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SPECIAL ISSUE: BIOETHICS AND CORONAVIRUS

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GIGANTIC DILEMMAS IN SEARCH OF ANSWERS

If it is necessary to make a choice, who should be saved? Who is to use the respirator: first of all the healthy young adults? Here is one of the countless bioethical dilemmas in Coronavirus time.

My purpose is to clarify this issue immediately: what I am about to write is not suitable for you, if you want only positive ideas for a better future to stem from the pandemic. If you want to cling to the optimism of the will, while reading this article you will find an unpleasant question, that is the one posed in the title, dictated by the pessimism of reason rather than the certainty of the events.

We should be aware of the fact that many things have been and are kept silent and unspoken during the pandemic; in the future, they will have to be taken into consideration and studied in depth. Even though the circumstance may have been officially denied, in some of our countries, even in the most technologically advanced ones, doctors happened to wonder, in fostering citizens' public health: Who should be saved during the pandemic, if everyone cannot be treated? Should elderly people, affected by multiple pathologies, be left to their fate? Should the efforts be concentrated only on young people, who can heal more easily?

Here is the dilemma, according to medical ethics.

Certainly, it has been considered a breaking news the fact that, in condition of limited availability of rooms in the intensive care units, it has been decided to give priority to someone, with the disadvantage of other ones. Did it happen or not? Did doctors adapt to these guidelines?

It is relevant to face an issue outlined both by prestigious medical authorities and by some equally famous mass media. Let's only give some examples. The topic was treated in a study published by the New England Journal of Medicine, where the ethical values that should guide resource rationing actions in condition of absolute scarcity are highlighted. The same problem was faced by the New York Times, where the word "disabled "was used in reference to patients affected by severe pathologies, such as cystic fibrosis.

Similar news were published on other media as well. Complex though it may seem, the issue can be synthesized in these terms: if it is difficult to find other solutions, healthcare professionals are

to give priority to those who have the greatest hope of survival and the highest life expectancy? How many hospitals in various parts of the world have been or will be on the verge of collapse?

This condition forces doctors and nurses to answer ethical questions every day. Thanks to the witness of some Italian anesthesiologists and resuscitating doctors, obliged to select between one patient and another, the fame of these difficult choices enters the collective imagination. Anyway, it is difficult to start a debate about these issues at the moment: ethical and bioethical guidelines are communicated after careful analysis and evaluations, resulting from the use of scientific and social sciences methods. We hope that citizens of no country will have to listen to a debate that shows opposite positions clashing on the principles of priorities.

The emergency cannot cause us to lose the right lucidity on ethical principles, waiting for the politicians to ask themselves how to prevent healthcare professionals from having to choose between the life and the death of a patient in the future.

Politics, of course. Pessimism comes back, about that. How many times and in how many countries in the world have politicians prioritized citizens' health conditions in this time? How many times have politicians prioritized business and Stock Exchanges over health care? We cannot forget it. Let's think about this, now!

In the following pages, the Newsletter collects many other gigantic bioethical dilemmas together with the questions we all ask ourselves in Coronavirus time. If it is true that you must believe in nothing in case you have not understood it before, certainly everything must be investigated so as not to jeopardize the dignity of human person.

Dr. Giacomo Sado
Editorial Board Director

Bioethics in the world

BULGARIA

COVID– 19 PANDEMIC

The Bulgarian Unit of Bioethics acknowledged the great importance of the scientific research on the COVID-19 pandemic and initiated a survey of Bulgarian and international students in medical specialties at the Medical University – Sofia (MU- Sofia). The study covers students' attitudes towards bioethical issues and the relevant information of the COVID- 19 pandemic. The project was approved by the Research Ethics Committee of the MU-Sofia. The Commission members unanimously gave a positive ethical assessment of the project methodology and the compliance of the questionnaires with the ethical requirements for conducting research involving people. Some of the results of the survey will be presented at the 14th Conference on Bioethics in Porto. 2021.

Professor Emil Vodenicharov, Head of the Department of Hygiene, Medical Ecology and Nutrition of the Medical University - Sofia, member of the Bulgarian Unit of Bioethics and IFT, actively participated in the last two months as an expert on hygiene in informing the public on the problem: "What do we know about COVID- 19 and how we can protect." As one of the most respected experts in the country, Prof. Vodenicharov participated in 8 interviews and discussions on national TV and radio channels. He shared essential prevention tips and rational methods for dealing with the virus. His professional advice on safety through strictly adhering to hygiene requirements, taking responsibility, keeping social distancing, and isolating oneself at the onset of clinical symptoms have been covered on multiple online and print media.

The Ministry of Health in Bulgaria has initiated a campaign to recruit volunteers to participate in the COVID- 19 pandemic control activities that have spread across our country. The members of the Bulgarian Unit together with the help of the Student Council in the Medical University- Sofia

popularized the idea among medical students, nurses etc. and 100 of them joined the teams of some University hospitals in the midst of the crisis with the spread of COVID-19.

The healthcare workers are mostly vulnerable and in order to help them, third and fourth-year students from the Medical University in Sofia have expressed their willingness to volunteer in three hospitals that have been transformed into centers for combating the virus.
We deeply admire their act, support them and we are proud of them!

Assoc. prof. Alexandrina Vodenicharova, PhD

Head of the Bulgarian Unit

THE GRIM ETHICAL DILEMMAS DURING PANDEMIC COVID-19

Jasmine Sidhu
2nd prof MBBS STUDENT from Government Medical College, Amritsar.

1.***Testing***
Clinically testing the COVID-19 patients aids in determining what actions should be taken for patients who are at low risk and high risk.
When we test indirectly it helps to limit the spread of disease by keeping the track of number of patients and classifying different areas as HOTSPOTS .

2. ***Healthcare Workers***
Hospitals don't have enough Personal protective equipment (PPE) , this puts even healthcare workers at risk of contracting infection .They have set of obligations that inclines them to go to work.

3.***Impact of schools , colleges and universities closings***
As in all public health emergencies, poor children and poor families will suffer the most .
Although online teaching is available , but seeing the scenario "Not everyone can afford to have that".

4.***Scarce resources***
Public needs to be prepared for the possibility of more dire scenarios.
We have government officials distributing food and necessities to the needy .
But here again , we need to emphasize that social disparity shouldn't exist.

5.***Treatment***
The most serious question coming up is " How to ration these resources fairly?"
With treatment we consider ICUs, ventilators, testing kits ,etc.
First and foremost step towards managing critical care resources is SCREENING OUT patients who are unlikely to need critical care and urging them to self-quarantine at home .
But eventually, what happens is you have not screened out all the folks who are at low risk of se-

rious illness , but have millions of people across the country who fall into high-risk groups.
If they get infected , many are going to need ventilators and other critical care .
So , the only way to deal with this ethically is to screen the patients based on medical utility.

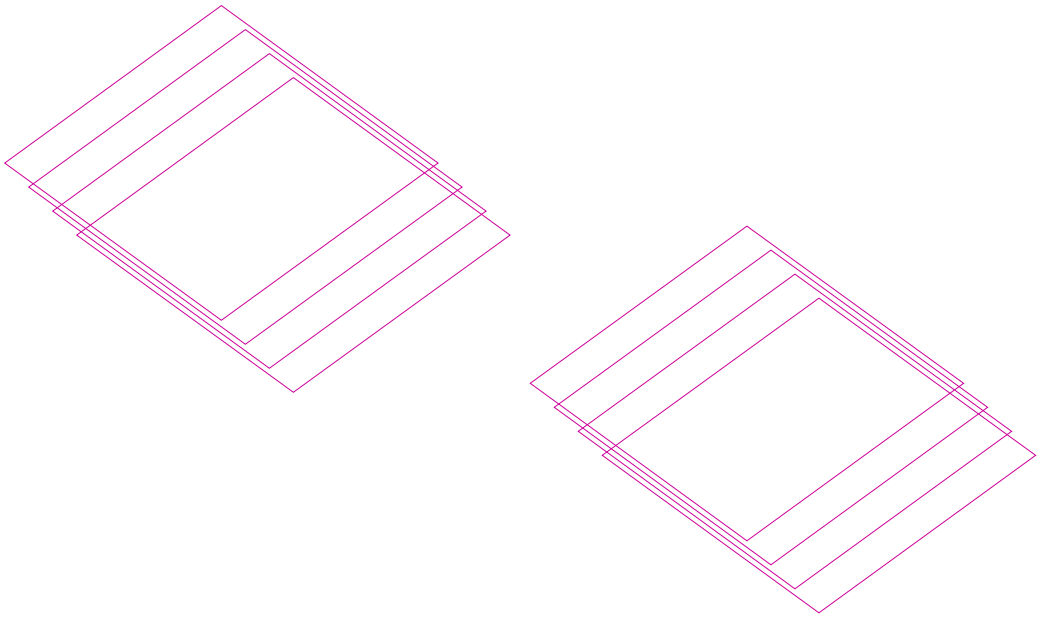
6. ***Travel Restrictions***
Quarantine is considered as a measure of last resort .
People should stay at home to break the chain of spread of COVID-19.

7.***Vaccine***
When a vaccine becomes available, healthcare providers will face the problem of rationing decisions until we get sufficient supply of vaccines to treat the entire population.

8. ***Whom to treat first ?***
Apart from other Ethical Dilemmas , doctors also face the dilemma about whom they should treat first .
As they treat patients they look upon providing equal treatment to ever patient in every possible manner .
TREATING THE SICKEST PATIENT FIRST is to be noted amongst priorities.

9. ***Impact on mental health of general population***
In this global pandemic , we see that how difficult it is for everyone to stay at home all the time .This has serious consequences like affecting the mental health of people.
So , it's very.

10. ***Role of Policymakers***
Policymakers have serious roles to play, they are to ensure supply of necessities to the general population until the situation turns normal .
Daily wage workers and other families below the poverty line should be taken care of.



CAMEROON

BEHIND OUR WINDOW PANE, WE SEE COVID-19 DEVASTATING THE WORLD, BUT NOT YET AFRICA

The announcement

The 28th of January 2020, a press release signed by the Secretary General of the Ministry of Public Health (MPH) warned the population that "*since 31 December 2019, an epidemic caused by a new type of coronavirus is prevailing in China with worldwide spread in countries such as Thailand, Japan, South Korea, the United States of America and France.*"[1] After a presentation of its characteristic symptoms, the author calmed down the communities: "*at this stage, no restriction on traffic or international trade is advised." Nevertheless, populations were called to be "more vigilant and respect basic hygiene rules*"[2] concerning washing hands, wearing masks covering the nose and mouth, coughing and sneezing in the crease of the elbow, the distance between people, and proper cooking of eggs and meat before eating them.

The warning ends by the attitudes to adopt after a contact with somebody who may be contagious, by calling the 1510 to secure oneself and others.

All the global village stick together for good

10 March 2020 meanwhile the ministers of Communication and that of Livestock, Fisheries and Animal Industries joined the Minister of Public Health started a joint press conference on COVID-19 at 5:19 pm, Cameroon Radio Television TV lunched the video show of 07 Tips to protect yourself from COVID-19 at 5:22 pm.

[1] Republic of Cameroon, Ministry of Public Health-, Press release, N° D13-34/MINSANTE/SG/CELCOM, 28 January 2020.

[2] Ibid.

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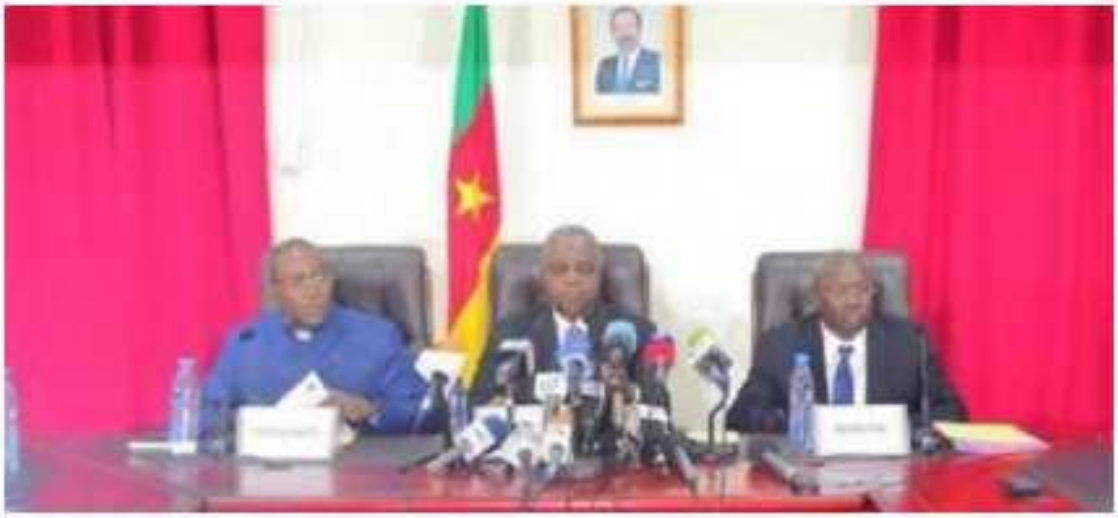

Conférence de presse conjointe Mincom-Minsante-Minepia (c) Mincom

The day after the World Health Organization **Director-General declared**: "*The number of cases of COVID-19 outside China… increased 13-fold, and the number of affected countries has tripled. …More than 118,000 cases in 114 countries, and 4,291 people have lost their lives.*"[3] That was enough for the WHO to assess "*that COVID-19 can be characterized as a pandemic. Pandemic is not a word to use lightly or carelessly. It is a word that, if misused, can cause unreasonable fear, or unjustified acceptance that the fight is over, leading to unnecessary suffering and death,*"[4] **he continued.**
Since then a jerk off the fight invaded the whole world. The declared enemy, coronavirus, of unknown origin, mounted on a ghost horse sows death wherever man forgets to oppose him with the barrier measures which consist in observing the prevention in force.

After the outbreak in China, where many people died, Italy, France and Spain in Europe and the United States of America have taken over. There corpses are numbered in thousands. Like a predator, the ghost horse mounted killer mostly strikes weakened diseased elderly people. Desperate in some cases we see him taking away our beloveds in black waters of death.

[3] WHO Director-General's opening remarks at the media briefing on COVID-19 – 11 March 2020
[4] Ibid.

COVID-19 Pandemic

Surprising Reason Northern Italy Crematoria Are Overwhelmed with COVID-19 Dead

By Sabina Castelfranco
March 30, 2020 12:42 PM

Coffins arriving from the Bergamo area, where the coronavirus infections caused many victims, are being unload military truck that transported them in the cemetery of Cinisello Balsamo, near Milan in Northern Italy, M
arch 27, 2020.ed from

https://www.voanews.com/science-health/coronavirus-outbreak/surprising-reason-northern-italy-crematoria-are-overwhelmed

Africa! fear the coming terrible massacre, says the whole world.

Though dead has been so present in media so that one couldn't easily conceive a nation without dead in daily reports about COVID-19. The fear of COVID-19 has become the cheapest cup of tea, available for everyone's breakfast, the meal all of us were bound to take. Videos showing multitudes of coffins and death announcements abound in media of all kinds. Given the poverty that prevails there and the weaknesses of the health systems, a terrible slaughter was possible in Africa, and in its sub-Saharan part in particular.

The fear of a coming terrible massacre was the message the whole world addressed Africa. Meanwhile a little care about what occurs in Africa allows the whole world to remember that one day one of the founders of the African paradigm of bioethics said and we quote: "*Puisque nous sommes réunis ici pour célébrer la VIE et non pour pleurer sur la Mort, appelons donc la VIE ! Appelons ce XXIe siècle qui vient, le Siècle de la VIE ! Puisque nous croyons à la BIOETHIQUE, c'est-à-dire au triomphe de la VIE sur la MORT, de l ' Ordre et de la Rigueur sur le désordre, de la LUMIERE sur les TENEBRES, de la LIBERTE sur la SERVITUDE, de la VERITE enfin sur le MENSONGE, . . . au moment où l'Occident déchire ses propres Déclarations des Droits de L'HOMME, bâtissons un monde de valeurs pérennes sur le roc inébranlable d'une COSMO-ETHIQUE; car chaque parcelle d'existence a en elle-même sa destinée, sa Dignité, sa Souveraineté.*

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Since we are gathered here to celebrate LIFE and not to weep for Death, let us call LIFE! Let's call this coming 21st century, the Century of LIFE! Since we believe in BIQETHICS, that is to say in the triumph of LIFE over DEATH, of order and Rigor over disorder, of LIGHT over DARKNESS, of FREEDOM over SERVITUDE, of the TRUTH finally on the LIE,. . . at a time when the West is tearing apart its own declarations of human rights, we are building a world of perennial values on the unshakable rock of a COSMO-ETHICS; for each part of existence has in itself its destiny, its Dignity, its Sovereignty."[5]

But the prophecy concerning Africa is written elsewhere

Making the 21st century the century of life. Africa is taking up the challenge launched 25 years ago. The natives, who have always believed in the abilities of our home medicines are proposing them today to curve the pandemic caused by coronavirus. Many African countries have developed medicines from their bushes and forests. And these are effectives, in accordance with the criteria for the recognition of effective traditional treatments. These medical values must first be appreciated according to their ethical environment.

COVID-19! Africa back to a greater respect for its culture and its roots

The pandemic due to coronavirus reestablishes the rights of the African Palaver, the proper place for the home African researches to enlighten darkness that has prevailed for a too long period, so far "their values are rooted on the unshakable rock of a Cosmo-Ethics." Furthermore, although special, it should be noted that COVID-19 is a flu. However each community group has a name for flu, and a specific treatment of its soil to appease the sick. We are therefore confident that many treatment proposals will be available in Africa, for the benefit of all.

Let us see what follows " *Ce qui est montré par le Pr Didier Raoult est l'action thérapeutique à spectre large d'une molécule pharmacologique d'origine naturelle. Plusieurs autres alcaloïdes issus des plantes médicinales ont déjà montré des actions similaires. L'un des exemples est celui de la palmatine, alcaloïde majeur contenu dans Enantia Chloranta (bois jaune). Cette molécule largement documentée, présente également un profil pharmacologique assez intéressant : antipaludéen, anti-inflammatoire, antipyrétique, antivirale, analgésique…*», a-t-il expliqué.

" Guy Stéphane Padzys, Doctor in Physiology-Pharmacology, teacher-researcher at the University of Sciences and Techniques of Masuku (USTM)[6] agrees. At a time when hydroxy chloroquine (an antimalarial) was adopted in France, to treat Covid-19, and that theories abound to propose a natural treatment alternative to this pandemic, he underlines that "hydroxy chloroquine is an antimalarial derived from quinine, a natural

[5] Journées Internationales africaines de Bioéthique (JIB 1995), Prof. Engelbert MVENG Conférence Inaugurale
[6] Located in Franceville East-South Gabon.

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alkaloid extracted from cinchona and specifies that" this theory does not make all natural antimalarials treatment alternatives to Covi-19.
What is shown by Professor Didier Raoult is the broad spectrum therapeutic action of a pharmacological molecule of natural origin. Several other alkaloids from medicinal plants have already shown similar actions. One example is that of palmatin, the major alkaloid found in Enantia Chloranta (yellow wood). This widely documented molecule also has a rather interesting pharmacological profile: antimalarial, anti-inflammatory, antipyretic, antiviral, analgesic ... he explained. "[7]

Certains spécialistes appellent le CS-Covid-19 à proposer une alternative locale pour le traitement du Coronavirus. © D.R.[Some specialists call on CS-Covid-19 to offer a local alternative for the treatment of Coronavirus. © D.R.]

The warning we should have in minds

It's important to note that, because respiratory viruses cause similar symptoms, it can be difficult to distinguish different respiratory viruses based on symptoms alone, and it should be clearly known that the seasonal flu death rate is 0,1% against 6% for

[7] https://www.gabonreview.com/traitement-naturel-du-covid-19-quelle-alternative-locale/

COVID-19. So a particular attention should be awarded to the patient suffering from COVID-19[8].

While there are a number of therapeutics currently in clinical trials in China and more than 20 vaccines in development for COVID-19, there are currently no licensed vaccines or therapeutics for COVID-19. In contrast, antivirals and vaccines available for influenza. …The influenza vaccine is not effective against COVID-19 virus.

What is happening to the designing and modeling of the COVID-19 pandemic in Africa ? The high mortality observed elsewhere and not yet in Africa invite the respectful minded Homo Sapiens Sapiens we are to sit together, to:

- Firstly, apologize for all the evil we caused to each other;
- Secondly, return the works to their true owners, in spite of all political opinions;
- Thirdly, be genuine scientist. Then let us path the way for African scientists to go back to the African Rationality.

Humanity will thus solve the question ever present in the minds of traditional communities: **how could be the trust worthy collaboration between traditional healers and medical doctors and pharmacists**. /

Authors :

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Doctor Victor Steve ATEBA EFFA, member of the Council of the Cameroon Unit, Deputy Permanent Secretary of CERB, Yaoundé.

[8] How does the new coronavirus compare with the flu?

CROATIA

ETHICAL AND MORAL DILEMMAS ABOUT LIMITING ACCESS TO HEALTHCARE AND RISK OF COVID-19

M.Sc. Jasna Karačić, PhD researcher in health diplomacy
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The most common patient right across the globe is the right of access to health care. As the COVID-19 pandemic increases the numbers of patients flowing into the hospitals with respiratory symptoms, health professionals are being extra careful about medical consultation for“ outpatients“. Many „inpatients“ are released from the hospital, as well, in order to protect them from infection.

This can present ethical and moral dilemma to health professionals who must choose between providing care or postponing already scheduled diagnostic and therapy process. Obviously, for some patients that can be very dangerous. They may be chronic patients with unrecognized complication or acute conditions, for whom delayed reaction and emergency response will not be adequate. We definitely deal with a world crisis, where everybody has a fear to become a regular, non-COVID-19 patient. However, we need to keep in mind that patients have their rights and that they must get full respect of their human right to health care even in the situation of COVID-19 or any other pandemic. We also have to keep in mind that this is a very difficult time for health professionals, who have to balance the fear about their own safety with providing full care to their patients.

The COVID-19 pandemic has also shown the importance of global health. COVID-19 transcends national boundaries and governments, and calls for global action to determine the health of people. However, understanding the needs of each individual patient locally brings together the best outcome of treatment and establishes a stronger relationship of trust between patients and health workers. Now, we can see how Public health is important: like an answer to the high-level question in health diplomacy. Also, it is not negligible that the private health system can bring an apprehension that even contagious, patients without insurance can be ignored.We need a more systematic and pro-active approach to identify and understand key current and future changes that impact patient rights, and to build capacity among the Member States to support the necessary collective action to take advantage of all opportunities in ensuring that these rights are fully observed. We need to understand better the tracking statistics so that we clearly see how patients we affected in relation to their non-COVID-19 health problem. Currently, we see many different numbers, and it is not clear whether deaths are due to COVID- 19 or the death occurred with but not directly from COVID-19. Figuratively, if you're shot, did you die from the gunshot or died with the bullet?

