COVID-19 – ETHICAL LEGACIES IN THE UK FROM THE FIRST TWO WAVES

During the first UK wave of the pandemic, there were two areas of immediate ethical concern for the medical profession. The first was the possibility that life-saving resources could be overwhelmed. Early reports from hospitals in the Italian city of Bergamo suggested that ventilatory support might need rationing and emergency ‘battlefield’ triage was a real possibility.1 In the UK, several professional bodies, including the British Medical Association and the Royal College of Physicians rapidly developed guidance for doctors should triage become a reality.2 The second issue was the acute shortage of personal protective equipment (PPE). Where doctors were unable to protect their patients — and themselves — from the risk of COVID-19, ethical challenges emerged. Ordinarily, doctors and patients do not present risks of significant harm to each other. To shift to a position where every patient — and every health professional — could potentially be a threat, presented serious clinical and ethical challenges. To treat with inadequate PPE, so options for mitigating harms are radically reduced, deepens the challenges. Among the questions the BMA wrestled with was the extent of doctors’ duties to treat infected or potentially infected patients in the absence of effective PPE. The BMA was clear that despite obligations to treat, medicine is not a self-sacrificing profession: there were limits to the risk doctors could be required to expose themselves to.3 These issues no longer seem so pressing. In the UK at least, there is adequate PPE and with the second wave, there is an equal number of vaccines, which is less likely that triage will be required in the UK. But as those concerns have receded so other ethical questions have arisen. Among them is a cluster of issues associated with what might be called COVID-19’s indirect harms. Understandably, in response to the demands of an unknown and deadly pandemic, the initial focus was on controlling the infection. Interrupting the spread of the virus was essential and traditional public health methods — social distancing of one form or another — took priority. But these methods, and continue to have, significant costs. Interrupting face-to-face contact meant not just closing pubs and restaurants. It meant that people were dying alone, with significant, if hard-to-assess harms both to themselves and to those close to them. Vulnerable elderly patients were sequestered without visit for extended periods of time. Funerals went minimally attended. Places of worship — sources of great succour for some — were closed. Many of the rituals associated with the beginnings and ends of life were interrupted. These are all moral harms and need to be considered when asking if social distancing measures continue to be appropriate.

As the fog of COVID-19 has started to lift it has become clear that the harms of the pandemic have not fallen equally.4 Socially determined inequalities in health in the UK preceded the pandemic. But COVID-19 has both savagely illuminated them and, to an undetermined extent, deepened them. Social distancing was far harder for those in multi-occupancy houses. For those working outside the information economy — mostly those in manual or direct customer facing employment — homeworking was seldom possible. These jobs are often among the more poorly paid, exposing those on lower incomes to a greater risk of infection. Those in the ‘gig’ economy, who seldom have access to paid leave or other benefits of more stable forms of employment, have been particularly vulnerable. If they do not work they do not get paid, and pressure to work either when unwell, or in the face of social distancing requirements, can be intense. As with earlier pandemics, data suggest significant inequalities between socio-economic groups and more and less affluent neighbourhoods.5 Given that non-Covid-related health burdens were already inequitably distributed, the suspension of large amounts of non-emergency treatment is likely to have further deepened those pre-existing inequalities. Those with underlying morbidities were more likely to be harmed by the pandemic. Further, without timely treatment, those underlying morbidities were likely to become more burdensome still.

The pandemic has also had a disproportionate impact on people from certain ethnicities. According to a report by Public Health England, after accounting for sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared with people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10% and 50% higher risk of death when compared with White British.6 The same report also suggests that these differences are strongly associated with higher comorbidities and levels of obesity, further pointing to the importance of underlying health inequalities.

Although we remain in thrall to this deadly pandemic, early reflection suggests that in addition to the immediate and urgent ethical challenges COVID-19 presented, there will be an ongoing legacy of critical ethical issues requiring close public scrutiny.

