Conference 2021 was held on 24th July which focused on Innovations in Primary Care. Speakers presented the latest developments in digital health, pharmacogenomics and novel therapeutics relevant to primary care. This opened many new conversations and potential collaborations between primary care practitioners and the providers of these innovative solutions, for the betterment of patient care during COVID-19 and beyond.

One of the challenges we faced was improving engagement among participants and bridging the distance of the virtual format. Aside from keeping updated on latest developments, attending CME events often provides treasured opportunities to catch up with old friends and interact with new colleagues to form collaborations for patient care.

We sought to create a virtual experience that provided attendees with similar opportunities by developing new modules with AskDr to facilitate forum-style interactions between the attendees and speakers in the lead up to the event as well as during the event. These were organised in virtual micro-forums along with an asynchronous poster presentation portal for health innovations submitted from researchers and start-ups participating in this conference. These innovations served to catalogue discussions and extend the long-tail impact of CME sessions through continued access, opportunities for interactions, and partnerships post-events.

As the pandemic rages on, many of us in primary care have started to see patients present as a result of the impact of prolonged social restrictions on mental health and wellness, with the latter extending to individual fitness given the closure of gyms and other facilities, women's health as well as men's health. In the next iteration of the conference, GP+ co-operative plans to curate topics that will address these challenges, for sharing of best practices in primary care to address them. We hope this will be in the interest of our fellow colleagues and we look forward to your continued support!

CM

Difficulties and Ethical Issues during COVID-19 Pandemic: *A FP's View*

by Dr Ng Chee Lian Lawrence, FCFP(S), Editorial Team Member (Team A)

Aim: To stimulate readers to think about ethical aspects of care, especially during the early days of the pandemic in 2020. Articles such as this do not make conclusions for the reader. It can only point the direction and it is up to the student or reader to think through the issues and the reasoning. He can then make his own decisions and form his own views. Secondly, it is a starting point for research ideas in Singapore about our experiences, solutions and public health policies related to COVID-19 and future pandemics.

Abbreviations
HCWs: healthcare workers
GPs: general practitioners
PPE: personal protective equipment
Swab: refers to swab for diagnostic testing of COVID
PHPC: Public health preparedness clinics

In Singapore, as GPs, we are located in housing estates, polyclinics or shopping centres. Unlike hospitals, we are much closer to the ground. We don't have layers of bureaucracy to shield us from the unhappiness of the public on the ground. It can be stressful when unhappy things happen unexpectedly in the clinic. (1)

As in the movie Wizard of Oz (1939), during the past 18 months, we have been caught up in a whirlwind with many things changing every day. Even while we cannot travel anywhere, the cheese has moved and carpets pulled from

(continued on the next page)

(continued from Page 17: Difficulties and Ethical Issues during COVID-19 Pandemic: A FP's View)

under our feet. Things are being torn apart by the winds of change and we wake up to realise that "We are not in Kansas anymore".

ETHICAL DILEMMAS

Especially in the early days of the pandemic, when there was uncertainty in patient care, doctors were told to "just do the best you can " without any help in ethical reasoning. (2)

As suggested by Sese, the priorities of HCWs seem to be torn between 2 competing ethical obligations which needs to be held in balance:

1. Duty to care. Relief of suffering, respect for rights and preferences of patients.
2. Duty to promote Equity and Equality in the distribution of the provision of care in society and the focus of public health services. (3)

Many of the issues encountered in this pandemic involve the balancing of rights, principles and values. In a French Cancer Centre, this conflict has been described as the Deontological vs Utilitarian approach. More than ever, we need greater ethical clarity in the decision-making process. Perhaps, a kind of "ethical watch" can help promote collegiality by meeting with ethics units for, say, each Primary Care Network of GPs or each polyclinic cluster. This may help in dealing with isolation, with the greater need for collegiality & interaction with fellow doctors. (4)