, INDIA

COVID-19 PANDEMIC

Dr. Praveen Kumar Arora
Head International Committee for World Bioethics Day, UNESCO Chair in Bioethics,
Haifa Professor and Head, Department of Forensic Medicine and Toxicology
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Namaste Everyone,
Yes, that's one way COVID-19 has changed our lives, 'the way we greet each other'. It's no more handshakes or hugs, but a hello from distance, the 'social distancing'. This is one new way we all have learnt amongst many others, but with 'social distancing' one more significant thing many of we humans have realized that, probably we all have come closer emotionally, humanly and have enhanced realization that we are members of one family of 'Beings' on this planet. Many of us have grown ethically and in compassion.

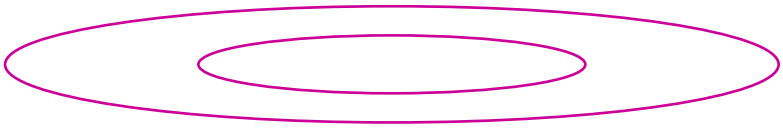
No doubt that this crisis is a huge blow on human race and the amount of suffering and deaths we have observed has shaken us all to the core. No one would have ever imagined such a huge suffering for humans. I express my sincere most condolences for those who have lost their lives and have empathy with those who have suffered and are suffering due to disease or due to its side effects. The lockdowns, closures of industries, businesses have cost all of us a lot, more so to underprivileged, those who earn their breads on daily basis, the workers of informal economy and labourers of unorganized business sector. It is estimated that approximately half of work force, that amounts close to 1.6 billion will lose their livelihood. Doctors, paramedics and other related departments are directly at front, fighting with disease and helping patients. Governments are trying their best to help, administrators are helping people and NGOs are working along with many other groups. The big question here is… what can I do as an individual? Can I help in anyway? But even bigger question is… Am I 'really' willing to help or just want to do it for the sake of putting myself in the good books of society? Every problem has two aspects… negative and positive. Negative aspect is as I tried to put above… loss of life, loss of jobs, starvation and many other expressions of suffering. The positive, are any?

This pandemic has touched almost all forms of life on earth… not just humans'. Lockdown on our racing life-styles have given us time to introspect in to the purpose of life-race; to realize the importance of ***'life'***, which most of us had almost forgotten… We had forgotten to 'live'. Although this crisis is one of the worst things human race has observed, but it has made us realize, how important 'life' is. Everything else can wait, everything else can stop, every meeting, every deadline, every target… which used to make us forget to live, which used to make us demean our own life and that of our fellow human beings. Yes, there were occasions when we used to feel bad for fellow humans who were suffering, we wanted to help and at many occasions we did, but next moment our 'conditioned minds' put us back in the 'rat-race'… rat-race to what? A rat-race of relativity?? 'Who is better than whom…' the worst ever illusion. Running after the illusions of life and forgetting to live life itself, is what we were doing. What is really important for us? What really matters? We forgot to focus on 'real things' of life and kept running after the illusions. This **'stop'** on life has many of us awakened to realize this.

, It also seems as if nature has paused humans to reclaim itself. Is this nature's way to tell us that this planet doesn't belong to humans only? We all are witnessing cleaner air, clean waters of rivers; various animals, birds and other lives enjoying the areas of earth which also belong to them but are invaded and occupied by humans. Humans had been exploiting earth for centuries, polluting it and making it unsuitable for all forms of life including their own. We did start showing concern recently, tried to contribute, but how genuine were our efforts? How efficient humans were to clean the planet, which they had polluted? How sincere humans were about the value of other living beings on this planet? We humans, divided by countries, regions, races, political inclinations, castes, religions, our physical abilities, businesses we do and more so by ourdesignations even. If we can just give some thought to what all I have mentioned above and anything other than that you know which humans use to divide themselves, we will realize that everything by which we separate ourselves from others is in fact only a concept, a thought or a hypothesis. None of these things is real. If we can realize and see that we all human beings are basically the same, that other living beings have as much right on this planet as we do, we can bring profound positive changes in everyone's life.

Most of the countries and states in the world are locked down… political leaders, administrators, economists, ethicists, social scientists, philosophers and people from many other sectors are all debating about the pros and cons of what is happening and of the best course of action any leadership and administration can follow to minimize the detrimental effects and maximize the superior outcomes. I feel that it is the best time for all of us to wake up and recognize what is 'real'. Can we all try to see beyond our 'mind created' identities and separateness, that we all are same, not just humans even other 'beings' on this planet? Can't we all unite at this time of crisis and help each other, again not just humans but other 'life forms' too? Can't each of us help the needy in our neighbourhood, those we see on the roads or at other places, those who are in our social circle, work with us or all those whom we can reach? If we help those who are suffering (all life forms), aren't we helping our own images that are the reflection of that 'supreme power' or 'the creator'?

I believe bioethics is not just a subject to read, it is a way of life, and we can only reflect our understanding of it by imbibing it and adopting it in our daily life. If we are ethical not only in the meetings, discussions or conferences on ethics, but in our day to day behaviour; if we have real love and compassion for life, we'll live all bioethical principles daily, as summarized in *Universal Declaration on Bioethics and Human Rights*; from respecting the dignity and rights of our fellow humans till protecting the environment and biosphere. At the end, I wish and pray that we all, the human race, come out of these tragic times successfully with minimum suffering further and also with lot better understanding, realizations, awakening and love for life. God bless us all.



JNDIA

THE WORLD AROUND THE PANDEMIC 2020

Paril Damor, MSAI member, GMERS MEDICAL COLLEGE, GANDHINAGAR

Coronavirus: The first case of COVID-19 was traced back on 17th November 2019.

"Today the global catastrophic don't look like nuclear wars, instead it looks like a VIRUS(microorganism). If anything kills over millions of people over next few decades, it's most likely a highly infectious virus."

-BILL GATES

Who knew that the TED TALK by Bill Gates in 2015 "The next outbreak? We're not ready" will become the truth of future and we'll be living it in 2020.

From the outbreak of virus to home quarantine humans, the corona virus took the world with a storm of negativity with mental illness, religious conflicts, poverty, drop in world economic to a beautiful positive corner where the world seems different, people with families, nature healing, animals getting the zone to feel free and the humans gets to feel what have we done to this beautiful planet.

With both the sides of the couch the virus taught us many things and gave us many headlines.

- Chinese virus- Donald Trump
- Fast pace life at halt with humans stuck in their home
- 20% increase in mental illness in India due to lockdown
- The covid-19 might push corers of people into poverty across India.
- Tablighi Jamaat-whom to blame the community or the wrong ones?
- Increase the budget to save people instead of investing in destruction
- "Parchi system" to overcome; alcohol withdrawal syndrome in Kerala
- PPE in shortage healthcare workers face a risk
- Doctors and police on frontline attacked

PANDEMIC – ON - POORS!

- *The poor have major impact of lockdown.*

The sudden implement of the lockdown has led to many problems. The people living below poverty line are already facing problems regarding food and sanitization. With lockdown,

the big question arises as how to feed the families as majority of them are daily wage workers. And as the outcome the daily wage workers walked to their respective hometowns as the basic needs of the people were in questionable state. One of the people said "We come here to earn money and feed the family ,if I'm not able to fulfill the basic requirements for my kids then there's no reason for me to stay here, as anyways it's a dead end scarcity of food or the virus. It's rather better to die with family around then having nobody around my death bed!

QUESTIONS

- *The government has put up so many programs for this people then why is there any need to panic?*
- *The government had transferred money to their bank account.*
- *The government has been providing with food packages and shelter where they can stay, then what's the need to walk mile?*
- *Why are these people panicking?*
- *Why don't they understand what government is trying to say?*

ANSWERS

- *The lockdown came into force on Tuesday 24th of the March 2020 by the honorable Prime Minister with 30 minutes of video explaining why we need a nationwide lock down. We being a developing country we need to worry about the poor people as the other class people will somehow will be able to sustain this situation. And when you take this huge decision you need to make sure that you talk about the ones who really are in need. In his speech on that day the P.M. has not mentioned anything regarding how the government is going to help the poor people. In those 30 minutes not even for a minute he has talked for poor people.*
- *This was very huge decision for the country and the government has tried to do everything they can do but they were not ready for the impact that we as country got by looking at the poor people suffer. They just should have been prepared for this and should have explained their point in a better way to the poor people in the first step because they don't have to worry about the other class people that much as they have to take care for these helpless people. Just a little bit of planning.*
- *The person defending the government says that we needed to stop the movement of the country so that spread can be stopped.*

Question: if they really wanted to stop the spread then they should have stopped bringing people from foreign first as they were the main vectors. The government can bring the people from

foreign countries as they are Indians but we as a country can't even arrange a bus for the poor who wanted to go home, why so? Aren't they Indians who live in India?

- *They provided the transport facilities for THE KOTA STUDENTS but they can't provide the same facility to the poor people. They literally have to walk for miles. Some even didn't have footwear to wear; the scarcity of food was killing people, the fear of getting hit by police. Why we never put any effort to support the poor people? Why is it so that a country leaves a major part of it behind?A kid was found crying on the road walking back to hometown. When asked, he said that he was afraid of police as they were hitting people found on the roads during lockdown. What is his fault? Can government answer this? People have left them hopeless and now this. At least show somewhat of humanity!*

Assumption: Let's assume that if we allowed them then there might be a possibility of spread and country would be in a very difficult situation.

Answer: The way we held screening of the people who came from foreign countries and were put under quarantine, same was done with Kota students, just assume taking more time if the shelter were prepared before-hand for the people to stay and if they were explained about how the government is going to treat them first. Then there would be a different situation.

People telling government has much more work to do don't put pressure on them; we can't even imagine the pressure how they are dealing with it?

Let me tell you people that the government has been elected to do the work for their people.

Malala Yousafzai – "we are just reminding the leaders what are their duties towards their citizens"

So, I just want to tell the government was not wrong with the decisions but with just few careful steps the situation might be different toady.

It has become difficult for the people to survive, either way they are risking their lives with starvation or by getting infected by Covid-19.

If not, this way they have no possible way to live a normal life,we can't imagine the amount to pain and the level of fear they live in as we have a life of gold sitting on couch watching them pay for everything going on in this country.

NOTE: This is about what should have been done before implementing the lockdown.

Now that the government is providing with every possible facilities it's our turn as the people of the country to respect what the government has to say.

It's a one-to-one correspondence things where along with the government the people also have be responsible with their duties!

WHY RELIGIOUS COMMUNITIES AND WHY NOT WRONG PEOPLE?

- *The negativity around the religious community.*

Tablighi jamaat: Health ministry stated earlier that the 30% cases in India are related to this event.

The Tablighi Jamaat congregation organized in Nizamuddin Markaz in first half of March has become the epicenter of the spread of Corona virus.

With all the ongoing events in India people have started blaming the whole Muslim community. Blaming a whole community is wrong at so many levels.There are people who disrupt the integrity of community but that don't give an individual any right to blame a whole community. There are many factors associated with the spread of covid-19, so stop blaming anyone because it has a negative impact on the people who haven't done anything wrong.

The man accused of attacking the doctors in Indore earlier that month fled from the hospital, where he was brought for the medical examination and was found positive on 11th of April. He along with other people, women and men all together attacked the doctors and police who went there for the testing of people of that area for Covid-19. Not only are these but there many instances where some of the Muslim people have attacked the doctors who were trying to help them in this difficult time going on.

But even after this if they keep on doing this type of provocative things no matter how much you try people will have negative thoughts for this community which can lead to a major breakdown between the people.

CHENNAI MOB

In a shocking repeat of what happened when a doctor from Andhra Pradesh died of COVID-19just a week ago, a mob attacked a group of persons, including doctors, during the burial of a neurosurgeon, who had died after he tested positive for COVID-19, in a private hospital on Sunday in Chennai.

Here the attackers were not from a particular community. It's not like a particular community attacks the doctors but the stupid people who fail to learn or practice the humanity will do such horrible things so it would be better that we start to not hate or blame a community and start to blame the wrong ones and punish them!

The conflicts of the thoughts where the dilemma lies whether to stand for the people or to oppose them have made me realize that what we have done with our opinions might have destroyed someone's beautiful life. Can just stop for a second and not blame anyone and try to help those unstable humans irrespective of the religion. Due to some of the morons it becomes a conflict in our country.

Our political leaders are so intelligent that they tend to feel that the power and money will save them from Covid-19. But sir, the virus don't bias regardless of the cast, creed, sex, etc.

The legendary former CM of Karnataka HD Kumaraswamy has courted controversy after a wedding in his family was solemnized flouting all the norms to be practiced during the lockdown.

So, the point is the rich ones get everything to exploit the people mentally as well as physically as the money works. The world is at the edge.People are living in anxiety and they want to marry but no one can question them as they come under the 1% class of India who can do anything.

MENTAL-ILLNESS

- 20% Rise in mental-illness during this lockdown in India says IPS.

Since the time lockdown has begun it has been a tough time for many of the people with all the overwhelming information around the global pandemic. A series of other disturbing events along with the ongoing Covid-19 have disturbed the people in many ways.

It's really hard to write it down how an anxious or a depressed person feels. It is a very difficult time for all of us.

- *The victims of domestic violence who have to stay indoors under the same roof with that monster will be more horrifying than corona virus.There is a lot increase in the numbers of domestic violence since the lockdown has begun. We need to let people know that we are there for them and they can speak up and raise their voice against them.*
- *The level of instability the poor are going through is unbearable. The people in general are going to suffer a lot during this pandemic.*
- *The doctors who have been working on and off don't have the time to process the deaths occurring around the clock and the level of stress and anxiety they go through might lead to the PTSD.*
- *The police, who have to stand doing duty whole day and after doing this much what they get is, disrespect from the people, are being attacked by the people. Can you imagine the level of stress they might be going through?*
- *Students left with their board exams and their entrance exam for the colleges.*

The students of 10th and 12th who have been studying since months now due to the pandemic their respective exams have been postponed. And the fact that they have to study again for certain subjects or entrance exams is giving them fear. They've been studying since a year a now and again they have to study. There is this saturation line of a person which had been crossed and now they are facing anxiety issues.

I'm not going to discuss about how they might be feeling but the major point of discussion should be how will we make people aware that they might be going through mental-illness and its okay to

talk about it and consult a doctor for the same. It's okay t *tive environment.*

- *The news channels covering about every disease but why they fail to cover the mental-illness topic in their news? They can be a major factor in promoting awareness for this issue.We need a team or counselors and psychiatrist for the doctors as many of them are going to have PTSD.Start having positive news everyday so that there is a positive side to this thing.Make people realize that everyone is prone to mental health and its okay.*
- *I came across this news that the companies are taking away the jobs of the employer. One of the uncle said he is worried for his family as he is not sure whether they are going to keep him or if they keep him, is he going to be paid? Please help people with not taking their jobs. Even the government has said no to unemployment of the employs of the country.*

BUDGET FOR HEALTHCARE SECTOR

Most of the first world countries are in the race to become the super-power of the world so that they become the first in rank in the world.

And along with the first world countries the other developing countries are also trying to become the super power of the world. Some of them have even become the super-power and India is one of them and I'm proud to say that.

But does becoming super-power brings you all the possibility to sustain every circumstances? Like-wise the situation of the COVID-19 a global pandemic, if we see the major countries healthcare sector have been shattered by this virus that they can't even stand facing this pandemic. Italy being the second in the healthcare sector in the world if is facing this much of the problems then we being a developing country nowhere near to Italy stand if we have to face the same outcome. Are we even ready to face a virus with this bad infrastructure of the healthcare system?

When will we realize that for a country to be an established developed country we need to balance out every sector of the country with a proper budget? Start investing in saving human life rather than investing in how to destroy the human life.

When will we realize that it's high time that we start investing to save human life on this planet because we caused a huge chaos with the nature collapsed, no humanity, the healthcare system are also collapsing.Do we realize we are with nothing in hands facing this huge catastrophe which is destroying the humans and healing the nature? Take action realize the mistakes which have been done and start acting responsibly towards a better life of humans as well as the planet!

Here's a small piece which I wrote for the ongoing battle with my thoughts

Collapsed human life!

I've been no more anxious around the clock never before,

, *With all the stuff going around and overwhelming storm surrounded me in.*
When it was just as say that a pandemic has broken out
It just took few days to lockdown over take the world.

Unexpectedly hosted a party with humans as guest,
Never knew the ones invited would fool around with the nature
It just took days for the nature to take back,
What used to be hers!

The virus was just living the karma
We were the ones who made the drama
Knowing that coexistence is major factor
Still we exploited the nature!

Here again the poor were left hungry,
As the money was feeding the rich one.
We stepped out of our houses to claps
But they walked miles to reach home instead stepping out of the house

"We are not ready for religious stand-up" well said.
We failed to acknowledge the human life
But we were so much up tight to support or oppose a political party.
Religions are meant to mend us not for a toxic fight to put on.
Animals never asked for anything
Nature never asked for anything
Religion never asked for anything
Ironically all they gave us is love, compassion and peace.

The white coats asked for more money
Do you know why?
They've spent time to learn how to treat you

But you know what we treated them with stones.

They stood on roads in heat for days

They came home bleeding

Uniforms give us respect

Withhumans like this even the uniforms were filled with blood stains

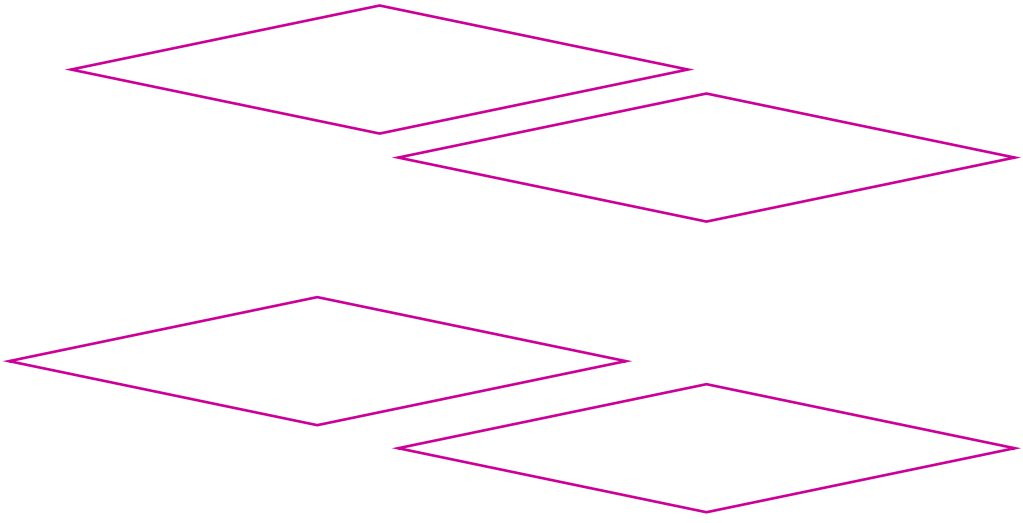
We have come so far in this

That even the alternate universe might think;

Were we supposed to be that way?

Or they are just acting?

-PARIL



ITALY

AFTER THE EMERGENCY RESUME THE PATH OF CARE THAT RESPECTS THE PERSON

Prof. Patrizia Borsellino
Full Professor of Philosophy of Law and Bioethics
University of Milano-Bicocca (Italy)
President of End of life Committee

Towards the end of 2017, when the Act no. 219 concerning "Norms on informed consent and advance directives was passed in Italy, many thought that the objective of guaranteeing the dignity of every person until the end of life would get closer. It was a conviction based on good reasons, because the Act states that every individual in any situation of illness can and must rely on appropriate assistance meeting his/her needs for care and being able to relieve him/her from suffering, always in respect of his/her will.

The extremely tumultuous and unexpected bursting of Covid19 has drastically reduced that belief. Especially in the initial phase of the pandemic spreading in the most affected areas, first and foremost in Lombardy, there was a dramatic scenario, in which, despite the commendable effort, and beyond the limit of personal sacrifice, made by health workers, many patients were, in the most serious conditions and without hope of recovery, did not receive palliative care, in particular terminal sedation, which would have allowed them to die without suffering. The older population, hosted in the RSA, was not allowed to access care, thus causing its therapeutic abandonment, whose condemnation seemed, at least in words, shared by all.

There is no doubt that in a situation of serious emergency, such as the one faced by the health system, the scarcity of resources has played a decisive role in making it difficult, or even impossible, to provide all those in need with adequate care that respects their dignity. And it can be understood that unpreparedness, combined with the need to act quickly and under strong pressure, has often led to putting aside communication with the patient, which is fundamental in order to gather their needs and wishes. In addition, priority criteria (e. g. based on age) have been adopted that are contrary to the ethical-legal principle which does not allow distinctions among individuals equally in need of assistance based on personal conditions. To understand does not mean to justify.

After the emergency, it will be up to those with institutional tasks to make choices and take measures to drastically narrow, if not eliminate, the gap between supply and care needs. And it will be up to all entities like VIDAS that have historically been involved in cultural and educational matters, as well as in health care assistance, to strongly reaffirm, in all possible contexts of debate and awareness raising, that, even and especially after Covid-19, there is no adequate alternative to the path of care that respects the person.

ITALY

COVID-19 PANDEMIC EXPERIENCE

Prof. Domenico Palombo, Genoa University - UNESCO Chair in Bioethics Italian Unit, Cardio-Thoraco-Vascular Department Director

The SARS-CoV-2 pandemic has severely affected Healthcare Systems all over the world and within the Italian NHS also our Polyclinic has faced an unprecedented health emergency. Departments and Operating Units have been reorganized in terms of wards and staff to avoid gatherings and ensure environments dedicated to isolation and continuation of care.

As regards to the ongoing experience of the Cardio-Thoraco-Vascular Department and particularly of the Vascular and Endovascular Department, our staff worked to ensure essential care services in accordance with the safety standards.

The reorganization of the activities involved the reduction of pre-hospitalization, limited to clinical conditions that cannot be delayed, and the elimination of non-urgent outpatient visits, medications and ultrasound Doppler diagnostics. Concerning the surgical activity, the operating schedule was cancelled both for Day Surgery and for most major surgical interventions, although maintaining the availability of operatory rooms for emergencies and not deferrable elective surgery due to the severity of the clinical condition.

We guaranteed a safe hospitalization thanks to careful triage and the use of nasopharyngeal swabs before each recovery, as well as the preparation of medical-nursing staff and the proper use of PPE. Although less exposed than other realities of the Polyclinic, our staff has been in direct contact with patients with suspected or claimed COVID-19 infection in the context of diagnostic exams, specialist consultation or surgery for inpatients of other Units or from the ER. Furthermore, in order to relocate properly the departments, our O.U. gave the availability to share the beds with the O.U. of Thoracic Surgery and Kidney Transplant Surgery.

The safety rules for social distancing meant that patients could not benefit from the presence of their relatives during hospital stay. Here too, our staff has shown to be careful and empathetic, remaining even closer to the patients (humanly speaking) precisely at a critical moments such as facing surgery. The interviews with family members took place on a daily basis also thanks to the support of video calls at patient's bedside to guarantee, even at the distance, a glimpse of humanity and closeness that in such a health emergency could have disappeared.

Nowadays we are gradually restoring activities according to the rules issued by the DPCM and by the Health Directorate, maintaining high attention in a situation that has deeply hurt us but that has shown us how even in such emergencies it was the humanity that brought us back to

those Hippocratic principles that make our profession noble.

