel surgeries unless some problems arise that override their decisions. In addition, nurses had to cover co-workers who had been sick from COVID, which is not efficient for the goal of patient safety since the patient-nurse ratio is affected. The lack of medical employees increases the risk of unmonitored patient risk while creating a conflict of duties for each healthcare worker.

If the public health system has its own entity, should it be entitled to have its own character? After all, the healthcare system and its employees have a common goal to save people. A professional worker has core beliefs and acts on her or his responsibilities. For instance, a teacher's core belief is to teach children quality education, and so other professionals act on their core beliefs. Since the healthcare field has its own be-

liefs and policies, it should also be responsible for its action as a system. If a system is its own entity with core values as a responsible individual, then it should be responsible for the lives of patients in the healthcare system.

If we emphasize more utilitarianism, such as healthcare policies that are supposed to help most people, it might disregard other people who might need that help in the future. For instance, the lockdown was efficient in utilitarianism by preventing most infections from spreading. On the other hand, if we emphasized more of Ross's prima facie duties, it might disregard future consequences of that action to other people, like for an individual who decides to self-quarantine because he or she felt the duty to protect other people from getting sick. However, if one carefully examines different circumstances such as medical history, one will see how public health recommendations such as lockdown and healthcare workers' duties are not absolute in their own way.

Virtue Ethics

Physical inactivity due to lockdowns was studied during the height of the pandemic. In a study from the American Journal of Physiology, researchers found an increase in social isolation or sedentary behavior associated with an increase in physical inactivity (Pecanha et al., 2020). Furthermore, it is well-known in medicine that sedentism increases the risk of cardiovascular disease because of a lack of exercise and other bodily movements (Pecanha et al., 2020).

The COVID-19 pandemic created new challenges in the healthcare system such as patient ratio and inefficient administrative tasks mentioned above. Social isolation did help most people but also created new problems in the healthcare system such as the increase in the risk of cardiovascular disease due to physical inactivity (Pecanha et al., 2020). Value ethics might give a different perspective regarding society's COVID-19 response. Value ethics are moral traits such as being truthful, kind, courageous, compassionate, and sincere actions towards ourselves and other people. As mentioned earlier, if health institutions are entities on their own and have beliefs and responsibilities, they should also have moral-

ly valued character such as being kind and compassionate as described above.

Another example that the healthcare system is an entity and responsible is the case of nurse RaDonda Vaught. In recent news by CBS (2022), a nurse was found guilty of a criminal neglect homicide. The nurse was ordered to get anti-anxiety medication, Versed, from the automatic dispensing cabinet, but the nurse did not find the medication in the automatic dispensing cabinet. Vaught has overrode the system to get the drug from a different drug compartment, but accidentally grabbed the wrong medication Vecuronium a muscle relaxant. This drug eventually killed the patient. It was noted that the hospital recently changed its electronic record system which led to delays in retrieving medications, and there was no scanner to scan the medication against the patient's I.D. bracelet (CBS News, 2022).

In this report, it is clear that Nurse Vaught's inattention in not double-checking the medication and overriding the system contributed to the death of her patient (CBS News, 2022). However, if one carefully examines the verdict and the report, it was not just negligence and inattention of the nurse's duty, but also an inefficient system of this healthcare institution. The drug that was supposed to be in the automated dispensing cabinet was not there in the first place. There was no scanner to scan the medication against the patient's I.D. to ensure that the drug belongs to the patient. As mentioned, the healthcare system is its own entity and is then responsible for patients' lives like its healthcare workers. The case of nurse Vaught is mentioned in this study to emphasize that the healthcare system is just as responsible as its healthcare workers in the lives of their patients.

Integrative Bioethics & Propose Changes

The healthcare field is such a complex and constantly changing environment. As the external world changes, people, and their health habits can also change. Treatments that are effective today might not be effective five years from now. Almost every year, providers must keep up with medical research regarding their practice to deliver updated quality

care for their patients. In addition, microorganisms such as bacteria and viruses also gain the capability to keep up with the current medical advancements. For instance, the influenza virus constantly changes its surface antigens (receptors of the virus) because they are highly mutable. It is almost impossible to eradicate influenza because vaccines or human antibodies that worked this year might not work on next year's new strain of influenza (Russel, 2011).

As one can see, healthcare is a changing field, and no policies or ethical principles are effective on their own. The patient-provider ratio, administrative documentation, and COVID-19 mandates cannot stand on their own. In the same manner, Kant's rule-utilitarianism, W.D. Ross prima facie duty, and virtue ethics cannot stand on their own in the world of health systems. The integration of different perspectives or principles in the healthcare industry must be implemented efficiently, rather than functioning as separate from each other.

The unsafe patient-medical worker ratio and inefficient documentation mentioned in this paper is a multidimensional problem that must be addressed properly. For instance, it could be that colleges are not efficient in their curriculums, prolonging healthcare students' educational timeline. It could be that medical schools are just becoming more expensive and students, especially those who do not have financial support, might choose to enter a different career with the same wage as healthcare workers. It could also be that the population is increasing, and the population of healthcare workers could not keep up with the increasing demand. It could also be that insurance companies have limitations on how much healthcare employees they can only pay for each patient. Lastly, it might be that insurance companies are putting strict rules on medical workers contributing to inefficient documentation. All of these are possible contributors to the shortage of healthcare workers and inefficient medical documentation.

Either way, one will notice that this is more of a systemic problem rather than an individual healthcare worker alone. To solve the patient-medical worker ratio, it might be best to possibly reformat the college curricu-

lum for both nursing and medical school to lessen the amount spent in education. It could also be helpful to lower tuition or provide financial support to attract more healthcare workers to a country. For instance, the U.S Department of Veterans Affairs (2020) has Pathways Internship Program that allows undergraduate students to gain experience and long-term training. In this program, students can learn about different healthcare career pathways, and it does not have to be related to their major in college. The benefit of this is that workers are well-trained while spending less time on additional schooling (U.S Department of Veterans Affairs, 2020).

In addition, the healthcare documentation might be reduced to a more efficient and accurate patient care outcome. For instance, paperwork and approvals during life-threatening situations can affect patient care outcomes. The Department of Veterans Affairs launched a new Electronic Health Record System this year, enabling medical providers at the VA facilities to have access to patient documentation anywhere in the world. This new step, however, has only been implemented in three states: Washington, Oregon, and Idaho to test its effectiveness (Department of Veterans Affairs, 2022).

Conclusion

The negative effects of pandemics like COVID-19 have been difficult for the healthcare system, contributing to challenges such as in the patient-provider ratio and inefficient administrative tasks. Patient-medical worker ratio has been shown to impact the quality of time spent on patients. The administrative work has also been shown to reduce the amount of time spent on patient care during the COVID-19 pandemic. This paper highlights the previous problem the healthcare system faced before COVID-19 but also gave importance to how discrepancies in the healthcare system can affect patient care during pandemics.

In addition, the use of ethical principles such as utilitarianism, prima facie duties, and virtue ethics has been helpful to decipher the biopsychosocial responsibility of the healthcare system to people's lives in the

COVID-19 pandemic. This research, however, only examined trereponreponsibilities based on the observed healthcare issues from the author's institution. Data gathered are mostly the integration of empirical data from different valid journals to support this paper. Future research must collect data from different institutions, and it is recommended to use other methods to examine the discrepancies in the healthcare system during COVID-19. Lastly, future research must further examine other factors that contributed to the unexamined responsibilities of the healthcare system that can have an impact on pandemics like COVID-19.

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