Traditionally, English-language biomedical ethics consists of 4 principles with autonomy being the crux of most ethical discussions since freedom of the individual is most highly cherished in the west and western literature dominates the world medical landscape. The other three principles are often not as contentious and are less attractive and less volatile but no less important: beneficence (do good), non-maleficence (do no harm to others) and, particularly relevant in a pandemic, social justice. As found in an Ethiopian nurses' review article, these traditional 4 basic principles of biomedical ethics, when challenged by the severe stresses of the COVID-19 pandemic, seem to create more ethical difficulties compared to during normal times or in less infectious disease situations. (5)

THE ASIAN ETHICAL APPROACH - A VIABLE ALTERNATIVE

Person-centred approach seems to have been overtaken by population-health approach. The (utilitarian) approach of "greatest good for the greatest number" seems to blanket over the approach that "everyone has the right to the best healthcare". It seems these 4 principles need to be balanced by another principle of relational ethics which is commonly found in East Asian Confucian societies, which does not emphasize autonomy. One author (Li) has "criticised Western discourses for their one-dimensional emphasis on individual autonomy and the idea of free choice… in which individuals can be separated from social context, relationships and even from… the human condition that is vital to human life, such as mutual care". Rosker went on to describe the relation between different models of ethics and their impact on crisis solution strategies against current and future pandemics, some ethical models from Confucian philosophy. (6)

All over the world, the once-inviolable patient-centred medicine is being prioritised below the health of the community. This change is taking place even while we are unwilling to admit it. (7)

Most Asian HCWs are less disturbed by this change as compared to Westerners. Traditionally, Asians give priority to family and society, giving social harmony and societal wellbeing a position equal to or even above the interest of the individual self. This is a topic for another article, but it is a wonder how the western priority of autonomy crept into Asian medical ethics and took top position on the totem pole. In fact, how did the 4 pillars of Beauchamp and Childress stealthily crept into and subjugated our Asian biomedical-ethical thinking which used to be family-centric (medical decision-making used to be a family-oriented affair) and the individual as a unit of society, rather than as an island unto himself. This has a great impact on how we approach end-of-life issues and on how Advance Care Planning is to be conducted and recorded. In a pandemic where so many are hospitalized, where relatives are not allowed to be present at the bedside of a loved one dying of COVID, this is longer an academic exercise but a matter of great relevance and urgency. No one knows who is the next victim of COVID even with vaccinations completed. Anyone of us can be the next person to die with a confused mixture of medical ethics, neither here nor there.

Another term which helps in ethical reasoning amidst the clash of traditional ethical principles is the ethical "lens of solidarity. Solidarity arises from a recognition of similarity in mutual vulnerability and interdependence and manifests as shared practices that reflect a collective commitment to carry costs to assist others for a common good. (8)

In fact, Solidarity is the name of one of the supplementary budgets in one of the relief budgets by the Singapore government. (9)

DO ETHICAL PRINCIPLES APPLY TO THE PUBLIC AS WELL?

The member of the public also has ethical duties. They may carry and spread the virus and, hence, are active players in a pandemic. Before falling ill, they are not passive recipients

of care. They can go out there and do some damage unwittingly. We need to recognise that anyone's behaviour or refusal to behave has implications for their health and that of others. Hence, it is no longer "live free or die" but rather "live free with the consequences to the health of others". If we apply the traditional principles of ethics, it will look something like this:

1. Beneficence: individuals acting for greater good by practising social distancing, accepting travel restrictions and wearing a mask.
2. Non-maleficence: individuals preventing harm from coming to others by not breaching stay-at-home orders
3. Autonomy: there are limits to an individual's freedom. In accepting these limits, individuals allow others to have greater freedom in the long run.
4. Justice: by practising the above, individuals are acting justly for the common good. (Goh LG. Personal communications 2020-07-03)

WILLINGNESS TO WORK
(Beesan Maraqua)

In a Palestine study about the willingness of HCWs to work, the author states that it is a common belief that those delivering healthcare have a strong obligation to perform, often in the face of personal danger. It is a duty that is enshrined in the professional code of conduct. (10)