ITALY

THE EFFECTS OF ISOLATION AT THE TIME OF COVID-19 IN THE UNIVERSITIES OF THE THREE AGES

Prof. Norma Trezzi, Vice-Presidente UNITRE Mariano Comense (Como), European Centre for Bioethics and Quality of Life - UNESCO Chair in Bioethics Italian Unit

UNITRE is an association of social promotion based on volunteering with offices throughout the national and foreign territory. The association, born as "University of the Third Age, today UNITRE" University of the Three Ages ", is based on the volunteering of all members and refers to the Universities of the Middle Ages, whose organization was headed by the students and in which the teachers they lent their work for free because they believed knowing a gift.

The teachers carry out their activities in a personal, spontaneous and free, non-profit way and exclusively for solidarity purposes.

The aims of the association are to educate, inform, train and promote research in the perspective of active and active aging through the activation of meetings, courses and workshops on specific topics.

UNITRE makes the elderly protagonists, in particular, so that by participating in the various projects, they will have the opportunity to unleash their creativity, re-appropriating significant roles and a rediscovered leisure that has no age.

The coronavirus epidemic has forced millions of people around the world into forced isolation, it has distorted our daily lives by interrupting many activities including those of the school world that has organized itself with telematic lessons and that must now rethink and reorganize next year academic between a thousand uncertainties and difficulties.

The pupils of elementary, middle and high schools have been able to adapt to the new situation, although some people with difficulty to the new way of online lessons while maintaining that relationship of continuity between teachers and students indispensable for teaching continuity. We are well aware that young people are well acquainted with the telematic tools that they habitually use and equally skilled in the new emergency situation of isolation.

Likewise also for UNITRE members, online lesson proposals were organized and in addition to this a competition on the topic of coronavirus with different expressive ways to keep alive the link with the teachers and among the students themselves.

In this moment of isolation that occurred with a sudden detachment of the social interaction of the entire population that had never occurred in modern times, to keep alive the contact with our members who are further away with the years, more fragile and more alone, perhaps even more afraid, it becomes a primary goal.

In the online meetings organized by the board with the teachers and the representatives of the members, the critical issues regarding the organization of the lessons for the next school year 2020-2021 were highlighted: in addition to the general sanitation rules, use of masks, gels, gloves, … .. the distancing required by law forces the attendance to be halved and requires that

some courses be done online.

In this period of isolation, online hyper-connection had a two-faced role: it saved us from isolation but in a long-term perspective will it be accepted as a way of meeting? In recent months, the time spent on social media has at least doubled in all age groups, including those over the age of seventy for whom this situation has been an opportunity to acquire digital skills which they will then find useful.

The responses collected later highlighted a certain common sense in the acceptance of the changes imposed above all regarding online lessons, provided that this method is temporary, but above all they highlighted the need to meet all together in the presence. There is a need for human contacts, exchanges of glances to laugh together to overcome that solitude more accentuated in this age group and heightened by the unexpected isolation to which we have been subjected.

PORTUGAL

COVID-19: A GLOBAL ETHICS FOR A GLOBAL HEALTH

Prof. Rui Nunes, Porto University
UNESCO Chair in Bioethics Portuguese Unit Head & Research Department Director

The recent pandemic by the coronavirus, and the associated disease - COVID 19, implies rethinking global ethics for different reasons. Firstly, because if it is certain that throughout the 20th century it has been developed a universal system of fundamental rights, which affirms the uniqueness of the human being and the basic human values, this system had a limited impact on uniting the different peoples, due to different geopolitical reasons. Indeed, in a realistic view of international relations, the exercise of power by the different sovereign states was the decisive factor in the relationship between different nations, and economic globalization was unable to promote a true universal ethics.

It is certain, however, that economic globalization has resulted in an improvement in the living conditions of hundreds of millions of people, reducing world poverty considerably over the past decades. And, therefore, the enjoyment of social and economic rights was indirectly promoted by this evolution. Today, many more people around the world have access to health services or to a quality education system. However, this positive externality of economic globalization was not accompanied by the construction of a true planetary awareness about the need for a "common humanitarianism", genuine, and centered on the essentiality of the human person.

And the coronavirus outbreak should remind us of the need for a broad ontological solidarity among all peoples, in order to join efforts to overcome global problems that need global answers. And also that there is no doubt that humanity will hardly be able to respond to this pandemic, to future pandemics that will surely arise, to pressing environmental problems and to climatic changes, to growing migratory phenomena, among many other global challenges, without a global ethics that unifies the different peoples, stimulating the best that exists in each society.

And health, although it is a personal experience, it is also a global phenomenon, since we are fac-

jng a pandemic with important global health repercussions. This implies the adoption of universal ethical principles on behalf of all people and, therefore, medicine, health technologies, and modern information and communication technologies (including artificial intelligence, quantum computing and big data) should be delivered in accordance with essential civilizational values. Namely the principles of respect for persons and their quality of life, of justice and equity, and of protection of individual privacy. Although imperative global public health reasons may, transiently, in a proportional way and with a concrete purpose, originate a different course of action.

In summary, nothing is the same after the coronavirus outbreak. And to the biological Darwinism we must propose a global social Darwinism so that humanity is prepared to respond to this type of phenomenon. With humility, because everyone is equal in the face of this threat, but with the ambition to build a better world for all people.

UZBEKISTAN

COVID-19 AND BIOETHICAL PRINCIPLES

Mukhamedova Z. M., Head of the UNESCO Chair in Bioethics (Haifa) Unit in Uzbekistan
Babadjanov J. B, Head of the Youth wing of the UNESCO Chair in Bioethics (Haifa) Unit Uzbekistan

The first case of COVID-19 in the Republic of Uzbekistan was detected on March 15, 2020 in Tashkent. The charts of morbidity peaked on April 14, 2020, when the number of found cases per day in the Republic reached 167. Since that day, the amount of cases began to decrease. Moreover, a clear increase in the number of recovered people has been noting.

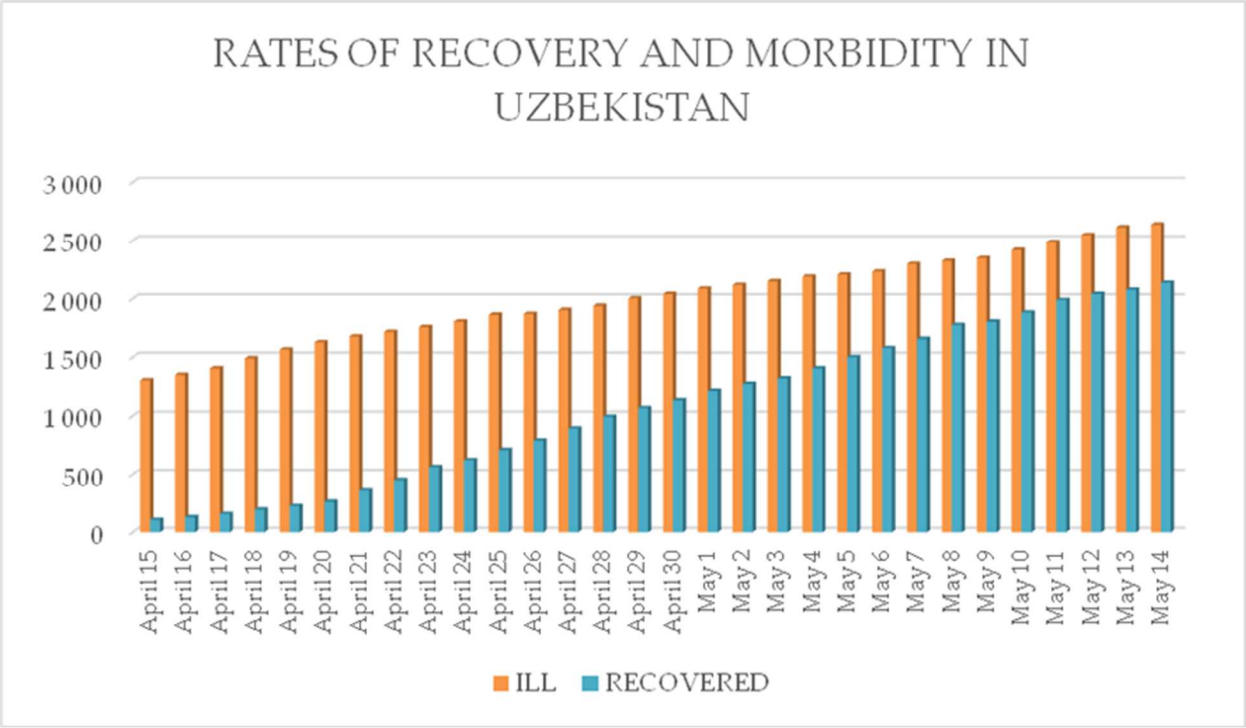
What made it possible to change the situation to the direction towards a gradual normalization? Definitely, first of all, an immediate reaction of the government did.
Since March 16, gradually, all major cities were quarantined, a number of rules were introduced – compulsory wearing of masks outside, social distance, no more than 3 persons together, etc.

Which bioethical problems appeared in this situation? One such question is about the principle of mercy. According to which factors do doctors have to take care of patients when time and resourses (drugs) are limited? Who is eligible for medical aid in the first place? Can age be a criterion for a rational distribution of resources and medical care? In Italy, for example, doctors are asked to exclude elderly patients from the priority list. In Uzbekistan, the conditions for patients with COVID-19 are the equal for everyone – both infants and pregnant women, children, persons of different ages. Doctors and nurses take care of every patient according to the

, basic values such as justice, equal respect for human dignity and help to reduce suffering.

The population of the country (especially socially vulnerable segments) is supported too. Young people show respect for elders, which is traditional in our culture: a lot of youngsters do volunteering, they help to deliver food and medicine to self-isolated older people.

On May, 14 there were almost 500 cases in the Republic of Uzbekistan, the mortality rate is 0.4%. However, it is not a finish yet, there is a long way ahead.



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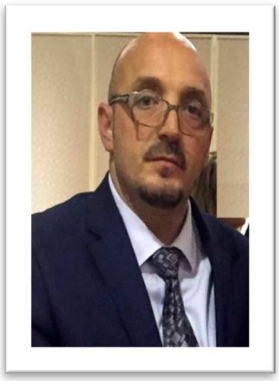
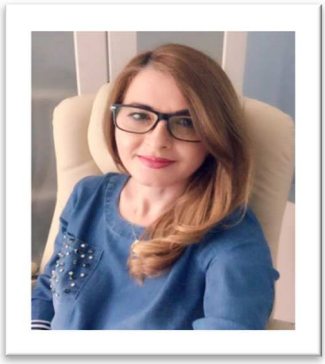


Dr.Miftar Zenelaj-psychiatrist
Head of Koosovo Unite in UNESCO
Chair in Bioethics(Haifa)

Behare Bojaxhiu-psychologist
Mental Health Center-Prishtina
Vocational therapist



IMPACT OF COVID-19 ON MENTAL HEALTH

These days, the citizens of our country have witnessed the development of an unusual situation, the COVID-19 pandemic or CORONA virus, which has affected not only our country, but all continents. This virus is not only affecting only the organic health, but it is seriously affecting and harming people's psychosocial well-being and mental health. It is normal for worries and distress to turn into stress and anxiety from fear of being infected with COVID-19, and this condition of some people is being manifested with emotional disturbances, organic disorders, and behavioral disorders.

Anxiety and panic arise from fear, and the main function of fear is to help a person survive in certain situations. In fact, fear to a certain extent is a mechanism of survival, so fear helps us learn to avoid dangerous situations through the process of activating the defense mechanism. Most of these issues are related to the thoughts which recur in people's minds about the situation created by the spread of coronavirus and the possibility of getting infected and risking life.

Some people may have mild reactions, while others may have stronger emotional reactions, and how people reacto this situation depends on many factors such as: the nature and severity of the events people experience in this situation, personal experience of previous disturbing events, organic health, age, support from family and society, etc.

The prefrontalneocortex is a neural structure that helps us think and plan for the future. It predicts what might happen in the future based on past experiences. When accurate information about the prognosis of this pandemic is lacking, the neocortex predicts different scenarios for what might happen, and creates assumptions that are possible when life is put in danger from something unforeseen, and at such moments, we begin to experience anxiety, which is very difficult to control in some people.

This can lead to mental health disturbances in the form of general anxiety which is manifested through concerns about threats to their health from coronavirus, thus "these people overestimate the threat from infection and underestimate coping ability". Coronavirus has plunged the world in an uncertainty due to constant information about the pandemic which has caused a considerable number of deaths and the possibility of spreading and recurrence.

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In the absence of accurate information, people worry and seek more information through various social networks in an attempt to resolve their anxiety and get rid of their insecurity. The world we live in has changed, although it seems to us that everything is going well. We live in the time when information and technology have revolutionized the world we have known. This intelligent technology has accelerated the distribution of information, in real time, around the world, and most of the information we receive during the day is toxic to the human brain.

Our brain functions as a magnet in accepting information, there is a chamber in our brainwhere the information received during the day is processed, and this information that comes in the form of news about the number of deaths from COVID-19, the number of infected and the possibility of spreading further causes stressful situations, anxiety and panic, but the problem is that our brain finds it impossible to control and direct emotions and thoughts in a rational way, which is caused by such information. How our brain solves and selects this information depends on the activation of the conscious part of our mind, and this determines our success in managing this situation, while most of the negative information we receive during the day accumulates in the unconscious part of our mind, which is later activated involuntarily.

This condition will eventually result in harming mental and physical health. The human mind functions in the form of an ecosystem, this information, negative to some extent has started to spread like an epidemic throughout the world, therefore psychiatrists and psychologists recommend protection of mental ecosystem, because the human brain is unique compared to other parts of the body. It is important to note that this anxiety and panic is in a way contagious. Spreading negative emotions from one person to another, in psychology is called psychosocial contagion or mental induction. This anxiety can be triggered simply by talking to someone who is anxious or even watching someone doing things that incite insecurity, such as fear of the future, and if I get infected or sick from this pandemic, am I going to survive, or am I going to have any health problems, or even the responsibility and worry for the family responsibilities and worries, so the rational parts of our brain may get out of track.

For some people, the situation of being self-isolated at home or quarantined in the hospital affects their mental health making them feel as being detached from the outside world, they experience anxiety because they are confined indoors for longer periods of time, which in psychology is known as “cabin fever” or they feel as if they are “going crazy”, so under the effect of panic we move in the opposite direction, panic may lead us towards impulsive behavior which is dangerous.

Fear and despair kill more than disease, and this shows that the factors which incite fear and despair are directly related to mental health, and they are plenty in times of pandemic. The inability to get out of mental isolation increases, and in that situation of meaninglessness, a person crawls through agony, and from the accumulated anxiety frustration arises which prevents the individual to think rationally, then he/she starts elaborating the fixations objectively in his/her head blocking other perspectives to contribute to clarity and objectivity of the things that are happening, and in such moments, the person forgets that isolation and physical distancing, and interruption of work activities are favorable to his/her life.

The research conducted on mental health in times of natural disasters has shown that emotional distress is prevalent among the population affected by Covid-19 pandemic, and after these situations, most of the people are more flexible, but the main concern remains post-traumatic stress

disorder which derives from the exposure to this trauma. This life-threatening viral infection does not meet the current criteria of trauma that would meet the criteria of PTSD diagnosis, but other psychopathologies such as depressive disorders and anxiety may occur.

But, some people may have sleep difficulties (insomnia), a feeling of anxiety or distress causing demotivation and decline in their life dynamics. Due to the anxiety experienced in such situations, some people may increase their negative habits such:uncontrolled smoking, alcohol abuse and narcotics. In these circumstances, when they wake up in the morning, they have no determination for future due to the prevailing situation, they wake up in the same place, with the same thoughts, they see the same people, they do the same things at the same time, then their personality creates a new reality, an unwanted reality which affects the behavior and the relationship with close family members, thus, the environment they live in is a confined space due to the isolation or home self-isolation and this affectstheir thoughts and emotions which may produce violent behavior.

Social isolation measures have been mandated throughout the world to prevent the spread of coronavirus, but these measures have also produced undesirable side effects. Staying with the family for longer periods of time may inadvertently lead to increased tensions and conflicts at home, so the isolation has produced other challenges, such as impulsive reaction and unjustifiable interpersonal conflicts, and this is due to several factors such as the daily routine which is manifested in confined environment, unemployment and economic concerns of the family, health condition of the family members, etc.

This isolation can put the lives of some people at serious risk as a consequence of domestic violence, including psychological and physical abuse of people living together in a confined space, and this may create a situation when a person is afraid of living in a family environment. This secondary effect of the coronavirus crisis has emerged in different parts of the world, including our country, so this phenomenon should be paid attention it deserves by relevant institutions.

With the imposed social isolation measures, victims of domestic violence may be trapped at home together with their abusers, because these people have been temporarily disconnected from their social and professional life, such as going to work or school or elsewhere.
What should we do on emotional level to keep our relations healthy and on a satisfactory level during this pandemic?

Our negative thoughts can disturb us emotionally, while our thoughts can cause concerns, thus it is possible that our thoughts can even heal us, make us happy, no doubt. This means shifting attention away from negative things and focusing on something positive that makes us feel happy.

Avoiding conflicts comes from the conscious part of the brain which is rational and analytical, making a selection of most suitable behavior, simply because it makes us feel better, we can practice replacing irrational behavior with useful behavior.

The more we see positive actions and compare them to the negative feeling of insecurity or getting anxious, the more our brain moves naturally towards positive thoughts and we feel better. Isolation should not be perceived as something bad, but as a protection health measure and the opportunity to spend more time with family, thus contributing to strengthening healthy family relationships.

COVID-19 IN TURKEY

The last known coronavirus disease is COVID-19 which has appeared in China, in December 2019, and rapidly spread worldwide [1]. It has caused a pandemic in the world. The first confirmed case of COVID-19 in Turkey was a 44-year-old male who was referred to the hospital on March 9, 2020 [2]. It was announced by the Health Minister of Turkey, Dr. Fahrettin Koca at a press conference on March 11, 2020[1]. Koca announced that a male citizen had tested positive and that he had been infected with the virus after returning from Europe. Koca also declared that the patient was completely isolated, his general condition was good, and all of his family members and those who had had contact with him were under surveillance [1]. Koca added that "The coronavirus is not stronger than the measures we will take. A quarantined patient cannot threaten society [3]"; and underlined that the problem was global, but the fight had to be national, and Turkey was prepared to fight against Coronavirus [1]. Turkey confirmed the first COVID-19 related death on March 17, 2020 [2].

The Current Status of COVID-19 in Turkey

As of May 10, there exist 138,657 confirmed cases of COVID-19 in Turkey. The reports of COVID-19 related numbers such as total cases, total deaths, total recovered, total tests, total ICU patients and total intubated patients are announced by Ministry of Health via its web page and twitter account, and these numbers are updated daily. According to this data on May 10 2020, 1,370,598 total tests have been done, 3,786 patients have died and 92,691 previously positive patients have recovered from the disease [4].

Health Minister Fahrettin Koca announced "Turkey is currently passing over the peak of the novel coronavirus pandemic but the drops in numbers must be consistent," on April 29, 2020. He also stated that "The number of recovered patients in Turkey in the past 24 hours reaches twice that of newly diagnosed patients," and shared new data of COVID-19. As reported by him, the death rate for intubated patients dropped from 74% to 14%, and for intensive care patients it dropped from 58% to 10% [5].

Healthcare workers and their efforts have been immensely important in Turkey and the Health Minister has thanked them for their hard work. As of April 29, he declared that at least 7,428 healthcare workers had been infected with COVID-19, which constituted nearly 6.5% of all cases [5].

On May 4, 2020, Minister Koca made a presentation about Turkey's fight againts COVID-19 at the video conference of the World Health Organization (WHO). Koca highlighted that they were effectively cooperating with all global partners, and that world needed a stronger WHO. According to Koca, "Solidarity is our strongest weapon against this unprecedented threat. At this point, we must put aside disagreements and focus on the solution. After overcoming these challenging times, we must come together and see what went wrong [6]." Koca, about the current situation of COVID-19 in Turkey, said that with great testing capacity and early treatment protocols, Turkey had been able to reduce the rate of disease progression to pneumonia from 60% to 12%. In the later stages of the treatment, Turkey did not rush to intubate patients. Instead, it was seen that giving high-flow oxygen to the patients in the prone position, yielded positive results. Turkey has

achieved a significant increase in the rate of recovery for non-intubated patients. The mortality rate of ICU patients have also progressively reduced from 58% to 10%. Turkey has been able to reach 99% of all contacts with filiation studies, and this means approximately 455 thousand people in 44 hours through this process. Koca also underlined the importance of health information technologies. He said that Turkey had achieved a peak level 30 days after the first death was reported as a result of the measures taken. The fact that Turkey was one of the countries the virus reached relatively late, combined with the fact that the peak level was reached earlier in Turkey than in other countries, have resulted in Turkey having one of the lowest case fatality ratio among European countries [6].

On May 6, 2020, Minister Koca stated that Turkey had completed the first phase of the fight against Coronavirus and entered the second phase, but that success was still dependent on outside conditions and measures taken. He underlined that the healthcare army had gone a long distance, and thanked the Turkish people for their support. Koca said that the number of recovered cases were quickly approaching the number of total cases; and that the number of recovered cases had surpassed the number of active cases that week for the first time.

These results are proof that Turkey has been successful in diagnosis, treatment and containment efforts. Koca warned the Turkish people that the pandemic was ongoing and that the facts about the virus remained unchanged. Home was still the safest place to be protected from the virus [7]. He added: "This should not mean that we are giving up on measures. We will be free in a controlled way [7]." Normalization means a controlled social life. Thus, Turkey is creating the new normal in the second phase and this new normal will be different than what Turkish people were used to. Therefore, life in Turkey will be reorganized as a controlled social life and this new situation will have its own rules. The people of Turkey will be free, in the constraint of two main rules: firstly, if they have to go out, they will wear masks and secondly, they will practice social distancing [7].

Finally, Koca stated that Turkey's goal is to zero the number of new cases and new deaths and also to ensure continuous success and achieve good results [7]. The Ministry of Interior of Turkey has also issued a circular on May 6, 2020 regarding the normalization period in Turkey [12]. Barbershops, beauty salons and hairdressers are allowed to begin work as of May 11, 2020. After then, many business sectors are allowed to reopen workplaces because of economic, social and psychological impacts of COVID-19 [13].

What Turkey Has Done in Comparison to Other Countries During the COVID-19 Pandemic?

The pandemic has reached Turkey later than many other countries. At first, most of the confirmed cases were linked to people coming from China, Iran and European countries; therefore the top priority for the Government of Turkey was to detect these cases by finding their contacts and isolating them as well. Like other countries [8], it was important for Turkey, too, to improve its capacity to detect cases not only at points of entry but also in health facilities and communities.

As mentioned before, the first COVID-19 case in Turkey was detected on March 10 and announced on March 11, much later than in many European countries. Four new cases were reported on March 12. Then new cases were added day by day. The death rate was 2.4% as of March 25 [15]. İstanbul has the highest number of cases compared to other cities in Turkey. The start of the epidemic in Turkey shows high similarity with the early stages of it in Italy and Spain. Although the Minister of Health and the Government of Turkey were quick to take the necessary

measures, a nationwide curfew was not declared. However, curfews for certain age groups (≥65 and <20) and weekend curfews for high-risk cities were implemented. Petersen & Gökengin argue that the consequences of an epidemic similar in proportion to Italy would have been devastating in Turkey [15].