MYANMAR: TARGETING OF MEDICAL PROFESSIONALS

Like much of the world, the BMA has watched the unfolding situation in Myanmar with increasing concern. On 1 February 2021, the Myanmar Armed Forces, the Tatmadaw, seized control of the government. They have detained the democratically elected political leaders of the country, including Aung San Suu Kyi, as well as key figures in civil society. Many have protested the coup and medical professionals have been at the forefront, setting up their practices in makeshift health centres and clinics instead of government hospitals. They have been specifically targeted by Myanmar security forces and violently discouraged from treating injured protestors, with many health workers now no longer wearing uniforms to avoid harassment from the Tatmadaw.7

The actions of the Myanmar military amount to serious breaches of international law. Not only is the imprisoning, assault and murder of protestors a violation of the human rights to free speech and free assembly, guaranteed in the 1948 Universal Declaration of Human Rights, but the targeting of medical professionals and interfering in their activities is an abuse of the principle of medical neutrality, enshrined in the Fourth Geneva Convention.8

Not only is this a violation of the rights of doctors and other colleagues, it is also detrimental to the healthcare of patients, diminishing their right to the highest standard of health which is guaranteed by the International Covenant on Economic, Social and Cultural Rights which was ratified by Myanmar in 2017. The provision of care has suffered: medical treatment is being provided in makeshift health centres with limited resources and facilities, while actions by the Myanmar military, such as cutting off internet access for large sectors of the country, further inhibit the provision of healthcare. It should also be noted that the coup will further harm Myanmar’s Rohingya population, who are already subject to a genocide from the Tatmadaw, and whose well-being will only suffer further now all organs of the Myanmar government are back under military control.9
The BMA has been contacted by a number of BMA members and activists in Myanmar requesting the Association look to provide support for medical professionals in Myanmar who are being targeted by the security forces there. A piece has been written for the British Medical Journal to raise awareness, the BMA has written to the Foreign Secretary requesting that coordinated international action be explored to oppose the human rights abuses of medical professionals, and a joint statement of solidarity with several UK royal medical colleges and other organisations representative of medical professionals has been published, which has collated resources that may be of use to those from abroad looking to offer support in Myanmar and for healthcare professionals in Myanmar also.

CHILDREN AND YOUNG PEOPLE - PUBERTY BLOCKERS

Previously, we highlighted a Judicial Review concerning whether a child or young person, who is experiencing gender dysphoria, has the ability to understand the consequences of taking puberty blockers to be able to give consent to the medical treatment. An appeal is now listed for June 2021.

Subsequently, a further judgement has been handed down – this time relating to whether parents can consent to children and young people being given puberty blockers for gender dysphoria. A mother of a 15-year-old sought a declaration that she and the child’s father had the ability in law to consent to the administration of puberty blockers (PB). The application was made in the light of the Bell v The Tavistock judgement, which had not considered whether parents could consent.

The daughter had been taking PBs since July 2019 and her next prescription was due in April 2021. There was ‘unanimity between the clinicians, the parents and (the daughter)…that she should continue to be prescribed PBs.’

Mrs Justice Lieven noted that whether or not the daughter was ‘Gillick competent to make the decision about PBs, her parents retain the parental right to consent to that treatment.’

Justice Lieven further concluded that ‘It is apparent from Bell that PBs raise unique ethical issues. However… I am wary of the Court becoming too involved in highly complex moral and ethical issues on a generalised, rather than case specific, basis’ and where there was not clinical consensus and ‘division of clinical and ethical views has become highly polarised…These are precisely the type of matters which are best assessed in a regulatory and academic setting and not through litigation.’

Shortly after this judgement was handed down, NICE (National Institute for Health and Care Excellence) published two relevant clinical reviews:

► to assess the evidence for the clinical effectiveness, safety and cost-effectiveness of gonadotrophin releasing hormone (GnRH) analogues for children and adolescents aged 18 years or under with gender dysphoria; and

► to assess the evidence for the clinical effectiveness, safety and cost-effectiveness of gender-affirming hormones for children and adolescents aged 18 years or under with gender dysphoria.

Neither review included recommendations but will now be considered as part of a wider review by NHS England into NHS gender identity services for children and young people.

Dominic Nordcliffe-Brown, Sophie Brannan, Martin Davies, Veronica English, Rebecca Mussell, Julian C Sheather

Medical Ethics, British Medical Association, London, UK

Correspondence to Dominic Nordcliffe-Brown, British Medical Association, London, UK;

domnicordiffie-brown@bma.org.uk

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