However, in any emergency event involving contagion or contamination, as in the COVID19 pandemic, there is the potential to alter HCWs willingness to work for reasons such as increased workloads, shortage and low-quality PPEs, fatigue, ambiguous work settings, rapidly changing guidelines, fear of catching infections themselves or infecting their families and psychosocial burdens of the pandemic. Hence, there is an ethical dilemma in balancing their ethical duty to care against their fears and concerns of catching COVID-19 and spreading it to their patients and families, as well as coping with constantly changing recommendations which can increase such concerns. (10)

Some doctors refuse to see certain patients e.g. putting up a sign at their doors to tell patients with ARIs to go elsewhere to seek care. They discharge themselves from such work, causing others to carry the increased workloads. Fortunately, in Singapore, due to the past experience with SARS, we have a huge network of PHPC (outbreaks-prepared) clinics who have committed themselves to stay open to manage cases during an outbreak. Part of the agreement is that the government will provide them with essential resources such as PPE which helps to reassure and boost the morale of HCWs.

LEARNING FROM SOCIAL WORKERS ABOUT STRESS REACTIONS

In an article about ethical challenges to social workers (involving 54 countries), support from employers is vital and they need to monitor the levels of stress among staff.

Like GPs who have to deal with psychosocial issues of patients, during this pandemic, social workers have to listen to a lot of people crying. Closing of social work offices led to increased working from home which led to greater use of telephone counselling. However, clients may not have handphones or are unable to use technology. There is the loss of touch as a gesture of caring and reassurance. Social workers have expressed the need to engage in ethical reasoning in each case. Some have said that there was no colleague immediately available to consult or seek advice and support. (11)

PERCEIVED STRESSORS

In the Palestinian study, 72% of HCWs had increased anxiety and stress, due to many factors such as long gruelling hours and fear, lack of availability of nurseries during country-wide lockdowns, sick elderly parents at home who need home care. Women need special mention as they do the delicate balancing of work and family obligations, taking care of children and elderly parents at home. Some HCWs harbour feelings of being exploited due to long working hours, a lack of appreciation and recognition, "not even a word of thanks". (10)

It is important for employers and government bodies to note that there needs to be a recognition of HCWs with chronic or immunosuppressive disease who could or should have been relieved from certain duties since they are more vulnerable to severe illnesses if infected. (10) This is something older GPs and those with chronic diseases wished to express when all PHPC clinics were invited to participate in "swab-and-send-home" (SASH) testing which increases the risk of contracting the virus at work.

Most felt the duty to work but raised concerns about their safety, raised questions about their allegiance to the Hippocratic oath and principles under which HCWs generally conduct themselves. Most HCWs wanted support during COVID-19; "(we need you to) hear me, protect me, support me, care for me". (10) Those with a lower perception of stress were more willing to work. Emotional turmoil is mitigated by support and institutional programs which address HCWs mental health issues and focus on their psychosocial well-being to build their resilience and reduce the magnitude of expected stress on the quality of healthcare services (WHO recommendation).

In the article about spiritual, moral and ethical dilemmas, the author wrote about doctors who face the predicament of confusion of their roles as doctors, the duty of following orders vs following conscience, what is right and what is wrong, what is one's role in this situation? (12)

(continued on the next page)

(continued from Page 19: Difficulties and Ethical Issues during COVID-19 Pandemic: A FP's View)

In fact, one may ask what is one's purpose in life and in work? Feelings of frustration and demoralization may set in. What is expected from the system? HCWs tend to indulge in ruminations about the conflicts and dilemmas, leading to a sense of helplessness and lack of motivation, loss of meaning, indecisiveness, fatigue and burnout. (12)

WE NEED SUPPORT BECAUSE WE ARE NOT SUPER-HEROES BUT HUMAN

Writing about professional life during the pandemic, the author said people tend to see medical staff as "tireless". Repeatedly working in isolation for long durations "created a sense of collective hysteria and a sense of disappointment". Uncertainty about the virus, increased workload, longer working hours, lack of PPE, all add to the psychological pressure. We use words like "heroes", implying a sense of invincibility, as an appreciation or a mark of respect. But these selfless acts can have long term negative consequences and sequelae. (13)