Turkey has already implemented some measures against the spread of the disease compared to other countries. The most important ones are the closure of educational institutions right after the first case, the prohibition of public gatherings and the cancellation of all public events such as football matches, theaters, cinemas, and religious activities in the following weeks [15]. The early preparation of the healthcare system with the Scientific Board was very important in the scientific management of the epidemic. Moreover, developments related to the pandemic in the world were followed closely, procedures updated, and healthcare workers trained by following the suggestions of the Scientific Board and the decisions of the Ministry of Health. The protection of healthcare workers was revised according to new regulations. Likewise, personal protective equipment (PPE) for healthcare workers was provided but providing enough PPE for all healthcare workers took time. The capacity of the available ICUs was also revised, elective surgeries that needed intensive care were canceled. COVID-19 cases which did not need hospitalization were isolated and all those with whom they had had contact were quarantined [15].

Turkey also evacuated its citizens in the COVID-19 pandemic from other countries such as Germany, Italy, Spain, and the USA. Turkey performed the first evacuation operation by bringing back 32 Turkish citizens and 6 Azerbaijani, 3 Georgian, and 1 Albanian citizens from China to the country on February 1 with a well-educated and equipped medical team. Those who were on board, the medical team, and pilots were quarantined at the quarantine hospital in Ankara when they were back in Turkey. Before and after the flight, everyone underwent a detailed medical examination and there was nobody showing any symptoms. Protective measures were also taken against the transmissions by droplets and aerosolization. When back to Turkey, nasopharyngeal swab samples were taken from people for PCR testing in the 3rd, 10th, and14th days in Ankara and all test results came negative. Then 14 days of quarantine was completed and the medical team and pilots also spent the last 4 days at their homes [16].

21,000 pilgrims returned to Turkey from Umrah in March and 6,448 of them who returned after March 15, 2020, were put in quarantine in empty student dormitories, in 7 different cities such as Ankara, Konya, and Eskişehir. Unfortunately, 224 COVID-19 positive cases were reported among them and taken under the treatment. Additionally, 4,821 people were brought back to Turkey from various countries such as Italy, Spain, Germany, Tunisia, Lebanon, Azerbaijan, Ukraine, and Kazakhstan. They were also quarantined in empty student dormitories, in different cities such as İstanbul and Bolu. Moreover, Turkey performed other evacuations from Iraq and Iran. 3,358 students who lived in Europe were brought back from different European countries on March 25. The students were also quarantined in government facilities, in different cities. This evacuation process is still being evaluated, in terms of its effects on the spread of the coronavirus, and its psychosocial outcomes in Turkey [16].

When compared to Asian countries, Turkey was behind South Korea regarding test capacity at first, but currently, more than 30,000 tests can be done in a day in Turkey. Turkey should learn the management and control of the epidemic from countries like South Korea, Singapore, and China. Turkey should continue to test, provide adequate PPE for each hospital timely, and also provide a healthy working environment and suitable working hours for healthcare workers [15].

The Lessons Learned from the Previous Pandemics in Turkey and Their Usage for the COVID-19 Pandemic

The National Pandemic Plan of Turkey was published in 2006. The Pandemic Influenza National Preparedness Plan of Turkey was updated according to experiences from 2009 Influenza-A pandemic. This Plan was prepared under the coordination of the Ministry of Health, General Directorate of Public Health (GDPH), and it was published in the Official Gazette as the Presidency Circular 2019/5. Then Provinces were requested to generate "Provincial Pandemic Influenza Preparedness and Action Plans" and 81 Provincial Health Directorates prepared drafts of own Action Plans. After the evaluation of these plans, Provinces were asked to complete their preparations in the frame of the feedbacks given. Then, Pandemic Coordination Boards and Operation Centers were established on the national and provincial levels. Since COVID-19 is caused by a virus that transmits via respiratory droplets like Influenza, The Pandemic Influenza National Preparedness Plan is also adaptable to the COVID-19 pandemic [2].

This National Pandemic Plan provides an outline of the minimum elements needed for optimal readiness. The aim of the Plan is to secure the continuity of public services. The Plan also aims to reduce transmission, the pandemic strain, the number of patients, hospitalization, and deaths due to the disease, and the socioeconomic burden due to the pandemic [2].

One of the key lessons learned from previous health crises in Turkey was that a rapid response from the Ministry of Health and other arms of Government, as well as the quick reaction of civil society and local communities was critical. Previous pandemics provided case studies of political, societal and socioeconomic consequences of such crises. Thus, this information highlighted that Turkey needed the cooperation of all sectors as part of the response to COVID-19.

Previous epidemics and pandemics in Turkey had also shown the importance of well-prepared national plans and their applications, trained health workers and specialists, and in particular public health specialists and services.

Which Measures Have Been Taken to Control the Spread of COVID-19 by the Government of Turkey?

Preparation for the COVID-19 pandemic had begun before the first case was detected in Turkey. The Ministry of Health of Turkey built teams to work 24/7, and set up a Scientific Board for COVID -19 at the Public Health Emergency Operation Center. This Scientific Board conducted the "COVID -19 Risk Assessment" and then, "COVID-19 Guideline and Case Report Form" was prepared on January 22, 2020. This guideline's first version was published on January 24, 2020. This way a standardized approach to suspect COVID-19 cases all over the country was provided. It is updated constantly in accordance with the updates of WHO, the current scientific developments, international developments, and course of the disease in our country and published on the website of the Ministry of Health of Turkey. Therefore, updated risk assessments, guidelines, case report forms, regulations of personal protective equipment, treatment algorithms, brochures and other related documents have been released regularly [2].

The Ministry of Health of Turkey have made many regulations for COVID-19 pandemic. According to regulations, the Public Health Management System (HSYS) is being used for the case-based

follow-up. All of the COVID-19 possible cases, people who came from abroad and had to be isolated at home and those with whom they had had contact are monitored with HSYS. The data of HSYS is started to be entered retrospectively on March 17, 2020. This data is shared daily. The samples for COVID-19 are being tested by PCR and rapid diagnostic kits, and analyzed at the Central Microbiology Reference Laboratory and other authorized laboratories in several provinces. In each province of Turkey, Pandemic Hospitals have been determined and all possible and confirmed cases have been admitted and treated in those hospitals. Additionally, nonemergency surgeries and nonurgent dental practices have been postponed. Scientific studies have also been conducted on virus isolation, vaccine, drug and plasma treatment and the studies are still going on [2].

Healthcare personnel and the public have been trained about COVID-19. Different communication channels and social media have been used for giving information related to the disease such as prevention and general hygiene rules [2]. Various preventive measures have also been taken by the Government of Turkey such as social distance orders, weekend curfews, limiting foreign admission to the country and air traffic, limiting ground transportation and trains, the closure of business and educational institutions.

In February, all flights to and from China, Iran, Italy, South Korea and Iraq were stopped. In March, President Erdoğan announced that Turkey suspended all international flights as part of measures to curb the spread of coronavirus [9]. Domestic flights were also restricted. Flight restrictions were, at first, to certain countries, then gradually expanded and all flights were suspended. Foreign nationals were prohibited from entering Turkey. 14-day self-isolation and symptom monitoring were requested from those who arrived from high-risk countries to Turkey. Those preventive measures are also applied to Turkish citizens who came from Umrah and who have been discharged from the quarantined areas. Moreover, health control measures have been taken at land, air, sea entry points and ships [2].

Measures have also been implemented in areas such as penitentiary institutions, dormitories, nursing homes, military barracks, hotels, restaurants, shopping malls, cinemas, theaters, airports, bus stations, train stations, public transport, and intercity busses. At first, some restrictions were implemented for gathering places or high-risk places for disease transmission, next all places such as entertainment venues, bars, night clubs, theaters, cinemas, concert halls, wedding halls, mosques, tea gardens, restaurants, cafes, internet cafes, all game halls, all indoor playgrounds, amusement parks, swimming pools, saunas, sports centers, hairdressers, barbers and beauty centers have been temporarily suspended. Moreover, prayers with the congregation, Friday prayers, funerals and following gettogethers, all meetings, social organizations and other organizations which bring people together, sports activities and all kinds of scientific, cultural, artistic and similar meetings or activities at national and international level were suspended. Hygiene and cleaning measures have also been taken for transportation vehicles such as public transportation and shuttle buses and the number of passengers allowed on such transportation has been limited to 50% of the capacity. Road and air travel are only allowed after obtaining a permit. Entrance and exit to and from 30 metropolitan cities and Zonguldak was restricted [2].

Educational institutions have been temporarily closed as of March 16, 2020, and distance education is still ongoing. Regulations such as flexible working hours and working from home for workplaces and offices have been applied. People with chronic diseases or those over 60 years old, disadvantaged or disabled groups, pregnant women, and nursing mothers entitled to nursing

leave have been granted administrative leave. A restriction has been implemented as a curfew for people who are 65 or older and who are with chronic disease on March 21, 2020, then it has been extended to young people who are under 20 on April 3, 2020. Lastly, weekend curfews and quarantine measures have been implemented for the same provinces starting from April 11, 2020 [2].

Morgue and burial procedures and autopsy procedures have been regulated and carried out for those who died of COVID-19. Personal protective equipment has been used in the undertaking of such tasks [2].

According to the current situation of the COVID-19 pandemic in Turkey, the Government of Turkey seems to have acted quickly to take the necessary measures for the interruption of transmission. The strategies of the government have aimed to identify cases early, isolate possible cases and trace contacts to prevent or limit person-to-person transmission. It has been especially important to put stringent early detection and surveillance measures in Turkey. For this reason, Turkey has deployed filiation teams for monitoring citizens to curb the spread of virus.

Health Minister Fahrettin Koca has announced Turkey's COVID-19 data, and informed the public about the process and the recommendations of the Coronavirus Scientific Advisory Board in press conferences almost every day. Koca said that there are 5,849 filiation teams in Turkey, and they have so far detected 468,390 people who had been in contact with the virus in one of press conferences following the meeting of the Coronavirus Scientific Advisory Board on April 29, 2020 [5].

Like other countries [8], since existing healthcare systems in Turkey are already dealing with many diseases and challenges, the main fear was that an unmanageably large caseload would be develop. As of 29 April, Koca said that Turkey had the lowest death rate from coronavirus among the European countries, and the country ranked 80th in the world in COVID-19 related deaths [5].

What is the Risk Profile of Turkey in terms of Susceptibility to COVID-19?

COVID-19 can lead to a serious lung inflammation, acute respiratory distress syndrome (ARDS), cardiac and renal injury. This disease can be serious in patients especially with older age and comorbidities (diabetes mellitus, hypertension, and heart failure). Patients can be divided mainly into two groups. The first group includes asymptomatic or mild cases that usually recover. The second group includes severe cases (approximately 15%) that develop multi organ failure, primarily respiratory failure and require intensive care unit (ICU) admission [2].

In the light of current information about COVID-19 in Turkey, it seems that older people and people with a range of underlying conditions have been more affected like in Asian and European countries. Turkey is still piecing together evidence based information and current experiences on how COVID-19 will affect different age groups and people. The Coronavirus Scientific Advisory Board is analyzing Turkey's COVID-19 data and updating the information for Turkey's act plan for this pandemic.

How Has Life Changed During the COVID-19 Pandemic in Turkey?

First of all, Turkish citizens have had to adapt to the preventive measures which were recom-

mended by the Government of Turkey to mitigate the spread and impact of COVID-19. Personal hygiene, in particular regular hand washing has become more important than before.

Although there were much misinformation and false preventive suggestions about COVID-19, the members of the Coronavirus Scientific Advisory Board and public health specialists have taken action to debunk misinformation through TV programs and their twitter accounts. The Health Minister gave information and reports about the current status of the pandemic in Turkey almost every day through press conferences and his official twitter account since the end of February. The public have closely followed him and paid much attention to his conferences, statements and tweets.

The evacuation operations were important periods for Turkey during the pandemic. Those operations brought some medical risks and new social problems to Turkish society. One of those problems was the transferring of coronavirus from one place to another despite the measures taken. Others were social and psychological traumas and concerns in society because of some COVID-19 positive evacuees. Like in other countries, some locals did not want people in their cities where the evacuees were quarantined. Thus, this situation also caused another public problem. Moreover, regardless of the social, mental, and economical status of the evacuees, they were put in quarantine strictly for 14 days [16]. For example, some evacuees did not want to stay in the dormitories prepared for the quarantine in different cities of Turkey, and some evacuees even tried to escape from those places. Likewise, some of the Turkish citizens blamed the evacuees and the government because of the spread of the disease. Thus, the Turkish people had to cope with those concerns, too. The tension between the evacuees and the locals decreased after the end of the quarantine process.

Turkish people have started to avoid unnecessary travel and take precautions to stay away from crowded areas in accordance with recommendations and measures taken by the government. Those over 60 or with underlying conditions, such as cardiovascular disease, diabetes, chronic respiratory disease or cancer are strongly recommended not to leave their homes and to avoid visitors. Those who are younger or in lower-risk categories are asked to be aware of their ability to spread novel coronavirus to those more vulnerable than them. Accordingly, the Government of Turkey declared a curfew for old people who are 65 or older and who have a chronic disease, and then extended this curfew to include young people under 20. Those who have been at home for over a month have had a hard time and psychological, physical and economic difficulties. Then Ministry of Interior issued a circular for those restricted with the curfew on May 6, 2020; according to this which those citizens who are 65 or older and citizens with a chronic disease were allowed to go out on May 10, between 11:00 am and 15:00 pm, complying with the social distance rule and wearing a mask. Likewise children who are under 14 years old will be allowed to go out on May 13, and young people who are in between 15-20 years old will be allowed to go out on May 15, between 11:00 am and15:00 pm complying with walking distance, social distance rules and wearing a mask [10].

After the curfew for the elderly and at-risk populations, military police, watchmen employed by the government, police, and municipalities started to help those people (e.g. for shopping, health issues, etc.) in Turkey. Vefa Social Support Group by the Government of Turkey also started to help those people for their personal needs. After then, President Erdoğan announced the initiation of a donation campaign called "We're Enough for Each Other Turkey" (In Turkish: Biz Bize Yeteriz Türkiyem) [14]. Turkish people have tried to help each other economically and psychologically. They supported their elderly neighbors and those with economic difficulties.

Especially some municipalities such as Ankara and İstanbul have supported the society with social regulations for making their life easier.

The situation of migrants is one of the important issues in Turkey. With the regulations related to COVID-19, migrants are examined in health institutions according to case algorithms, too. If necessary, samples are taken from them and isolation rules are applied for 14 days under observation. The migrants are also trained on COVID-19 in Migrant Health Centers. They are informed about the prevention measures of the disease. Likewise, informative materials on COVID-19 are prepared and translated into other languages for them. The Ministry of Health has also made regulations for everyone to utilize personal protective equipment, diagnostic tests, and medications used for related COVID-19 treatment regardless of whether if they have social security or not [2].

Currently, it is mandatory to wear a mask in public places such as markets, buses, and subway trains where physical distance rules might not be applied. Measures for physical distance rules must also be taken in such environments. Sales of products such as clothes and toys have been stopped, only food and cleaning products are allowed to be sold [2]. However, there are still some difficulties in practicing physical distance rules, especially in markets. Moreover, markets and public places are getting more crowded because of the good weather and Ramadan.

The Lessons Learned from the COVID-19 Pandemic in Turkey

The world is still learning a lot about COVID-19 and how it will affect different populations [8]. Every country wants to take all possible measures to guard itself against COVID-19, so does Turkey. As in all countries, it is possible that some cases of COVID-19 in Turkey are still being missed, but it is thought that most are being picked up.

At first, there was too much misinformation about COVID-19 and it was really dangerous for the public health in Turkey. It has been seen that people should be informed about such diseases from reliable sources. It has also been seen that the spread of rumors and misinformation can cause the potential panic and discrimination.

Prevention and mitigation interventions by the government must be employed, and the government has to work on this seriously with the help of specialists. Additionally, evacuation and quarantine processes should be prepared in a very detailed manner. The economic, psychological, and social aspects of them should be evaluated carefully. Some practices in those processes can lead to health concerns, economic and social anxieties in the public [16]. Therefore, new problems might appear in time, which can also make the existing situation even harder. The Government of Turkey should be well-prepared for those processes and should manage them keeping in consideration all possible social problems.

One important point is about the socio-economic status of people in Turkey. Turkish citizens who are living in poor and overcrowded areas and who had to close their business places temporarily or who had to leave from the work during the pandemic have been confronted with significant socioeconomic obstacles. In these circumstances, the government should support those people socially and economically with well-prepared regulations. According to the article of Açıkgöz & Günay, the Government of Turkey announced a $15.4 billion economic stimulus package on March 18, 2020, and introduced “a mix of tax cuts, payment deferrals and increased pension pay-

puts to help citizens and businesses"; but the government should take measures for long term to save jobs and reduce the burden on people who have left work. Turkey has been the host country for the largest refugee population, in particular for Syrians, in the world for quite a while, and this situation will also bring a financial burden to Turkey [17]. Hence, the Turkish economy is under the danger of a financial crisis, and Turkey should take life-saving measures to cope with this crisis.

COVID-19 pandemic in Turkey has revealed the value of the health-care workers. Like previous pandemics, it has also shown the importance of a well-prepared national pandemic plan, trained health workers and specialists, in particular ICU specialists, infectious disease specialists, public health specialists and epidemiologists. Turkey has also seen that the importance of education, training, adequate personal protective equipment, especially masks, tests, ventilators and updated protocols. Additionally, the importance of public advices, sanctions and applications regarding hygiene and social distancing has been understood. In sum, like other countries in the world, Turkey has seen that national preparedness and community engagement is very important for fighting pandemics, too.

The Ministry of Health of Republic of Turkey has not collaborated with the Turkish Medical Association during the COVID-19 pandemic. The Ministry of Health should work together with the Turkish Medical Association, and they should inform the public with common infographics, texts, brochures, videos, etc. which is important for creating an environment of trust in Turkey [11]. Moreover, the decisions of the Scientific Board have not been shared during the pandemic. Those decisions should be shared with Turkish society transparently again for creating trust in the management of the pandemic [18].

Consequently, Turkey should work on worst-case scenarios and prepare for mitigation measures in a pandemic like the rest of the world [8]. Turkey also has to rethink the health services and health policies to ensure the continuity of critical health services. The Government of Turkey and its partners have to prepare health services well and work on other critical measures and possible challenges for such health crises like pandemics. Additionally, as Açıkgöz & Günay argue: "This pandemic has severe adverse effects on the employees, customers, supply chains and financial markets" and it will probably cause a global economic recession [17]. Açıkgöz & Günay also argue [17]: "It seems that this pandemic will lead to a permanent shift in the world and its politics, especially in health, security, trade, employment, agriculture, manufacturing goods production and science policies". Therefore, Turkey also should develop new strategies to prepare for the post-pandemic world like other countries in the world.

REFERENCES

Ministry of Health of Republic of Turkey Web Page (2020). "Koronavirüs, Alacağımız Tedbirlerden Güçlü Değildir" [online].Website: https://www.saglik.gov.tr/TR,64383/koronavirus-alacagimiz-tedbirlerden-guclu-degildir.html [accessed 5 May 2020].

Demirbilek et al. COVID-19 outbreak control, example of ministry of health of Turkey. *Turk J Med Sci* (2020) 50: 489-494. doi:10.3906/sag-2004-187

Anadolu Agency Web Page (2020). Turkey confirms first case of coronavirus [online]. Website: https://www.aa.com.tr/en/latest-on-coronavirus-outbreak/turkey-confirms-first-case-of-coronavirus/1761522 [accessed 6 May 2020].

, Ministry of Health of Republic of Turkey Web Page (2020). Türkiye Günlük Koronavirüs Tablosu [online].Website: https://covid19.saglik.gov.tr/ [accessed 6 May 2020].
Anadolu Agency Web Page (2020). Turkey currently passing over peak of pandemic [online]. Website: https://www.aa.com.tr/en/health/turkey-currently-passing-over-peak-of-pandemic/1823201 [accessed 6 May 2020].
Ministry of Health of Republic of Turkey Web Page (2020). "Koca Briefs WHO on Turkey's Fight Against COVID-19" [online].Website: https://www.saglik.gov.tr/EN,65414/koca-briefs-who-on-turkeys-fight-against-covid-19.html [accessed 7 May 2020].
Ministry of Health of Republic of Turkey Web Page (2020). "Turkey Has Completed the First Phase of the Fight Against Coronavirus" [online].Website: https://www.saglik.gov.tr/EN,65455/quotturkey-has-completed-the-first-phase-of-the-fight-against-coronavirusquot.html [accessed 7 May 2020].
Payne, C. COVID-19 in Africa. *Nat Hum Behav* (2020). https://doi.org/10.1038/s41562-020-0870-5
Anadolu Agency Web Page (2020). Turkey cancels all int'l flights amid COVID-19 outbreak [online]. Website: https://www.aa.com.tr/en/latest-on-coronavirus-outbreak/turkey-cancels-all-int-l-flights-amid-covid-19-outbreak/1782602 [accessed 6 May 2020].
Ministry of Interior of Republic of Turkey Web Page (2020). 65 Yaş ve Üzeri/20 Yaş Altı/Kronik Rahatsızlığı Bulunan Kişilerin Sokağa Çıkma Kısıtlaması İstisnası Genelgesi [online]. Website: https://www.icisleri.gov.tr/65-yas-ve-uzeri20-yas-altikronik-rahatsizligi-bulunan-kisilerin-sokaga-cikma-kisitlamasi-istisnasi-genelgesi [accessed 7 May 2020].
HUBAM (Hacettepe University Center for Bioethics) Web Page (2020). "COVID 19 Pandemisi ve Etik" Duyurusu [online]. Website: http://www.hubam.hacettepe.edu.tr/ekler/pdf/pandemi/covid19/covid19pandemisiveetik.pdf [accessed 7 May 2020].
Ministry of Interior of Republic of Turkey Web Page (2020). Berber/Güzellik Salonu/Kuaförlerin Açılması Genelgesi [online]. Website: https://www.icisleri.gov.tr/berberguzellik-salonukuaforlerin-acilmasi-genelgesi [accessed 9 May 2020].
Anadolu Agency Web Page (2020). Turkey to keep industry alive: Industry minister [online]. Website: https://www.aa.com.tr/en/economy/turkey-to-keep-industry-alive-industry-minister/1832746 [accessed 9 May 2020].
Ministry of Interior of Republic of Turkey Web Page (2020). Main Page [online]. Website: https://www.icisleri.gov.tr/ [accessed 9 May 2020].
Petersen & Gökengin. SARS-CoV-2 epidemiology and control, different scenarios for Turkey. *Turk J Med Sci* (2020) 50: 509-514. doi: 10.3906/sag-2003-260
Şencan & Kuzi. Global threat of COVID 19 and evacuation of the citizens of different countries. *Turk J Med Sci* (2020) 50: 534-543. doi: 10.3906/sag-2004-21
Açıkgöz & Günay. The early impact of the Covid-19 pandemic on the global and Turkish economy. Turk J Med Sci (2020) 50: 520-526. doi: 10.3906/sag-2004-6
Halk Sağlığı Uzmanları Derneği (HASUDER) Web Page (2020). Yeni Koronavirüs Hastalığı (Covid -19) Pandemisine Türkiye'de Hazırlıklılık ve Yanıt: 28. Gün Değerlendirmesi [online]. Website: https://korona.hasuder.org.tr/pandeminin-28-gun-degerlendirmesi/ [accessed 9 May 2020].

Bioethics & Dis-abilities (different-abilities)

LIFE DURING COVID-19 PANDEMIC:
IT'S TIME TO THINK ABOUT, IT'S TIME TO CHANGE

Dr. Alessandra Pentone, International Adviser UNESCO Chair in Bioethics Italian Unit

Planet Earth, year 2020: our world and our life has changed in a surreal way. It seems that suddenly we are all playing a reality TV show, the worst one, against our will, not enjoying it at all. Time and space dimensions do not belong to us anymore, as we were always used to think, supposing to manage them, according to our rhythms and personal choices.

The SARS –CoV-2 virus reigns supreme affecting all our relationships, from the closest to the farthest one, in multiple and various manners.

Banning kisses, hugs, handshakes, and any other physical contact forcing ourselves in a private zone at least 3.28 foot distant from the next human being.

Hiding our smiles behind a surgical mask or, even worst, a facial one that the community of health care workers has to wear, denying to the patient even the so important and needed fair reassurance visual expression.

At worst, denying the right or the duty of the people who lost their familiars, friends, colleagues or neighbours of taking from them the last leave.

Relegating and segregating everyone in his /her home (if you are so lucky to have one) only a few people are still allowed to go out to do their job (again, if you have the privilege to have one) high -tech tools allows the most smart working from their laptops.

Empty cities, desert roads, a strange silence surrounding every corner of each block states a new balance. Nature celebrates human being absence giving back the sky its mantle of sparkling stars, the air its freshness and clarity, the sea its transparency and clearness, the dawn and the sunset their true colours. Birds, fishes, different sort of animals enjoy their environment: no one complains the strange lack of people.

PTSD, anxiety, depression will replace Covid-19 in the next scenario where the human survivors, literary and metaphorically speaking, from the first moment complained a sense of loneliness, uncertainty for the future, a constrain feeling to be locked up in a cage, and so on.

Under this frame concerning humanity as a whole, we suggest to "take advantage" of this particular time to think and reflect on a few simple issues.

There is a minority living and feeling this kind of dimension since ever. They are called dis-able,

and, according to some universal declarations on human rights, they seem to belong to humanity, too. Their daily life, with or without Covid-19, is ALWAYS characterized by “a sense of loneliness, uncertainty for the future, constrain to be locked up in a cage”. Their right to a “normal” life, being able to express themselves, to move around, to choose what to do and where to go, to have a job , and build relationships, states in legislations of different nations all over the world. In reality, it often seems to be utopia. Why? Because in 2020, the big handicap for this “kind” of people, despite their personal limits and their effort to overcome them by different abilities, is a pandemic disease without effective vaccines or medication able to eradicate it. Its name is INDIFFERENCE, and its roots take place deeply in human minds and souls. Ignorance, selfishness, and prejudice nurture this dangerous invisible monster that hides itself behind a mask of hypocrisy, false promises and untrue kindness. When and if this Covid-19 will end and everyone is supposed to come back to his/her normal life, what will happen to this minority? Should they deserve at least once a chance to try to live their life and not only to survive? Will we learn from this unique experience trying to change the ongoing system? At the end of the day, will anybody care at all?

ITALY

COVID—19 AND DISABILITY: DIFFICULTY OF LIVING THE EMERGENCY AND THE PAIN OF DIFFERENCE

by Alessandra Fabbri , Genoa University

The coronavirus forces us to live a different existence than the one we were used to. Our The coronavirus forces us to live differently than we were used to do. Our freedom of movement is reduced; socialization has only become possible online: hugs, physical closeness, sharing a dinner have been forbidden. This is a very difficult test for all of us because, as Aristotle wrote, "A man is a social animal”.

Even though isolation involves dismay and sometimes depression, it gives us the opportunity to reflect on our lives, choices and relationships in order to let us understand how important they are to us. Pierre Hadot recommends practicing the spiritual exercise of meditation so that you can know yourself. This kind of philosophy guides us in our actions and becomes an art: the art of living.

During an emergency, as the one we are going through, each of us feels lost. All habits have changed and it is difficult to adapt to the new ones.

How does a person affected by disability experience this emergency situation? Every condition of disability shares these common elements: the first one is pain and the second one is the difficulty in living out of the normal conditio . In order not to misunderstand this issue, I would like to provide further information. As Canguilhem recalls : " The concept of abnormality, that is the difference from the norm (a statistical element often considered a “value "), produces painful and negative effects on the disabled people: when the anomaly is interpreted in its effects, in relation to the activity of the individual, and therefore to the representation that he makes of his own value and destiny, it is invalidity. (...) For the disabled there can be a possible activity and an honorable social role. But the forced limitation of a human being in a unique and invariable condition is

judged negatively, in reference to normal human ideal which consists of a possible adaptation to any kind of unimaginable conditions».

This deviation from the norm leads to a different consideration of what occurs to us. Experiencing an emergency like the one connected to Covid-19 can amplify the perception of our own handicap. I refer to my personal experience: staying housebound for weeks constraints us to tackle the challenge of daily commitments that cannot be practically carried out.

The consequent feeling of powerlessness which stems from this situation may crush us. The uncertainty about future is likely to become unbearable. At this point, I'm speaking about the fear of not knowing how to move practically. Let me explain: I have a physical disability that forces me to move with two crutches. Despite this fact, I can be pretty free-standing: I move independently, taking public means of transportation, I have my social life. In a sentence, I have conquered my normality.

In spite of this, in the current condition of " suspended reality" I am very afraid. My rehabilitation therapies have been interrupted. Every day, I struggle to walking and I don't know how public transportation is organized, if and how I will be able to get on a bus.

In all the government decrees issued in this period, disability is never mentioned: it seems a condition that affects only a few people. Is it better to keep it hidden? I feel really invisible, unsupported by the politicians. I feel anxious and I don't know how to react. But I try not to get overwhelmed by fear, I try to keep calm and reflec.

How is it possible to overcome this situation? How to make ourselves visible and achieve a well-being that allows us to find a balance between the things we cannot do and those we can do? How to look for satisfaction and well-being? How can we achieve our wellbeing, in spite of our disability? It is difficult to give an univocal answer: everyone reacts to his/her disability in different ways, according to his/her own psycho-physical condition, her/his processing capacities, and the social context in which she/he lives. Our aim is to achieve a balance in order to get a good health and well-being condition, and it is likely to attain this goal even in case of disability.

The World Health Organization has defined health as: " State of complete physical, mental and social well-being and not just the absence of disease"; it follows that people's conditions and well - being (feeling well) are to assume an essential importance; on the contrary, diseases should not be taken into consideration. ICF model (International Classification of Functioning, Disability and Health, OMS, 2001) is based on this definition. It doesn't refer to a structural or functional disorder and it doesn't connect it to a condition that has been considered healthy. In addition, it is relevant that this classification lists the environmental factors that interact to determine a disability situation, which is defined as the result of a complex relationship among individual's health condition, personal and environmental factors related to the context the individual belongs to.

In summary, placing well-being at the center of our interests involves the transition from a welfare model based on a cost-benefit calculation, where efficiency and effectiveness are measured in quantitative terms, to another one based on the choice of prioritizing the qualitative aspects of well-being .

Jf we seriously take into consideration the qualitative dimension of wellness, even in an emergency situation, we are to take care of all the people, even those living in conditions of remarkable vulnerability, as people with disabilities.

I think that people experiencing these conditions have not been taken into account by the politicians, even in this emergency. This happens because the amount of the treatments does not have an effective recognition. In order to give a social value to treatments, politicians should promote well-being and limit the psychological and social damage that comes from pandemic and isolation.

What does the word “care” mean and how is it related to well-being?

In English language the word “care” refers to two different terms: Cure and Care. Cure includes a number of treatments designed to bring back diseased organs to a normal condition. Care is, on the other side, aimed to the well-being. Anyway, this concept is not so simple to explain, due to the use (or abuse) of this word, so common today: in fact, you can see a set of meanings and practices that are inspired by this purpose. The issue related to well-being, and consequently to well-living, which are tightly connected, refers to a series of further questions. Who decides what is well-being? And who chooses how to make it?

In this perspective, important tools (such as a methodology based on analysis and action) are provided by Ethics of Care and, more in detail, by the political version of the care, developed by Joan Tronto.

Tronto undertakes a careful reflection in order to build up a new situational ethics, based on ethical feelings, such as inclusion, empathy and sympathy. She starts her research from the needs and, reflecting on them, she affirms the close relationship among democracy, market and care.

Tronto underlines the fact that care is a process usually entrusted to women, especially those who occupy a positions of economic and social disadvantage: "Caring activities are devalued, underpaid and disproportionately carried out by the relatively powerless people in society ".

In order to change the patterns proposed by the current political trends, Tronto suggests using the tools proper to Ethics of Care, which promotes a more equitable distribution of resources and, above all, the inclusion of all the social actors, even those traditionally excluded.

Care practice demands four fundamental elements from a moral point of view: attention, responsibility, competence and responsiveness.

Care can be considered a constitutive dimension of our moral life: the pursuit of caring is to be practiced in its transitivity. Care is a key element of a political theory based on justice and it cannot concern only the private sphere of individuals’ life.

At this point, a question arises: how is it possible to integrate care into our political vision?

It is necessary to reflect on two concepts: dependence and autonomy.

According to Joan Tronto, considering care as a fundamental aspect of human life results in interesting consequences: firstly, it means that we cannot consider people as fully autonomous be-

jngs, but we have to highlight their condition of interdependence.

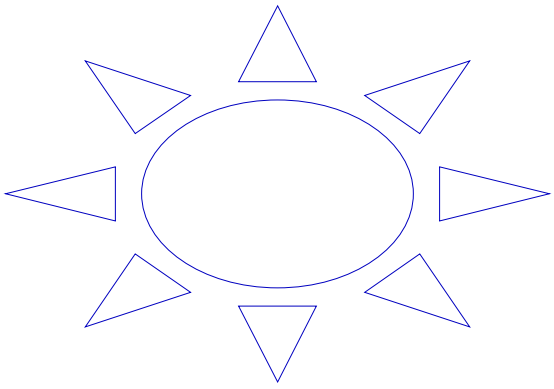
« It is typical of our vulnerable human nature the fact that our autonomy emerges after a long period of dependence and that, in many respects, we continue to remain dependent on others. In the same way, we have to take care of other people. Since we are sometimes autonomous, sometimes dependent, sometimes caring, we may be described as inter-dependent individuals ».

It is essential, therefore, to think again about the two concepts of dependence and autonomy, referring to Ethics of Care. A more complex concept of autonomy is to be studied in depth; dependence should not be considered a permanent condition, but one that is to be overcome.

Tronto stresses that the qualities of attention, responsibility, competence and responsiveness must not be restricted to the immediate objects of our care, but can also model our practice of citizens. This favors a policy centered on public debate about needs and a fair assessment of the intersection of needs and interests.

If we want to include the value of care into a theory of political justice, it is necessary to reflect on the concept of need and on the origin and nature of emerging needs within different contexts, which vary not only according to people, but also to the ages of human life: a child and an elderly person have different needs. Only by recognizing each individual as a man/woman characterized by needs will we be able to deal with the problem of resources allocation with greater awareness. It is relevant to take into consideration those who have extraordinary need, finally making visible people living in disadvantaged conditions.

In a period dominated by emergency politics, concerned with hurriedly made decisions, social problems should be solved by going to the root of issues. In this age, troubled by lack of respect and responsibility, caring and Ethics of Care seem to be the only way to appreciate people, both from individual and social point of view.



Bioethics and Legislation

RULE OF LAW COVID-19

Dr. Shanthi Van Zeebroeck, PhD, Law and Bioethics, Université Libre de Bruxelles – Belgium/ Europe/USA

Health is the most important part of a human life. Regrettably, in 2020, we face a global pandemic, a public health crisis like no other, in the form of COVID-19 (C-19). Due to the infectious nature of C-19, a major challenge in the field of law, is to uphold the Rule of Law itself, without infringing on one of the most fundamental part of human rights, the freedom of movement.

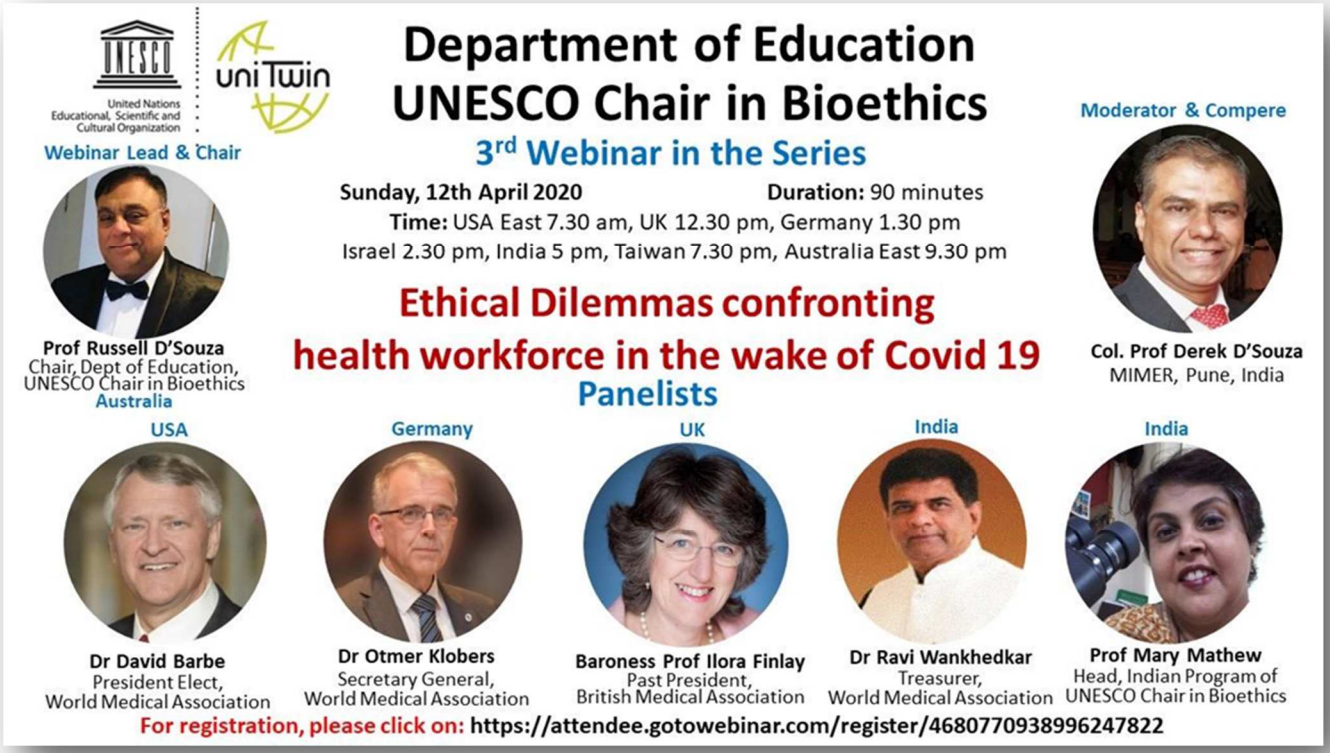
Rule of Law mandates that no one is above the law, and that every individual, and/or an institution, is equally, justly, and fairly accountable to the principles of law, without compromising human rights. Yet, we witness the swift imposition of government rules, such as lockdowns, social distancing, and quarantining of people. These rules, while implemented, and executed for the benefit of combating C-19, have an equal harm of restricting human movement, especially to continue livelihoods, in order to feed families, which is backfiring in the form of protests in Italy, New York, and Paris among other states, and countries. Human right to freedom of movement is as important as is human right to a livelihood to maintain life itself.

It is therefore important, that governments, in placing pandemic-related rules in place, follow legal instruments that provide proper guidance in ensuring fundamental human rights are protected, and that the Rule of Law is ultimately upheld. For instance, European countries can look to The European Social Charter, (ETS No.163, Revised) which is a treaty documented and maintained by the Council of Europe and is looked upon as the "Social Constitution of Europe." https://www.coe.int/en/web/european-social-charter for guidance.

In the USA, the federal government implemented the **Families First Coronavirus Response Act (FFCRA)** to ensure protection of families and their rights during this pandemic. https://www.dol.gov/agencies/whd/pandemic

Upholding the Rule of Law, while protecting human rights is a major legal dilemma we face in our fight against C-19.

Education


Department of Education
UNESCO Chair in Bioethics
3rd Webinar in the Series
Sunday, 12th April 2020
Duration: 90 minutes
Time: USA East 7.30 am, UK 12.30 pm, Germany 1.30 pm
Israel 2.30 pm, India 5 pm, Taiwan 7.30 pm, Australia East 9.30 pm
Ethical Dilemmas confronting
health workforce in the wake of Covid 19
Panelists
Webinar Lead & Chair
Prof Russell D'Souza
Chair, Dept of Education,
UNESCO Chair in Bioethics
Australia
Moderator & Compere
Col. Prof Derek D'Souza
MIMER, Pune, India
USA
Dr David Barbe
President Elect,
World Medical Association
Germany
Dr Otmer Klobers
Secretary General,
World Medical Association
UK
Baroness Prof Ilora Finlay
Past President,
British Medical Association
India
Dr Ravi Wankhedkar
Treasurer,
World Medical Association
India
Prof Mary Mathew
Head, Indian Program of
UNESCO Chair in Bioethics
For registration, please click on: https://attendee.gotowebinar.com/register/4680770938996247822


Department of Education
UNESCO Chair in Bioethics
4th Webinar in the Series
Sunday, 19th April 2020
Duration: 90 minutes
Time: USA East 7.30 am, UK 12.30 pm, Germany 1.30 pm , Kenya 2.30 pm
Israel 2.30 pm, India 5 pm, Taiwan 7.30 pm, Australia East 9.30 pm
Navigating a Public Health Emergency
Ethically and legally in the wake of Covid19
Panelists
Webinar Lead & Chair
Prof Russell D'Souza
Chair, Dept of Education,
UNESCO Chair in Bioethics
Australia
Moderator & Compere
Prof J S Bamrah
Chairman, BAPIO,
British Med Assoc
UK
UK
Prof Vivienne Harpwood
Prof of Healthcare Law & Chair,
Powys Health Board, Wales
Israel
Prof Ilana Belmaker
Prof of Public Health
Ben Gurion University of the Negev
Kenya
Prof Marion Mutugi
Vice Chancellor, Amref
International University Nairobi
India
Prof Abhay Gaidhane
Director, School Of Epid & Public
Health, DMIMS, Wardha
India
Prof Mary Mathew
Head, Indian Program of
UNESCO Chair in Bioethics
For registration, please click on: https://attendee.gotowebinar.com/register/4680770938996247822

, **ETHICAL AND LEGAL IMPLICATIONS OF NAVIGATING A PUBLIC HEALTH EMERGENCY IN THE WAKE OF THE COVID-19 PANDEMIC**

DEPARTMENT OF EDUCATION UNESCO CHAIR IN BIOETHICS HAIFA

WEBINAR SUMMARY REPORT

Prepared by Emeritus Professor Des Cahill RMIT University Melbourne Melbourne Australian Bioethics Unit of the UNESCO Chair in Bioethics Haifa

This report summarizes a Global Panel Discussion Webinar in the Wake of COVID 19 held on Sunday night (Melbourne time), 19th April 2020 under the sponsorship of the Department of education UNESCO Chair in Bioethics located at the University of Haifa which works to encourage the teaching of bioethics in Medical Health Sciences and Law courses across the world. The two-hour meeting was chaired by the Melbourne-based Professor Russell D'Souza Chair Department of education International Program of the UNESCO Chair in Bioethics and was facilitated by Professor J S Bamrah from the University of Manchester UK. Input came from ten specialists in Australia, Germany, India, Israel, Kenya, the UK and the USA. Approximately 420 persons were registered online participants and spectators. And asked questions through the chat box which was monitored by Professor Dr Mary Mathew Head of the Indian Program and Col Professor Derek DSouza Education Department Pune India.

The webinar began with opening remarks from Professor D'Souza who said that since the March 11th declaration by the World Health Organization the world had entered an unprecedented crisis with major challenges at policy levels and within ethical and legal frameworks. He observed that "equity and public health go hand in hand. We are only as safe as the most vulnerable globally". A balance needed to be maintained between patient-cantered care and public-focused duties. And there were competing sources of moral authority. In his view, health care leaders had three fundamental duties: (1) the duty to plan in managing the uncertainty and responding to the unprecedented challenges, (2) the duty to safeguard, especially in the support and protection of health workers and (3) the duty to guide in continuing and elevating the level of care. Other issues were the balance between public health needs and civil liberties together with the public's right to know in relation to decision-making of governments which must make very difficult decisions and take measures hard for the public to accept. To what extent can and should a government maintain secrecy about the details behind such decision-making?

He asked the questions: what are the legal rights of health care workers in less than ideal work conditions? And what are the legal implications in insurance and compensation for health care workers? There are clearly very different challenges in the various countries. In the UK, the COVID-19 virus was impacting disproportionately upon minority groups. We need to think about the ethics of the lockdown and the cordon sanitaire.

Professor Ilana Belmaker from the Ben Gurion University of the Negev Israel spoke about the balancing of the number of deaths and the effects and limits of the quarantining of people. She asked whether it was not more appropriate for elderly people to be in lockdown while allowing young people to be free. She referred to the situation of Orthodox Jews with their large families

]iving in poor areas. Israel had adopted the practice of quarantining 'hot spots' in towns and cities. Some people were now afraid of going to hospitals for whatever purpose. In Israel police must explain the reasons for lockdown before issuing a penalty.

Professor Marion Mutugi, Vice-Chancellor of the Amref International University in Nairobi Kenya spoke of the disconnect between knowledge, attitude and practice. Human nature has poor compliance unless there is a motivation or a sanction. She mentioned that one of the earliest recorded epidemics was the Justinian plague in 541 CE that resulted in 30-50 million deaths in Europe, North Africa and Arabia.

Constantinople was completely decimated. She compared the two Italian cities of Bergamo and Lodi. Bergamo took the route of half-way measures whereas Lodi had enforced lockdown – Lodi has had half the number of positive cases. She drew attention to the matter of culture, particularly in regard to funerals where mourning and closure were very important in African culture. But death is also a taboo subject. She also mentioned that long-distant truck drivers and other transportation workers were major conduits as they had been during the AIDS crisis.

Some African countries are worse than others, led by Egypt, South Africa and Morocco. There was in most countries little or no capacity or infrastructure to test and there was some stigmatization. Decisions about resource allocation need to be made within an ethical framework – in prioritizing ventilators: a patient or a health worker? Lastly, she drew attention to the ethics of health journalism and the use of statistics and fake news.

Several participants drew attention to the situation in India. Professor Abhay Gaidhane of the Datta Meghe University of Medical Sciences at Wardha in the north-east Indian state of Maharashtra and Professor Amatav Banerjee fD Y Patil University rom Mumbai drew attention to urban slums where social distancing was very difficult with people living in such close quarters with each other, using the same open toilet etc.. India has a large percentage of young people so India could have taken a different strategy to lockdown. There is an extra complication. Each day 1,400 people die from TB in India every day and so should health experts have recommended the strategy when so many die from TB and child mortality? "We never had a curve to flatten", noted Professor Banerjee. He also commented later in the webinar that the WHO and Indian government responses to the masks issue had been 'terrible'.