We are only human and, as humans, we have limits to our physical and psychological capacity for overloading. In the long term, this can lead to fear, frustration and exhaustion. As the pandemic drags on, and post pandemic, we need to plan and provide for a) mental healthcare b) for the backlog of serious cases now needing care c) for an exhausted and disheartened medical workforce. (14)

Here in Singapore, collegial support is available such as from Primary Care Networks (PCNs) which are island-wide loose support groupings of private GP clinics coordinated by Agency for Integrated Care (AIC), informal WhatsApp chat groups and College of Family Physicians Singapore (CFPS) Wellness Webinars, held via Zoom app in the evenings. With such online support, it is possible for GPs working in relative isolation to have positive experiences: "huge sense of cooperation, we would work together as a team and support each other". It engenders a sense of "working together" vs "feeling alone and unsupported". (10) Hence, it is vital that GPs, especially the older and technophobic ones, avail themselves of a smartphone or a mobile device such as a tablet to stay in touch with their fellow doctors and Government and governmental agencies.

DEFERMENT OF NON-COVID CARE

Attention, time and resources have been diverted away from patients with chronic diseases, non-communicable diseases and palliative care for terminally ill patients, vaccinations, non-emergency etc. It seems that we could have been neglecting other persons' suffering and ignoring their needs. This questions the values and compassion of the professional. Living with such stress at work can lead to depression, anxiety, sleep deprivation and post-traumatic stress disorder. In doing their job, they hope not to be exposed to legal liability and that they still have the public's trust. (5)

During a severe lockdown (called "circuit breaker" in Singapore) in 2020, the provision of non-critical, non-COVID care had to be deferred. The intention of placing these cases after COVID-19 cases is to preserve resources (PPE, ventilators and un-infected HCWs). Areas of care affected include diagnostic, therapeutic and supportive care. The deferment of non-emergency care led to the hastened implementation of alternative forms of delivery of care such as teleconsultation and medication home delivery. (14)

PRIVATE CLINICS FINANCIAL SUSTAINABILITY

Many healthcare organizations (HCOs) such as clinics and hospitals are privately-owned and funded. Ironically, its services are considered essential to the public. Like any other private businesses, they need revenue to function at normal operating levels. This has been affected in 2 ways: a) to control the spread of COVID-19, especially during the Singapore-styled lockdown called "circuit breaker" in 2020, clinics and hospitals have to reduce or cease "non-essential" services they provide; these impacts negatively on their revenue and operating budget b) reduced ability of patients to pay due to loss of income from unemployment which gives them their healthcare coverage and insurance. Patients may be unwilling to seek care. They worry that they won't be able to afford the copay or deductibles. (14)

HCOs are expected to remain open to manage outbreaks despite high operating costs.

However, HCOs are at financial risk of having to shut down due to loss of revenue. Government needs to consider how to help HCOs survive and stay open to serve the community during a pandemic. However, HCOs are at financial risk of having to shut down precisely because of the pandemic causing financial distress. (14)

GP CLINICS AS A RING OF PROTECTION FOR GOV POLYCLINICS AN EMERGENCY DEPARTMENTS

Let's use the analogy of the sea. Without private GP clinics, the tsunami of sick people and those seeking testing will quickly overwhelm the polyclinics and emergency departments of the government. Overcrowding would be like overheating, causing the system to buckle under undue pressure. GP clinics are like the cooling towers of the damaged nuclear reactors of Fukushima. Knock out the cooling towers and the nuclear reactor will overheat and explode, adding the nuclear fallout as a second layer of damage to the first destruction inflicted by the tsunami. This is something all governments need to plan and prepare for: the long-term financial sustainability and support of private clinics and

hospitals to prevent them from being knocked out even before the true fight against an outbreak takes place. In Singapore, we are fortunate that the government had the funds to support the one thousand-strong GP-PHPC clinics with a substantial SGD$10,000 grant per clinic in 2020. (15)