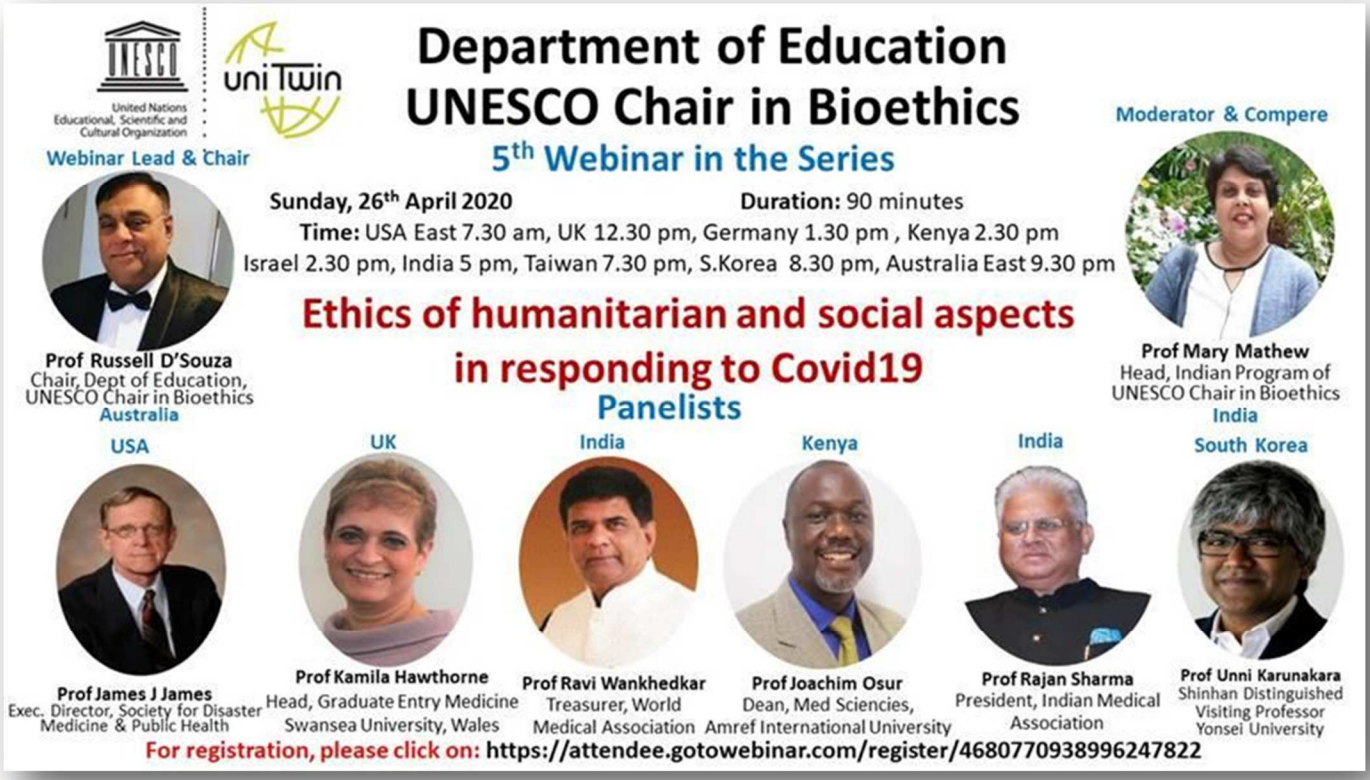
In Germany, according to Professor Gerard Fortwengel from the University of Hanover, the situation was under control following the implementation of various measures such as domestic isolation and contact ban. The German Medical Protection Act, in place for a long time, had proved very useful. The German health insurance treats everyone equally. The government had communicated appropriately, and was trying to minimize the side effects. But how long can a population follow the recommended restrictions? Some shops were expected to open the following day (April 20th) but regular businesses would not resume until May. Schools and universities are closed so now there are digital classes. The country had been running out of masks but the government had solved this problem. And there were now 10,000 free hospital beds in ICUs. People are very appreciative of and relaxed about the government's actions.

Professor D'Souza spoke of how Australia was doing well, certainly on a per capita figures collected by the John Hopkins University in Baltimore. Seventy persons had died. The death rate was 0.24 deaths per 100,000 population, compared to Belgium (45.20 deaths), Italy (37.64), Spain (42.81), the United Kingdom (21.97) and the US (11.24). The Australian government had moved fairly quickly in closing the borders, closing down non-essential business and introducing social distancing. Many employees were working from home accompanied by many online meetings. Very crucial has been the successful formation of a national cabinet composed of the prime min-

jster and State/Territory premiers with health experts, the first time since World War II. University classes were now online as were school classes. A major problem has been cruise ship passengers, and a police investigation is being conducted about how passengers were let off the Ruby Princess in Sydney without proper testing. Hundreds of thousands of people have lost their jobs, and governments have been offering job payment schemes at very great cost to offset the economic impact.

Professor Joe Thornton University of Florida USA spoke of the US situation. Covid19 had highlighted the country's weaknesses and there were major disagreements about the allocation of resources in balancing the various demands on care. As well, decisions are being made politically. New York has been heavily impacted whereas rural regions had more options. There was a need for good science on which to base good decisions. There will be social disruption until November.

Prof Vivienne Harpwood, Professor of Healthcare Law at the University of Cardiff and Chair Powys Health Board NHS Wales UK, spoke of how quickly the Coronavirus Act had been passed by Parliament though there was some pushback by those who wanted to protect personal autonomy. She worried about vulnerable groups: the homeless, cancer patients and people with mental illnesses. There was also the issue of very expensive treatments. She finally concluded, "We will have to reflect on the inadequacies when it is all finished".



, ETHICS OF HUMANITARIAN AND SOCIAL ASPECTS OF THE PUBLIC HEALTH EMERGENCY IN THE WAKE OF THE COVID-19 PANDEMIC

DEPARTMENT of EDUCATION, UNESCO CHAIR in BIOETHICS, UNIVERSITY of HAIFA

WEBINAR SUMMARY REPORT

Prepared by Emeritus Professor Des Cahill, RMIT University, Melbourne and Australia Bioethics Unit of the UNESCO Chair in Bioethics, University of Haifa.

This report summarizes a global panel discussion webinar in the wake of COVID19 held on Sunday night (Melbourne time), 26th April under the sponsorship of the Department of Education's UNESCO Chair in Bioethics located at the University of Haifa which works to encourage the teaching of bioethics in medical and health sciences and law courses across the world. The two-hour meeting was chaired by the Melbourne-based Professor Russell D'Souza, Chair, Department of Education (International Program) of the UNESCO Chair in Bioethics and was facilitated by Professor Mary Mathew, the director of the Indian component of the Chair Input came from eight specialists in (with the % of deaths per 100,000 population from the John Hopkins University data centre): Australia (0.33), India (0.07), Kenya (0.03), the UK (31.82) and the USA (17.20). Approximately 5000+ persons were registered online participants and spectators and asked questions through the chat box.

The guiding questions were:

1. What are the ethical/humanitarian implications of imposing a full lockdown? 2. What are the challenges and barriers in implementing lockdowns and social distancing in humanitarian settings? 3. Are there more alternatives and humane approaches? 4. What role do governments have in times of health and social stress?

The webinar began with opening remarks from Professor D'Souza who said that since the March 11th declaration of a global pandemic by the World Health Organization the world had entered an unprecedented crisis with major challenges at policy and practice levels and within humanitarian and social parameters. He observed that "equity and public health go hand in hand. We are only as safe as the most vulnerable globally". There has been a worldwide and serious breakdown of structures which were and would impact, particularly upon those in the most vulnerable situations, and disproportionately so, such as poor people, homeless people and so on. A particular worry is for those with no access to running water.

The key concept to guide us must be human solidarity. Hence, the questions becomes: how do we engage ethically with those very affected by COVID-19 together with combatting the risk of exclusion and stigmatization, the plight of the rural poor and their dying of hunger or of the infection. At the forefront of our considerations in maintaining the views, and rights of people must be human dignity. These human dignity principles must insist that all have equal access to standard health care.

Social networks have been compromised, thus damaging social connectedness, especially among those without the internet or even a phone. Hence, it has become critically important to recognize and protect social connectedness even though the very threat is embedded in that very

ṣame network. “COVID-19 is no respecter of persons”.

Professor James J James, Director of the US Society for Disaster Medicine and Public Health USA, who had had experience with the anthrax outbreak, argued that “we are schizophrenics in stance” with the individualized medicine vs population health medicine reaching different conclusions. He observed that many health systems were overrun with different measures and even the notion of social distancing differs from country to country. He asked the question: is there any valid evidence that such measures work? Unfortunately there is no consistent evidence to say that they work, and no consistent evidence that lockdown works. Is there a way to achieve the desired results without lockdowns? In the US, the only lockdown ever was in 1918 but only in some cities, e.g. St. Louis and there is no legal basis for a lockdown.

In response to the question, why have we been so accepting of inequality, Professor James pointed out that no one can truly reach the right conclusion. The outbreaks have mainly occurred in high density communities and in economically depressed areas where people live in congested areas. This is where we need to look.

Professor Unni Karunakar of Former International President Medicins sans Frontiere who is visiting Shinhan Professor at the Yonsei University in Seoul said there had been no lockdown in South Korea which, however, had acted very early with social distancing and much tracing and testing. “Lockdown is a very blunt instrument”. Restaurants and pubs are open. However, the country had used app technology to reinforce social distancing. Part of South Korean culture observes distancing with more bowing, less hugging etc. Also South Koreans have a better sense of community and trust in government is most important as seen in Singapore and Kerala. They take the government measures seriously. Testing is not necessary to have universal coverage. The quality of the tests is also very important since the early tests were not reliable. The most at-risk groups have less access to COVID-19 services such as testing. The first victim to die in South Sudan was a UN health worker so the country has stopped all international entry.

In the UK, Professor Kamila Hawthorne Head Graduate Entry Medical School at Swansea University Wales, related how social distancing had been in place for four weeks but already people were looking forward to their lifting. The country had been in a unique situation with the life of the prime minister under life-threat. Everyone is allowed out once a day for a walk or a cycle and food is able to be taken to a relative, friend or neighbour. According to her, the National Health System had risen to the occasion thus far. She regretted the lack of a global response and the poor response from many leaders such as Xi, Trump, Putin and Johnson. The theory about herd immunity is medical nonsense. Professor James said, “Do not write herd immunity off!” He added that most people have been exposed and hence he cautioned against doubting the herd immunity approach. Professor Ravi Wankhedkar called it ‘a poisoned pill”.

She expressed concern for the homeless and very special measures have been introduced to house and protect them. Really vulnerable were the people in aged care facilities

In Africa, Professor Joachim Osur, Dean of Medical Sciences at Amref International University in Nairobi, said that once one person has been diagnosed, the country goes into lockdown. Countries are already in lockdown for other reasons. Somalia and the DR Congo are in lockdown because of war and humanitarian crises. Also weak health systems are broken, and vulnerable groups cannot access the system. The problem is deeper than social distancing and lockdowns. As with ebola, the issues are trust in the health system and in governments. Africa is awash with congested slums. There has been a rise in looting leading to a shortage of money to buy food. Many children are not immunized, and many people are not taking their malarial medicine. Do I spend money on sanitizers or on food?

Professor Rajan Sharma, President of the Indian Medical Association, suggested that "no infrastructure could have been ready". The key is educating the masses such as in the wearing of masks. A vaccine is no good for a country as big as India. No matter how many ventilators, it would not be sufficient. It is necessary to stop the quick doubling of cases as has happened in the US. We have to emphasize cleanliness.

Professor Ravi Wankhedkar, Treasurer of the World Medical Association, summarised, "In India, lockdown is on the pause button". He worried about the urban slums and evictions of the poor. This social discrimination worried him as did the irrationality of social media. And one wonders about the rationality of the critical media. He drew attention to the plight of doctors in villages, and because of lack of burial facilities, three Indian doctors were not properly buried after dying from the virus. As well, there have been attacks on health and tracing personnel in some Indian villages. And young doctors have been evicted from apartment blocks because of the fear. It was not only in India that health workers were feeling insecure.

Professor Russell D'Souza Australia Chair Department of Education asked: how do we enhance social solidarity? Professor Unni Karunakar suggested there has been no global coming together. Hence, there needed to be more regional cooperation and solidarity. What had to stop was "instrumentalizing health for political purposes". Professor James argued that there was a need to look at groups within a nation so it was difficult for a totally integrated approach. But a global effort was needed for preparedness. "Every disaster is local". There is a need for 80 percent of a population to be immune. The global fear narrative has been created by the media whereas public health needs ought to control the narrative

ETHICAL ASPECTS OF MEDICAL EDUCATION IN THE WAKE OF THE COVID-19 PANDEMIC

DEPARTMENT of EDUCATION, UNESCO CHAIR in BIOETHICS, HAIFA

WEBINAR SUMMARY REPORT

Prepared by Emeritus Professor Des Cahill, RMIT University, Melbourne and Australia Bioethics Unit of the UNESCO Chair in Bioethics, University of Haifa.

This report summarizes a global panel discussion webinar in the wake of COVID-19 held on Sunday night (Melbourne time), 3rd. May, 2020 under the sponsorship of the Department of Education's UNESCO Chair in Bioethics located at the University of Haifa which works to encourage the teaching of bioethics in medical and health sciences and law courses across the world. The topic was the ethical aspects of medical education, a topic close to the UNESCO Chair's mission. The two and a half hour meeting was chaired by the Melbourne-based Professor Russell D'Souza, Chair, Department of Education (International Program) of the UNESCO Chair in Bioethics with the co-chair and facilitator, Professor Mary Mathew, the director of the Indian component of the Chair. Input came from eleven medical educators and students from eight countries in (with the % of deaths per 100,000 population from the John Hopkins University data centre): Australia

(0.38), China (0.33), India (0.10), Israel (2.58), Portugal (9.95), the Sudan (0.10), the UK (42.42) and the USA (20.29). Approximately 740+ persons were registered online participants and spectators and asked questions through the chat box.

The webinar began with opening remarks from Professor D'Souza who set the scene, observing that India alone has over 600 medical schools. Since the March 11th declaration of a global pandemic by the World Health Organization, the world had entered an unprecedented crisis with major challenges at policy and practice levels for medical education. He noted that "we are all in this together. We have to confront issues never previously faced". There has been a worldwide and serious breakdown of structures which were and would impact, particularly upon those in the most vulnerable situations. The key concept to guide us must be mutual humanitarian solidarity with the common interest being the good of everyone.

The webinar was divided into two parts. **The first part looked at the doctor-patient relationship**.

Medical education services are in a totally new situation with universities closed and no face-to-face classes with no practical classes available. It has transitioned to online teaching and learning, including online assessment. In all this, have we lost the essence of the doctor-patient relationship in these new challenges with the loss of human interaction to digital interaction? How will distance learning impact on medical standards? Are there some virtues in digital learning? Is it the end of professional education as we have known it?

To gain a student perspective, Alaa Abusufian Dafallah from The Sudan reported that exams had come to a halt because of the limits of technology in her country and "so we are in a vacuum in our final year". Dr Shava Joshi, from the student wing of the Chair now doing his residency, focused on theory vs. practice. Webinars can only help so far in developing the practical medical skills. Also lost has been the soft skills picked up from conferences and mutual collaboration. It is no longer possible to collect data for the small thesis as part of the residency requirement. Exams are tough at this level but "we are being called back to hospitals for duty". Should exams be postponed?

Dr. William Pinsky, President and Chief Executive Officer of the Educational Commission for Foreign Medical Graduates (ECFMG) in Philadelphia, questioned the use of unqualified medical students in interacting with patients. There are many factors involved but it is very important that students be asked to do only what is within their capability, and they need to be supervised. Students should not be put at risk, and they must have the right skill sets. What happens when students really want to come into the frontline? The answer depends on the particular situation. If they are not fully licensed as medical practitioners, they can still help 'on the sides'. Also there is the issue of payment for services. This depends on resources, and pay is not the defining element.

Professor David Gordon, Emeritus Professor of the University of Manchester and President of the World Federation of Medical Education, said that "our students are at the frontline and are being paid". He added that no one can be exposed to a situation where they do not feel competent. But, "let us be honest. We do not always know what we are doing. Physicians are learning to deal with a nasty illness. Students are often more competent than what they give themselves credit for". He related how 80 years ago, the UK faced the Nazi threat and senior staff went off to join the armed forces. Mid-level qualified staff and students were often called upon, and they learned a lot very quickly. Regarding payment, there is no single answer.

In China, according to Professor Ming Kuang, Vice-Dean of the Zhongsan School of Medicine at the Sun Yat-Sen University in Guangzhou, said that all medical students have had to stay at home, and their training is being delivered online. They are not paid.

Professor Ved Prakash Mishra from the Krishna Institute of Medical Sciences at Karad, a small city in Maharashtra, spoke about students on the frontline. “We need to understand that we are in a contingency emergency situation. But they must not be put into a position beyond their capability – this would be unethical. Those in residency are in a different situation. They are qualified but they need to be under supervision”. It is important that health workesr are not put at risk. Students are paid a stipend, not a salary.

Professor Trevor Gibbs, President of the Association for Medical Education in Europe (AMEE) in Dundee, argued that student frontline should be voluntary and not part of the medical curriculum. Safety is paramount e.g. PPE clothing. Role clarity is most important and all students should be indemnified by their universities. They must work at their level of competence with supervision that is supported. Universities must support their students. He added that disrupted clinical studies constitute a problem. Can face-to-face supervision be substituted in the transmission of hands-on skills. This cannot be answered as yet.

Professor Jeanette Mladonovic, Professor of Haemotology at the Oregon Health and Science University and President of the Foundation for the Advancement of International Medical Education and Research, asked the question: should patients be told they are being treated by someone not fully qualified? Could the students do harm to a patient? Do we want them to learn on patients? There is always a risk. In the UK, the Dean of the Medical School at Swansea University, Professor Kamila Hawthorne related how social distancing had been in place for four weeks but already people were looking forward to their lifting.

Professor Gibbs raised the issue of empathy. He was of the opinion that student empathy for patients cannot be developed online. “A course on empathy does not achieve much. It cannot be learned from a lecture. But it should be a golden thread through all subjects”. Professor Pinksy related it to the more general issue of telehealth. “It is not a bad thing and it means more will have access to health care”. Professor Ming said that Wuhan is the epicentre of the coronavirus; it had been out of the imagination of the doctors and nurses. Postgraduate students worked with more experienced colleagues. “We showed the students what to do online”. Establishing collaboration is important.

Professor Jeanette Mladonovic said that there are different ways to learn empathy. “We should be capitalizing on the pandemic to learn empathy in face-to-face interaction. And to learn to communicate better e.g. for telehealth. It is a chance and opportunity to think differently”. Professor Madalena Patrico from the University of Lisbon and President of the Best Evident Medical Education (BEME), also spoke of how important is empathy. “We always need to ask the students to step up”. Professor Sujarah said that soft skills are MUST skills that you need for life, and should be embedded into the curriculum.

To round off this discussion, Ms Alaa Abusufian Dafallah reported that in the Sudan there had been no online learning sessions as 40 per cent of students do not have access to the internet. “Students are embedded in the strength or its lack in the national health system”. She added that in the aftermath of COVID-19 there was the urgent need to develop e-learning – with more collaboration, the impact of the shock would be lessened. Her preference was for face-to-face teaching. Professor Mary Mathews observed that students are very precious, and innovative ways of teaching and learning are being forced upon us.

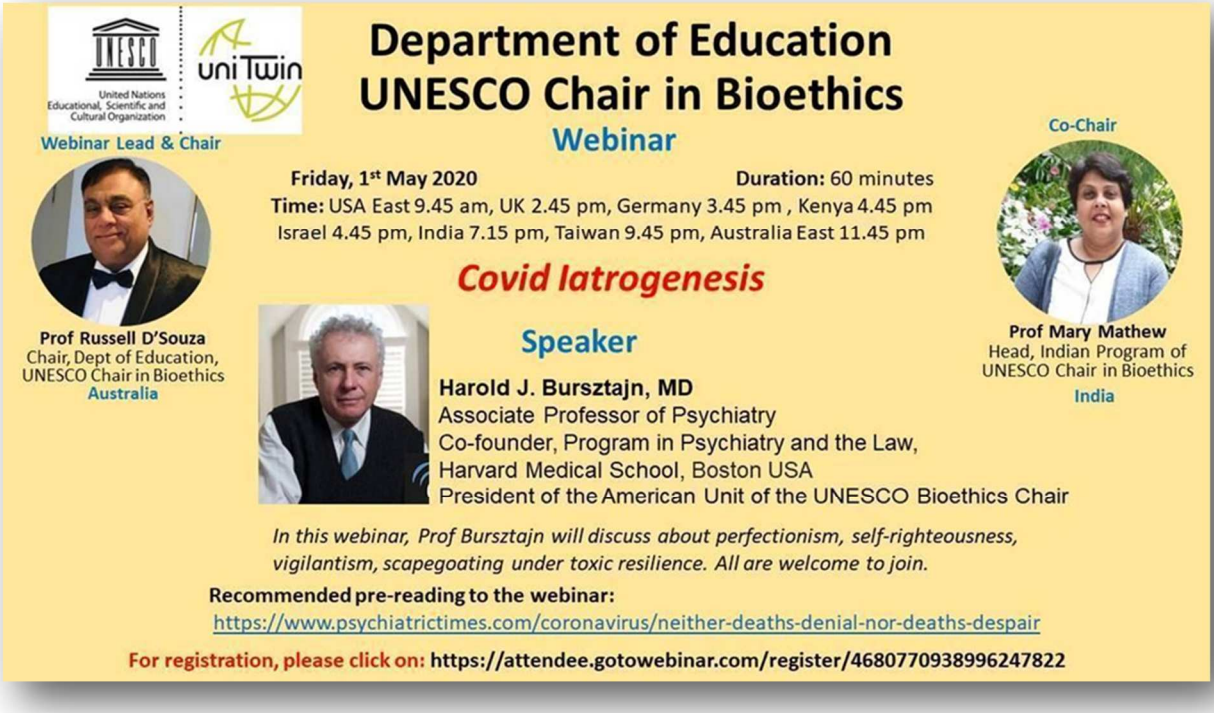
The second part of the webinar looked at technology and medical education.

Most schools and faculties have moved over to the high use of technology, and so there are many opportunities for analysing the management of change. Professor Ming said that “we have learned a lot” from the SARS virus. But there is unfortunately a lack of collaboration between

doctors at the frontline and research scientists. This needs to be reformed.

Professor Patrico saw a real dilemma in online education and maintenance of high standards. There was now enormous pressure on university teachers. There has to be a higher quality of online lectures but how does one protect the 'humanization of education'? She also worried about cheating in online assessment. Professor Gordon argued that more medical education can be done online in the non-clinical aspects. Professor Pinsky suggested that there was the issue of access to technology in the various countries and the other issue of sharing and protecting intellectual property across the world. Professor Mladonovic said that with online learning, artificial intelligence and student access to online learning, the issue for her was knowing the students well and knowing their abilities. There would need to be much more workplace assessment.