Private clinics need to be seen as a resource to the nation just like government polyclinics. Private GP clinics form a protective ring around the government healthcare resources, saving these from being overrun. Governments should not play favourites, funding and supporting one and not the other. GP clinics should be seen as part of the defence at the coastline and they protect the nation inland. In the 16th century, Korea learnt this the hard way when the advisers to the king focused on the army inland but neglected the navy which had severely shrunken due to prolonged lack of funding. By the time a powerful and lethal enemy defeated the navy and landed on the coast, it was too late to rely on the land forces to repel the invasion. (16)

CONCLUSION

The fight with COVID is far from over but we have gained considerable experience and insights into the ethical and other difficulties so far. Over the past 18 months, in Singapore, the people, HCWs, health systems and government have all done extremely well.

While our response has been robust, quick to adapt to changing situations, we realise that more can and should be done to support one another and that includes our own government bodies and agencies who also come under great pressure.

"(We will be) remembered as frontline workers who risked (our) lives and those of (our) families to save as many as possible." (7)

REFERENCES

1. Yahoo News, Cases of harassment or abuse of healthcare workers rose to 1,300 last year. 21 Feb 2021. https://sg.news.yahoo.com/cases-healthcare-workers-harassment-abuse-rose-1300-last-year-143001438.html
2. Kramer, Jessica. Ethics in the Time of Coronavirus: Recommendations in the COVID-19 Pandemic.J Am Coll Surg 2020.04.004
3. Sese D. Ethical considerations during the COVID-19 pandemic. Cleveland Clinic J of Med. 26 May 2020. doi:10.3949/ccjm.87a.ccc038
4. Blot, F, Dumont SN, Vigouret-Viant, et al. Ethical Issues related to the COVID-19 pandemic in patients with cancer: experience and organisations in a French comprehensive cancer centre. BMJ Supportive & Palliative Care. doi: 10.1136/bmjspcare-2020-002504
5. Gdiom Gebreheat. Ethical challenges of Nurses in COVID-19 Pandemic: Integrative Review. J of Multidisciplinary Healthcare. 2021:14 1029-1035. Published 6 May 2021
6. Jana S. Rosker. Chinese philosophy of life, relational ethics and the COVID-19 pandemic. Asian Philosophy. 2021, vol 31 no. 1,64-77
7. McKenna Hugh. Covid-19:Ethical Issues for nurses. Guest editorial. Int J of Nursing Studies.110 (2020) 103673
8. Fong JM, Anantham Devand. Health ethics in COVID-19: no better time for solidarity
9. Ministry of Finance Singapore. Solidarity Budget. https://www.mof.gov.sg/singapore-budget/budget-2020/solidarity-budget-booklet-(english)
10. Beesan Maraqua. Mixed method Study to Explore Ethical Dilemmas and Healthcare Workers' Willingness to Work Amid COVID-19 Pandemic in Palestine.Frontiers in Medicine Jan 2021 vol 7 article 576820
11. Banks, S., Cai, T., de Jonge, E., Shears, J., Shum, M., Sobočan, A. M., Strom, K., Truell, R., Úriz, M. J., Weinberg, M. (2020) Ethical challenges for social workers during Covid-19: A global perspective, Rheinfelden, Switzerland: International Federation of Social Workers 29 June 2020
12. Chaturvedi, Santosh K. Spiritual, Moral and Ethical Dilemmata for Healthcare Professionals During Covid-19 Times. J. Psychosis. Rehab Met Health (2020) 7:197-198
13. Maryam C. Professional Life During COVID-19 Crisis: An Emotional and Ethical Dilemma for Medical Staff. Soc for Disaster Medicine and Public Health. https://doi.org/10.1017/dmp.2020.394
14. McGuire, Amy. Ethical Challenges Arising in the COVID-19 Pandemic: An overview from the Association of Bioethics Program Directors (ABPD) Task Force.The Am J of Bioethics, 20:7, 15-27, DOI: 10.1080/15265161.1764138
15. https://www.straitstimes.com/singapore/health/10000-grant-each-for-over-900-designated-clinics-in-covid-19-battle
16. https://en.wikipedia.org/wiki/The_Admiral:_Roaring_Currents

CM