Professor Abijath Sheth, President of the National Board of Exams in India, said that the various parts of medical training cannot be compromised. The knowledge pillar and the experience of dealing with practical cases lead to clinical insights. However, whatever is done online must be structured. And Professor Pinsky ended off by saying the challenge was in maintaining high standards which could be placed in jeopardy.



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7th Webinar in the Series
Ethics of Psychological and Mental Health Issues in the wake of COVID-19
Date: Sunday, 10th May 2020
Time
USA (E) - 7.30 am
Argentina - 8.30 am
UK/Portugal - 12.30 pm
France - 1.30 pm
Kenya - 2.30pm
Israel - 2.30 pm
India - 5 pm
Malaysia - 7.30 pm
Australia (E) - 9.30 pm
Webinar Lead & Chair
Prof. Russell D'Souza
Chair, Dept of Education, UNESCO Chair in Bioethics, Australia
Co-Chair
Prof. Mary Mathew
Head, Indian Program of UNESCO Chair in Bioethics, Manipal, India
PANELLISTS
Prof. Harold J. Bursztajn
Harvard Medical School Boston, USA
Prof. Joe Thornton
University of Florida, USA
Prof. Jean Furtos
Emeritus Scientific Director National Observatory for Mental Health and Social vulnerability Lyon, France
Prof. Matcheri Keshavan
Chair, Psychiatry, Harvard Medical School, USA
Prof. Shabbir Amanullah
Dalhousie University, London / Canada
Prof. Moty Benyakar
USAL University Buenos Aires, Argentina
Prof. E. Mohandas
Sun Medical and Research Centre, Kerala, India
Prof. Parameshvara Deva
UTAR University KL, Malaysia
Prof. Frank Njenga
Amref International University, Narobi, Kenya
Prof. J.S. Bamrah
Manchester University UK
Prof. Cao Dang
Sun Yat-Sen University, Guangzhou, China
MODERATOR
Prof. Rajiv Tandon
Western Michigan University USA
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After registering, you will receive a confirmation email containing information about joining the meeting.

,ETHICAL ASPECTS OF PSYCHOLOGICAL AND MENTAL HEALTH ISSUES IN THE WAKE OF THE COVID-19 PANDEMIC

DEPARTMENT of EDUCATION, UNESCO CHAIR in BIOETHICS, UNIVERSITY of HAIFA

WEBINAR SUMMARY REPORT

Prepared by Emeritus Professor Des Cahill, RMIT University, Melbourne and Australia Bioethics Unit of the UNESCO Chair in Bioethics, University of Haifa.

This report summarizes a global discussion webinar in the wake of COVID-19 held on Sunday night (Melbourne time), 10th. May, 2020 under the sponsorship of the Department of Education's UNESCO Chair in Bioethics located at the University of Haifa which works to encourage the teaching of bioethics in medical and health sciences and law courses across the world with 250 centres across the world. The topic was the psychological and mental health consequences of the COVID-19 pandemic across the world. The two and a half hour meeting was chaired by the Melbourne-based Professor Russell D'Souza, Chair, Department of Education (International Program) of the UNESCO Chair in Bioethics with the co-chair, Professor Mary Mathew, the director of the Indian component of the Chair. Input came from eleven panellists from nine countries in (with the % of deaths per 100,000 population from the John Hopkins University data centre): Argentina (0.67), Australia (0.39), Canada (13.01), China (0.33), France (39.28), India (0.16), Kenya (0.06), the UK (47.62) and the USA (24.08). Online spectators asked questions through the chat box.

Professor Russell DSouza Australia a Psychiatrist as chair of the webinar welcomed the participants. In addressing the psychological and mental health issues facing humanity, he drew attention to the fact that all eleven discussants are psychiatrists representing the world. The co-chair, Professor Mary Mathews, head of the Indian section of the UNESCO chair, began by observing that many queries about mental health issues had been received, "we have not seen the end of this in regard to mental health issues".

The webinar was inaugurated by Emory University's Professor Patrice Harris, a psychiatrist and the first female Afro-American to be President of the American Medical Association. She thanked the chair for the invitation. With this public health crisis, there needed to be global collaboration. "We see the needs of our patients and the general health issues across the world. We need to elevate our thinking and think about public health issues".

Professor Russell DSouza began the discussion by emphasizing therapeutic principles and article 13 of the 2005 UNESCO Declaration on Bioethics. Solidarity is a mutual obligation, an ethics of commitment particularly towards the most vulnerable, in examining the pandemic from a psychological and mental health perspective. He introduced the moderator, Professor Rajiv Tandon Chair Psychiatry Western Michigan University in Kalamazoo USA.

Professor Tandon introduced the topic, saying as editor of the Asia Journal of Psychiatry he had received 550 articles relevant to COVID-19 and 48 of them are to be soon published. Altogether he has read about 2,000 articles on the topic. "We are the psychiatrists of the world in solidarity". He said that the webinar would be focused on three issues:

1. The impact of COVID-19 on the general population
2. The impact of COVID-19 on people with pre-existing mental health issues

The impact of COVID-19 on mental health workers

He said that initially his psychiatric colleagues were downplaying the relevance of COVID-19 to psychiatry and the impact of past epidemics as well as the effects of media reports. It was essential to apply ethical

was dramatically changing and becoming more important with greater access to health care now possible. There was also the issue of liability. He concluded, "we need to move nimbly to a balance between telehealth and face-to-face patient care". Professor Thorton believed that the value of telepsychiatry had been understated. It had been done for six weeks in Florida with positive results. The immediacy of the interaction, even if diminished, still had positive results. In face-to-face consultations, the psychiatrist has a protective shield and the patient protective principles and to keep them in balance. "The psychological challenges are still to emerge". He asked Professor Thornton University of Florida to lead off the discussion.

Professor Joe Thornton from the University of Florida said that as a clinician the impact on the general population would be significant with unemployment for millions of people. The traumas are multilayered, impacting with psychological illnesses, including of caregivers and the 'the self-inflicted consequences. He asked, 'Who is making good decisions?' The level of decision-making has not been good because the decision-makers have not had to bear the consequences. He came back to the 15 principles of the UNESCO Declaration. He contrasted healthy resilience with toxic resilience. Solidarity is a necessity in decision-making.

Emeritus Professor Jean Furtos, the Director of the Observatory for Mental Health and Social Vulnerability in Lyon France, said he had been surprised at the strength of 'a community and emotional contagiousness'. He noted five components of this contagiousness: firstly, there was a general fear of others because of the danger of catching the virus; secondly, among many there was almost paranoid thinking that other people are dangerous, causing many to be anxious; thirdly, this led to an almost schizophrenic affect of not feeling in control because of factors outside one's personal control with a psychic focus as though 'surrounded by the virus'; there was a communal obsessive compulsive impact with an over-focus on social distancing and handwashing and, lastly, as very important, a community fear of dying. It is necessary to avoid over-pessimistic hypotheses, especially on the media whereas there is an alternative optimistic scenario. The balance must be maintained between being overly positive and overly negative. Also politicization leads to distortions. The media challenge was huge. Professor Jack McIntyre Past President APA of Rochester University USA agreed it was important to counter the fake news and the American Medical Association had been 'a beacon of light and hope'. He also praised Dr Fauci with his tremendous expertise.

Professor Chao Dang from Sun Yat-Sen in Guangzhou University said that China had now reached a turning point with less patients. "The general population have good mental health, even those with prior psychological conditions". Everything in Guangzhou was now back to normal. The country had had previous experience with SARS, the sister of COVID-19. 150 health workers had been sent from his city to Wuhan.

Professor Frank Njenga Psychiatrist from Amraf International University of Medical Sciences in Nairobi said that in Kenya and across Africa generally there had been a trust deficit in governments well before COVID-19 so "we are in a dire lockdown. But the reality is that in Kenya there had only been 30 deaths in a population of 50 million and only 2,000 deaths across Africa".

Professor Moty Benyakar Psychiatrist from the USAL University in Buenos Aires Argentina said he had previously lived in Israel undergoing five wars, thus understanding the main problem of fear. Argentina was in the first stage of the pandemic and so there is much concern about 'the uncertainly of the future'. He said, "If you give certainly, you distort". The new problems were as yet unknown. Would it elevate levels of anxiety? manic depression?

Professor Parameshvara Deva HOD Psychiatry from the University of Kuala Lumpur said Malaysia was in lockdown. A Director-General of Health gives a report every day at 4.30 p.m. – the man in the street believes him more than all the other experts. Most media are biased, and not 100 per cent of the media reports are accurate with some distortions. How do we maintain a balance in the media? Psychiatrists are generally slow to react as had also happened after the tsunami.

Professor Harold Bursztajn Psychiatrist of the Harvard Medical School asked what is meant by psychological contagion and what happens now. There is coming into operation an acute avoidance contagion. The extreme personal change will impact on the community's personality profile with toxic resilience. "We have a a unique social laboratory with our patients". He contrasted the situation with that in Germany after the First World War where the psychological consequences had been poorly handled – this led eventually to the rise of Hitler. "We are doing triage which is a military terms in war and this leads to dehumanization and undermines solidarity". He spoke of the need for an extreme personality change. As an example, consideration must be given to allowing grieving families into hospitals to see their loved ones and hold their hands. As an example of the so-called 'work-arounds', he cited the example of Israel where relatives are allowed to wear protective clothing to see their COVID-19 patients. It is also necessary to be fully aware of the impact on the mental health sufferer.

He raised the issue of telepsychiatry which led to a general discussion on the topic. He wondered whether it developed a therapeutic relationship.

Professor Matcheri Keshavan Chair Psychiatry Harvard Medical School Boston said that one major ethical issue with telepsychiatry is with COVID-19's acuteness nature which is also emphasizing the gap between those who can obtain care and those who cannot. Telehealth can overcome this, but there are many challenges. But the situation clothing – what kind of interaction is that?

In Kenya, according to Professor Frank Njenga, there had been no contact with patients for the last two months. Telehealth was happening but it is by phone in 95 per cent of cases. Professor Dang said that telehealth communication was being utilized in Wuhan. "It is useful for patients who are afraid to come into a hospital".

Professor Shabbir Amanullah Psychiatrist from Dalhousie University in London, Canada raised the issues of nursing homes and co-morbidities as well as delayed reactions. He expressed great concern about geriatric centres, including with elder abuse. The precautions in these centres had simply been inadequate. He noted that the reaction is more delayed when relatives are not present at the deaths of their loved ones. Professor Viswanathan Psychiatrist from New York University that there was a systemic issue with nursing homes in his city as in Canada.

Health Workers

Professor Jaswinder Bamrah, a senior psychiatrist in Manchester and an honorary Reader at the University of Manchester UK, raised the issue of health workers. "Legislative change is very important". In the UK, 216 health workers, including 26 doctors, had been lost. He had had to ask himself, "When I am sectioning patients, am I sending them to their deaths?" He felt that the virus had wreaked havoc amongst mental health patients.

According to Professor Dang, those health workers sent to Wuhan initially could not sleep but

this had gradually changed as time went on. Professor Viswathanan said it was critical to have group support for psychiatrists, nurses and other health workers. When doctors are wearing protective clothing with headgear etc., this was confusing and dehumanizing for patients because they cannot see the carer as human. Professor Mohandas Warrier Psychiatrist from the Sun Medical and Research Centre at Thrissur in Kerala said that trust in communication is very important. But he asked about the longterm effects, especially of loneliness and quarantining. And the financial consequences? What does business ethics say in regard to the vulnerable?

The question that terminated the webinar was: what happens when we come to the end of the lockdown? The advice was: “always be curious”.

, ETHICAL ASPECTS OF OPENING THE COUNTRY AND THE VALUE OF LIFE IN THE WAKE OF THE COVID-19 PANDEMIC

DEPARTMENT of EDUCATION, UNESCO CHAIR in BIOETHICS, UNIVERSITY of HAIFA

WEBINAR SUMMARY REPORT

Prepared by Emeritus Professor Des Cahill, RMIT University, Melbourne and Australian Bioethics Unit of the UNESCO Chair in Bioethics, University of Haifa.

This report summarizes part of a global discussion webinar in the wake of COVID-19 held on Sunday night (Melbourne time), 17th. May, 2020 under the sponsorship of the Department of Education's UNESCO Chair in Bioethics located at the University of Haifa which works to encourage the teaching of bioethics in medical and health sciences and law courses across the world with 250 centres across the world. The topic was the ethics of re-opening the country and the value of life in the wake of the COVID-19 pandemic across the world.

Unfortunately this is a truncated summary as there were serious technical difficulties. The webinar began late at 9.42 p.m. (Melbourne time) and whilst your summarizer could clearly see all the panellists, there was no voice. Many others were experiencing the same problem. By ten o'clock more people were leaving the website than entering it. This report begins at 10.11 p.m. after the sound issue was solved by leaving and then re-entering the ZOOM website. The webinar finished somewhat early at 10.58 p.m.

The shortened (74 minutes) meeting was chaired by the Melbourne-based Professor Russell D'Souza, Chair, Department of Education (International Program) of the UNESCO Chair in Bioethics with the co-chair, Professor Mary Mathew, the Head of the Large Indian Program of the Chair. Input came from eleven panellists from nine countries in (with the % of deaths per 100,000 population from the John Hopkins University data centre): Australia (0.39), India (0.21), Singapore (0.39), Tanzania (0.04), the UK (51.96) and the USA (27.13). Online spectators asked questions through the chat box.

Professor Mary Mathews Moderated and mentioned how different countries were implementing different strategies. She asked, are lives to be sacrificed? Whose lives? Professor Adam Block, a Health Economist from the School of Health Sciences and Practice at the New York Medical College, explored the dilemma: lives vs the economy? There are lots of complexities. In 1918 with the Spanish flu, there were no vaccines and there was no waiting period for a vaccine. "We must remember that risk is relative; every time I walk out my door, I am at greater risk". We can take on a risk, but the virus is a fundamentally different risk. Unemployment in the US has now reached 15 per cent so mental health and nutritional issues are emerging. It is now necessary to take on a little extra risk to earn a living. Human lives do not have infinite value. For example, would it be ethical to have a 10year lockdown just to save a few lives? He concluded, "We have to take risks. Part of this is having a good plan to go back to work". Professor Iza Bedzow Rabi and Professor of Medicine New York Medical College USA suggested that one must consider the risks and the benefits before making decisions such as locking down or staying open Professor Muraldhar Kanchi gave an Indian perspective. India has been divided into zones which will follow different strategies. "We need to build up the economy and build up herd immunity even though a herd immunity strategy does not work".

Professor Yei Waei Chong from Singapore raised the issue of a second wave as Singapore had been thus hit. Singapore is a small country (5 million) but it has one million foreign workers. The virus has exploded amongst these workers with 22 deaths so far but they are generally young. “A lot of medical resources are being thrown at the problem”. Baroness Professor Ilora Finley, a palliative care specialist and a member of the British Parliament, reflected that a second wave raised the issue of the value of lives. The four parts of the United Kingdom (England, Scotland, Wales and Northern Ireland) are moving at different rates. “We cannot separate lives and the economy. Clear public messages need to be sent out in easing the lockdown. A second lockdown would be disastrous and would kill the economy”. Other issues were that black people have lower Vitamin D levels and an exhausted workforce. With Prince Charles and Boris Johnston catching the virus, the British people had been made well aware that it respects no one.

In Australia, Professor Michael Robertson, a psychiatrist and health care expert from the Medical School at the University of Sydney, said that a three steps plan in easing the lockdown had just begun. Australia with its 25 million people has had ‘a charmed run’ with less than a hundred deaths and noone under 60, and as an island continent, borders were easily and quickly closed. The curve had been well and truly flattened though hotspot outbreaks were not the issue in an abattoir and several nursing homes. Regarding trust in government, the disastrous bushfires in December and January had been badly handled by the Federal Government. However, for the coronavirus, good systems had been put in place and there was now trust in government with sound leadership. Key to this has been the formation of a digital National Cabinet composed of the Prime Minister and the State/Territory Premiers with the Chief Medical Officer always in attendance.

Prof Stacey Gallin from the US said she hoped that lives were not being traded. We need a sense of ethics to guide us in this crisis, but how do we use this system of ethics? Dr. Ashraf Nazami, President of the Pakistani Medical Association, said that Pakistan had implemented ‘a smart lockdown’ but fundamentally the government wanted to end the lockdown. The Indian panellist said that in India the first priority are old people because generally India is composed of young people. “I cannot agree with Professor Block”. The last points made were about the fact of resilience and the use of technology during the crisis and its helping to resolve issues. Ms Alexandrina, Vodenicharova a participant from Bulgaria who wanted to comment was brought to the screen. She reported Bulgaria was opening the country and economy., she expressed that there was concerns that economy was being preference over health. Ms Alessandra, Pentone a participant from Italy wanted to ask the panel her question on Disability and post COVID but while she appeared the audio did not work so her question was deferred to the next webinar

Professor Russell DSouza finally apologised for the technical problems while asking each of the available panellists to summarize their points. Given that this avenue has layers to contend with and with the fact that many regions are in the process of opening their societies and their economies it would necessary to revisit re Opening of Societies and economies in an extended International Panel Discussion.

Professor Derek DSouza who was moderating questions from the participants summarized the Questions and comments from the participants via the chat and thanked the panel on behalf of the participants.

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GLOBAL DENTAL LOCKDOWN
ETHICAL ASPECTS OF RE-EMERGENCE STRATEGIES IN THE WAKE OF THE COVID-19 PANDEMIC

DEPARTMENT of EDUCATION, UNESCO CHAIR in BIOETHICS, UNIVERSITY of HAIFA

WEBINAR SUMMARY REPORT

Prepared by Emeritus Professor Des Cahill, RMIT University, Melbourne and Member of the Australia Bioethics Unit of the UNESCO Chair in Bioethics, University of Haifa.

The ninth global webinar of the UNESCO Chair in Bioethics focused on the dentistry aspects of the COVID-19 pandemic looking at the ethical aspects of the re-emergence strategies in the lifting of lockdown provisions. It was held on Sunday night (Melbourne time), 24th. May, 2020 under the sponsorship of the Department of Education's UNESCO Chair in Bioethics located at the University of Haifa which works to encourage the teaching of bioethics in medical and health sciences and law courses across the world with 250 centres across the world. The two+ hour meeting was chaired by the Melbourne-based Professor Russell D'Souza, Chair, Department of Education (International Program) of the UNESCO Chair in Bioethics with the co-chair, Professor Mary Mathew, the director of the Indian component of the Chair.

Moderators were Professor Derek D'Souza, Head of the National Training Courses in India and Professor Rajiv Ahluwalla of the Santosh Dental College in Delhi and Head of the India Dental Bioethics Committee. Input came from eleven panellists from seven countries though internet bugs prevented the participation of Dr Peter Wanzala from Nairobi. Infection rates for these countries are currently (with the % of deaths per 100,000 population from the John Hopkins University data centre in Baltimore): Australia (0.41), India (0.29), Kenya (0.10), Sri Lanka (.04), Thailand (.08), the UK (55.28) and the USA (29.68). Online spectators asked questions through the chat box. The webinar began at 9.31 p.m. (Melbourne time).

Professor Russell D'Souza in Australia as chair of the webinar welcomed the participants. In addressing the dentistry issues facing humanity, he drew attention to the fact that all discussants are dentists. The co-chair, Professor Mary Mathews, head of the Indian section of the UNESCO chair, observed that the global dentistry fraternity had come together for this webinar. Professor Derek D'Souza in introducing Dr. Khabanda said, "C-19 has changed everything in visiting, transport, education etc.".

The webinar discussion was initiated by Dr Kharbanda from the Indian Council of Medical Research in Delhi by raising the topics of risks in the present scenario. He asked, "Is it safe to come to a dental clinic? How safe is it for those working in the dental clinic?" He outlined the issues of (1) the parameters of minimum and maximum protection, (2) taking care of infected health workers and (3) the expense of preventative equipment in India. Dr. Chad Gehani of New York University and current president of the American Dental Association added the issue of the patient. He asked, "What happens when you find out 3/4/5/6 days later after treating a patient with all the precautions that he or she is C- 19 positive. Do you inform all those in the waiting room at the time?" There has been a big impact on dental practice. But one must always take into ac-

count the great good of the public. Dr Gehani travels often between New York and Chicago. “In early March, we were watching Europe and Asia with so few US cases. Then suddenly it hit. We had no idea how rapidly it would hit. California began with lockdown measures with dentists operating via computer. We wanted PPE for all medical colleagues, including those dealing with dental emergencies. But in increasing protection, where does it stop?”

Dr. Nilantha Ratnayake reported on the Sri Lankan situation where the dental lockdown began on March 19th. And only emergency cases were subsequently dealt with. The number of such cases was declining. Guidelines for safe behaviour were issued and on May 18th, as a profession Sri Lanka dentistry leaders considered how dentists can adapt to the new situation. PPE is being widely used. In Sri Lanka, dental services are provided free of charge by the government. There are many oral cancers yet “we are not doing normal consultations, and so it is ethically changed and we are in an ethical dilemma”. There is also the issue of the poor in all the sub-continent countries.

Professor Robert Love, Dean of the School of Dentistry and Oral Health at Griffith University on the Southport campus in Australia, considered online dental education. Online classes were working well, and they will continue for the remainder of 2020. However, exams are more ‘tricky’. “By the end of the year, hopefully there will be more traditional assessment methods in place. Australia has done exceptionally well. We quickly went to emergency care and now we are coming out of this phase. Tomorrow (May 25th.) at Griffith University, the PG program begins. And by the end of June it will be back to normal except for social distancing. We are confident we can deliver dental education and get back to clinical work as soon as possible”. In Scotland, Professor Peter Mossey, Associate Dean (International), School of Dentistry at the University of Dundee, raised also the clinical aspects and the ethical dimensions. There is a clinical lockdown but there are the examinations to be conducted under the auspices of the General Dental Council – “this is a challenge”. He continued, “Before that, we have the exams and we use the TURNITIN software to detect academic fraud. This has been very successful. For the lower years we are leaving the clinical aspects till later”.

Professor Mossey raised the issue of dental aerosols and the possibility of transmission in such procedures as opening a cavity and doing root canal therapy. “We will have to be innovative in invasive dentistry”. Dr. Gehani said, “as we talk, I am throwing out aerosols. Rubber dams are very important to minimize droplets. We all need to assess our own clinics”. It had become more difficult to do dentistry with PPE because risk has to be minimized. But innovative techniques will emerge, not least in the less aerosols issue and the danger of transmissibility through aerosols.

Dr. Shalli Pradhan, the founder president of the Nepalese Society of Periodontology and Oral Implantology, asked urgently for clear global guidelines in these challenging times. In Nepal, there has been a dental shutdown except for emergency cases. So the question arises as to what happens to treatable conditions. Dr Prathip Phantumvanit, former Dean of the Faculty of Dentistry at Thammasat University in Bangkok, reported that “the situation in Thailand is not so bad but we are concerned with transmission”. Dental schools have closed but may open soon and in the meantime there has been online delivery of classes. A significant problem are private dental clinics about which there has been much discussion. Generally there is the need for more discussion, and for simple cross-national guidelines. “We have to dress properly. This is very important and we must use our best shields”. There is emergency, urgent and elective treatment. But what is the dividing line between emergency and urgent treatment, especially in dealing with C-19 patients and also patients under investigation?”

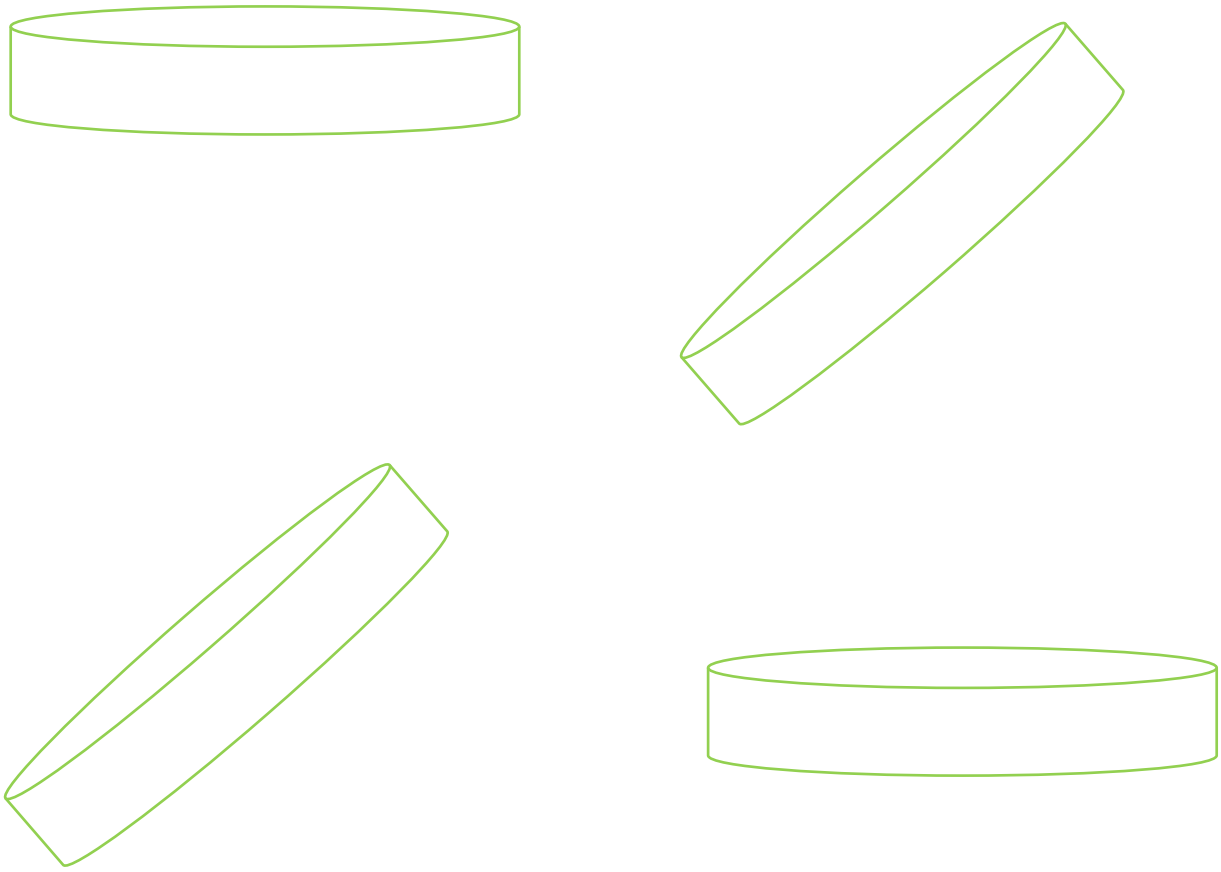
Dr Khanbanda raised the issue of telemedicine and tele dentistry whereas ‘patients want treatment”. There is the danger of wrong treatment and over-treatment. The Medical Council of In-

dia haspositively endorsed telemedicine. Issues are the legitimate identity of the doctor, follow-up consultations, drugs prescribed and ethical privacy. There was also the issue of antibiotics and their over-use. He asked, “where do we stand on tele dentistry?”

Professor Love speculated about the dental practice future and the direction of health planning. He expressed confidence in the future of dentistry though there will be changes, not least in the pre- operative area. Social distancing will be relaxed as will PPE guidelines. “We are seeing the globalization of dentistry and dentistry solidarity”. But he was concerned about the ethical issues where there is dental compromise and risk assessment. And then the issue of fees. Proper guidelines must be based on proper science.

Dr. Chad Gehani reminded the webinar that patients must come first because dentists are obligated to the patient. “The common enemy has brought us together”. Dr Khabanda made several points: firstly, safety as the priority; secondly, design changes in clinics; thirdly, new guidelines and lastly, as very important, post-treatment follow-up. Professor Mossey mentioned how with this interim period there is a risk of deskilling and “we must allow for the recovery of skills”. He added that the guidelines of WHO, the World Dental Federation (FDR) and the International Association for Dental Research (IADR) need to be brought together for greater consistency and standardization. Dr D’Souza said, “maybe we have been too complacent; this has brought solidarity”.

The webinar finished at 11.43 p.m. (Melbourne time). Professor Russell D’Souza said it had been an excellent and informative seminar and had generated solidarity and cooperation.



YOUTH BIOETHICS EDUCATION

DISTANCE LEARNING AND LINGUISTIC MINORITIES RIGHTS

*Prof. Gabriella Vernetto, Department of Educat*ion, University, Research and Youth Policy of the Autonomous Region of Aosta Valley, Italy

The Aosta Valley is an autonomous region with a special Statute in the north-west of Italy. In addition to Italian, which is the national language and the language of the majority of the population, four minority languages are spoken in this region: French, Francoprovençal and two dialects of Germanic origin, *titsche* and *töitschu*, spoken in the Walser villages of the Lys valley.

The French language is protected by the autonomous Statute of the Region, Article 38 of which states that French is the official language of this territory along with Italian. The Statute also states, in Article 40bis, that the languages and culture of the Walser people living in the Lys Valley are protected. Finally, national law No 482/1999 includes Francoprovençal among the minority languages to be protected and enhanced in the Aosta Valley territory, in addition to French and the Walser dialects.

Moreover, linguistic communities from other Italian regions or from other countries are present on the regional territory, following a series of migrations which have been taking place since last century.

The regional education system takes this linguistic diversity into account and protects minority languages. French is taught at all school levels, from pre-school to secondary education, pursuant to Article 39 of the Statute, and it is used as a language of instruction for other subjects (e.g. history, geography, science). Similarly, pursuant to Article 40bis, German is taught in the villages of the Walser community. Francoprovençal is promoted through specific projects (e.g. Le francoprovençal en milieu scolaire). From the point of view of language teaching methodology, an approach is applied that fosters curiosity towards all languages and cultures and their respect.

With the emergency linked to the spread of the coronavirus pandemic, which led to the closure of the schools and the shift to distance learning activities, the decision-makers responsible for education were faced with the challenge to guarantee the peculiarity of the Aosta Valley territory and its school system. At a time when considerable efforts were being made at national level to support distance education with a clear predominance of the Italian language, it was necessary to protect the rights of linguistic minorities to education in their own language and the promotion of their culture (UNESCO, Convention on the Protection and Promotion of the Diversity of Cultural Expressions, 2005).

The actions implemented in response to this issue concerned three main areas: teacher training, dissemination of teaching materials and use of media and social media.

For the teachers training, the Department of Education has created a series of virtual classes for

the main subjects taught in the different grades of school, in order to promote and support online training activities and share model lessons and best practices.

A virtual class has been created for the Francoprovençal and the other classrooms propose activities in French for non-linguistic subjects (history, geography, science...).

The Department has also created a repository of links to selected sites and provided support for the teaching of French and in French, as well as the promotion of linguistic and cultural diversity. The pages, published on the official website of the Aosta Valley schools, *Webécole*, are organized by school grades, regularly updated and visited by an average of 150 teachers a day.

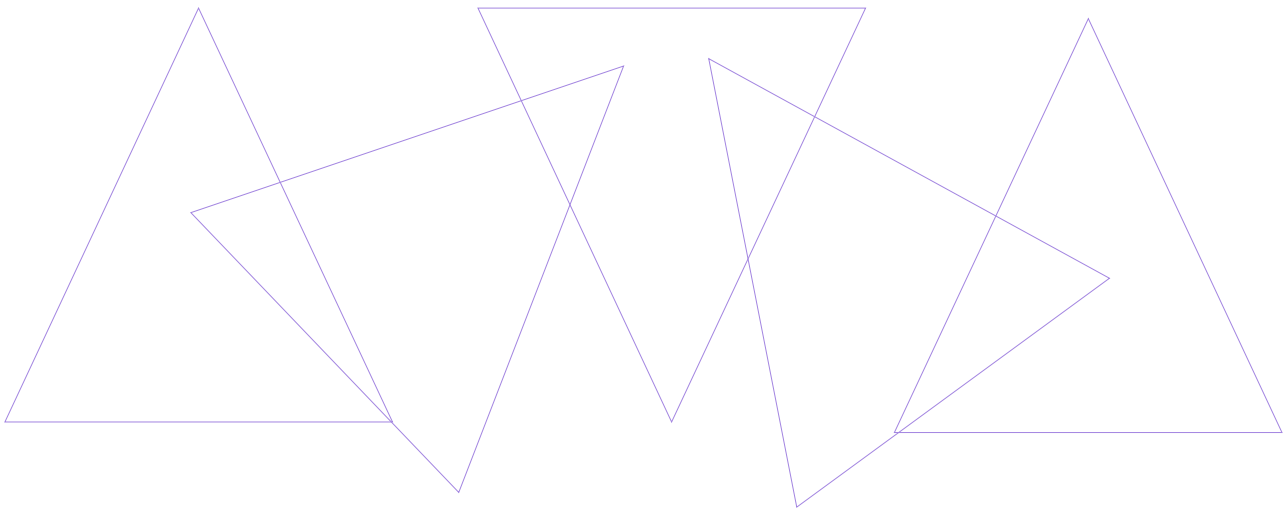
Finally, in order to reach the largest number of families and offer further support to teachers, the Department of Education has offered a series of television programmes, produced in collaboration with the regional seat of RAI, which were broadcast on weekdays from 20th April to 7th May 2020.

L'Explorateur, this is the name of the TV education programme, consists of ten 40-minute episodes and is dedicated to pupils, their families and teachers. It consists of video clips of varying length, depending on the target public: from a few minutes for the little ones to about 10 minutes for the older ones. The language of the broadcast is French, but the videos are representative of the other languages of the region, in particular the regional languages. Therefore, children and their families can find in these broadcasts the same multilingual and multicultural context that school offers.

Thanks to social media, the various episodes that make up these series are also available on the Facebook page of the regional RAI, on the official YouTube channel of the Regional Administration and on the website of the Superintendence of Studies, created for this initiative (scuole.vda.it/lexplorateur).

L'Explorateur website provides parents with further ideas for recreational and educational activities, in addition to those proposed by the TV programme presenter. The original works of children and teenagers are then sent to *lascuolanonsifermavda@mail.scuole.vda.it* and are shared on the website. Teachers can also find suggestions for educational activities.

The broadcasts published on the Region’s YouTube channel as well as the didactic suggestions will remain available to teachers even at the end of this period of lockdown and distance learning and could be used for the next school year's class activities, when distance learning is likely to be confirmed.



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Research

RESEARCH OF THE EUROPEAN DIVISION OF THE UNESCO CHAIR IN BIOETHICS ON THE COVID-19 PANDEMIC

Prof. Vojin Rakic, UNESCO Chair in Bioethics European Division Coordinator

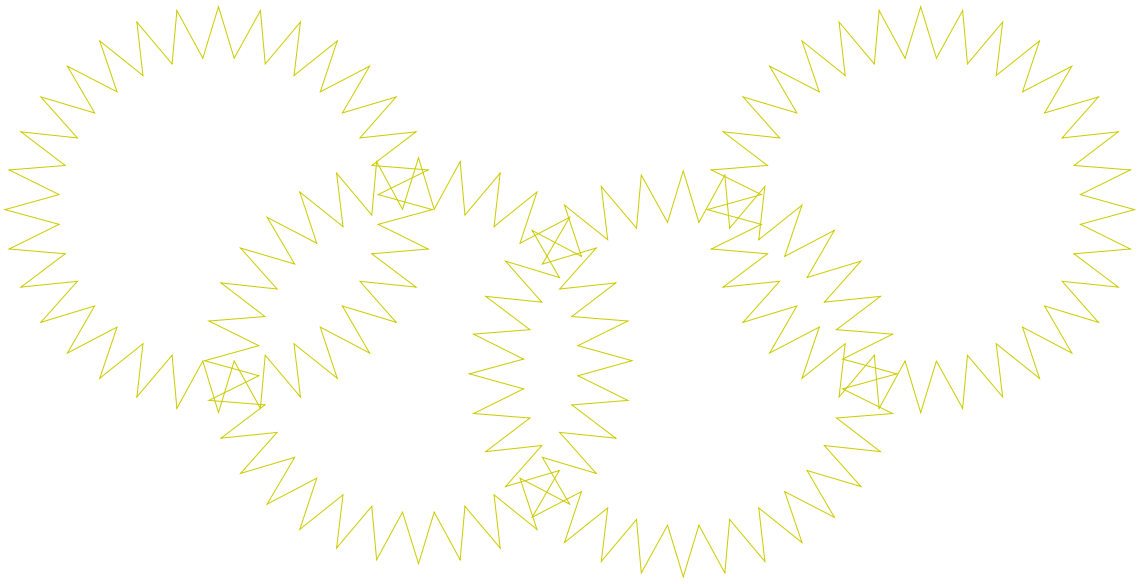
The European Division of the UNESCO Chair in Bioethics conducts two major research activities related to the Covid-19 pandemic. Almost all member units of the European Division are engaged in them.

On the basis of existing empirical data, as well as of the data we acquire from our units (grounded on two types of questionnaires) we investigate the following two ethical issues:

1) Are the limitations, primarily the ones on citizens` freedoms that are being imposed by different states, proportional to the threat to public health posed by the Covid-19 pandemic.

2) How should scarcity of medical resources be avoided, and if it cannot, which criteria ought to be used to prioritize patients if the demand for medical resources exceeds its supply.

Our aim is to apply for European funding for these projects.



References

RESOURCES AND DATA CORONA RESEARCH

Prepared by Shai Linn, MD, DRPH (Israel)

Version 1.

Please send the Chair comments or new links and send a copy to me to linnshai@gmail.com

We will send updates periodically

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AMA Journal of Ethics COVID-19 Ethics Resource Center___5
University of Washington Medicine COVID-19 resources https://covid- 19.uwmedicine.org/Pages/default.aspx__5
The Nuffield Council:_5

(Selected list, by Shai Linn, 10-5-20)

US CDC
https://www.cdc.gov/coronavirus/2019-ncov/index.html
https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/index.html

The U.S. Centers for Disease Control: Ethical guidelines in Pandemic Influenza
https://www.cdc.gov/od/science/integrity/phethics/docs/panflu_ethic_guidelines.pdf

A New Resource for Genomics and Precision Health Information and Publications on the Investigation and Control of COVID-19 and other Coronaviruses

Wei Yu, Marta Gwinn, Muin J. Khoury
doi: https://doi.org/10.1101/2020.04.21.050922

WHO
https://www.who.int/emergencies/diseases/novel-coronavirus-2019

Coronavirus Disease (COVID-19) outbreak
Coronavirus Disease (COVID-19) Mythbusters
Rolling updates on Coronavirus disease (COVID-19)
Coronavirus Disease (COVID-19) Questions and Answers
World Health Organization: Managing Ethical Issues in Infectious Disease Outbreaks
https://www.who.int/ethics/publications/infectious-disease-outbreaks/en/

Comparing countries on health systems and handling COVID19
https://www.covid19healthsystem.org/searchandcompare.aspx

WORLOMETER
https://www.worldometers.info/coronavirus/

AMAZON DATA
https://aws.amazon.com/blogs/big-data/a-public-data-lake-for-analysis-of-covid-19-data/

Publications database on COVID19
Litcovid
https://www.nature.com/articles/d41586-020-00694-1

AMA resources
https://journalofethics.ama-assn.org/covid-19-ethics-resource-center

Johns Hopkins University COVID-19 resource center

https://coronavirus.jhu.edu/

US National Academy of Medicine

Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2
https://nam.edu/duty-to-plan-health-care-crisis-standards-of-care-and-novel-coronavirus-sars-cov-2/

COVID Clinical Research Coalition
www.covid19crc.org

Google health care

HCA Healthcare, Google Cloud launch platform to pool all hospital COVID-19 data
https://www.fiercehealthcare.com/tech/hca-healthcare-google-cloud-launch-platform- to-pool-all-hospital-covid-19-data

Registry of research on Corona
https://wprn.org/

International Monetary Fund IMF
https://www.imf.org/en/Topics/imf-and-covid19

SAGE UK resources
https://www.gov.uk/government/groups/scientific-advisory-group-for-emergencies- sage -coronavirus-covid-19-response

Hasting Center

Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS -CoV-2 (COVID-19); Guidelines for Institutional Ethics Services Responding to COVID-19: https://www.thehastingscenter.org/ethicalframeworkcovid19
AMA Journal of Ethics COVID-19 Ethics Resource Center
https://journalofethics.ama-assn.org/covid-19-ethics-resource-center

University of Washington Medicine COVID-19 resources
https://covid-19.uwmedicine.org/Pages/default.aspx

The Nuffield Council
Guide to the ethics of surveillance and quarantine for novel coronavirus https:// www.nuffieldbioethics.org/news/guide-to-the-ethics-of-surveillance-and- quarantine-for-novel-coronavirus

PUBLICATIONS

PHILIPPINES

ALLOCATION OF SCARCE RESOURCES IN THE TIME OF COVID 19: A UST FMS MEDICAL ETHICS VIRTYUAL TOWN HALL

As the whole world come in to a stall and as everyone drifts into extreme extraordinary times, the medical community is encouraged to reflect and ponder which principles and values should inform the current decision-making process amid the coronavirus pandemic. Common questions include; how do we distribute goods and services fairly and efficiently? How do we prioritize which patients benefit finite resources? Is it in the practitioner's hand to decide who lives or who dies? These are just some ethical dilemmas challenging the healthcare workers on the frontlines.

Allocation of scarce resources is a perennial topic for Medical Ethics 3, however, the discussion was made more relevant in the light of the current pandemic. The topic's relevance and weight has been highlighted now, more than ever.

On April 6, 2020, a virtual townhall meeting entitled; "Allocation of Scarce Resources in the Time of COVID 19" was organized by the department. It was attended by the medical school faculty staff, clinical practitioners from Metro Manila and some provinces as well as the medical students. The discussion was led by the faculty staff of the UST FMS Department of Medical Ethics. In the Philippines, the department is also a UNESCO Bioethics Unit of the International Network of the UNESCO Chair in Bioethics (Haifa).

The immediate-past chair of the department, Dr. Patrick Gerard L. Moral served as the moderator. It has been a momentous feat for a highly esteemed specialist in the field of Infectious Diseases and Bioethics served as a reactor and resource person. Prof. Dr. Rosario Angeles Tan-Alora, is a clinician, researcher and academician. Prof. Alora held positions such as the Executive Director of the South East Asian Center for Bioethics. She was a former dean of UST FMS.

The Town Hall recording can be accessed through this link:

https://au-Iti.bbcollab.com/recording/d8cc438e267e4bd8b3c49b817047f401

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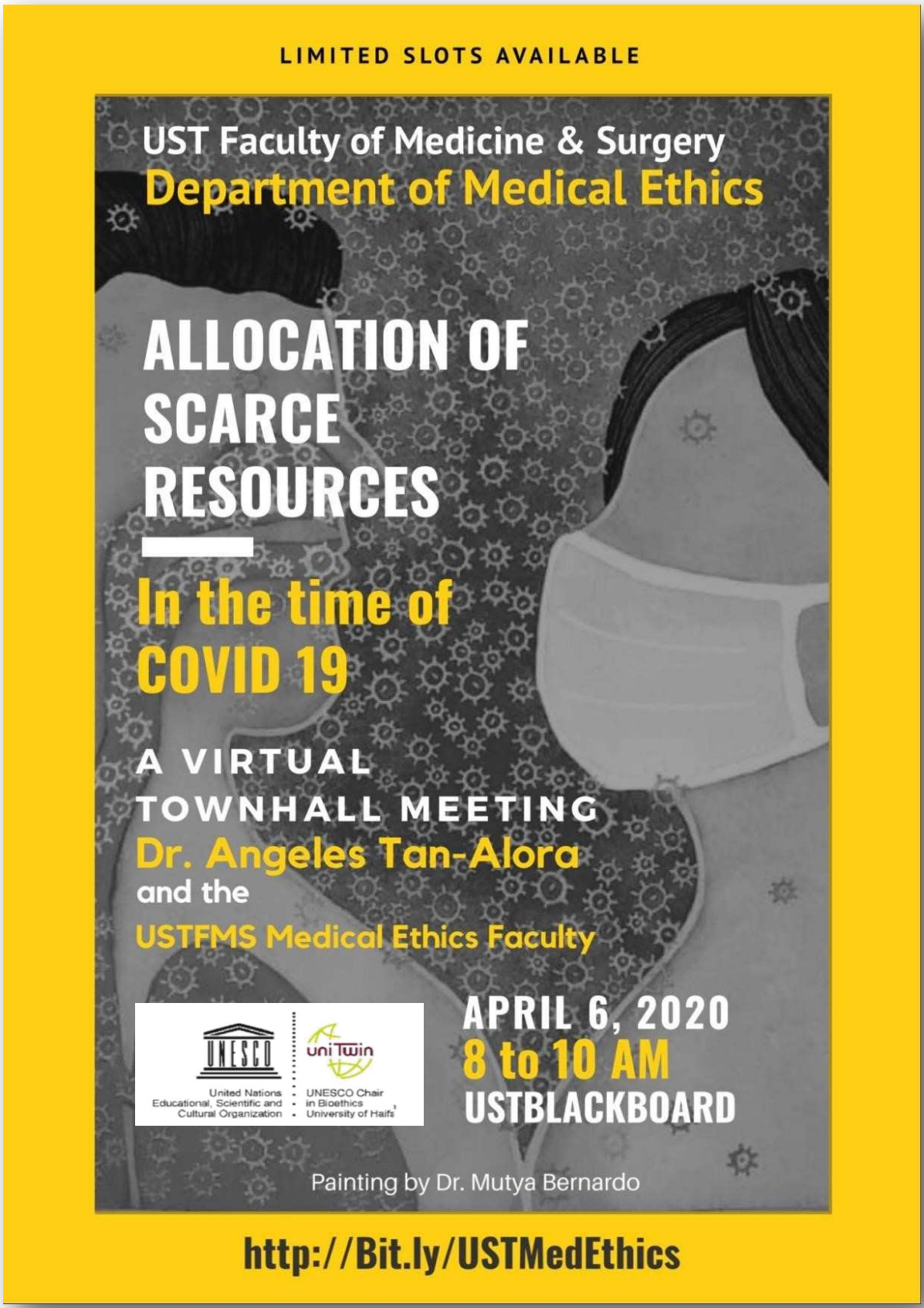
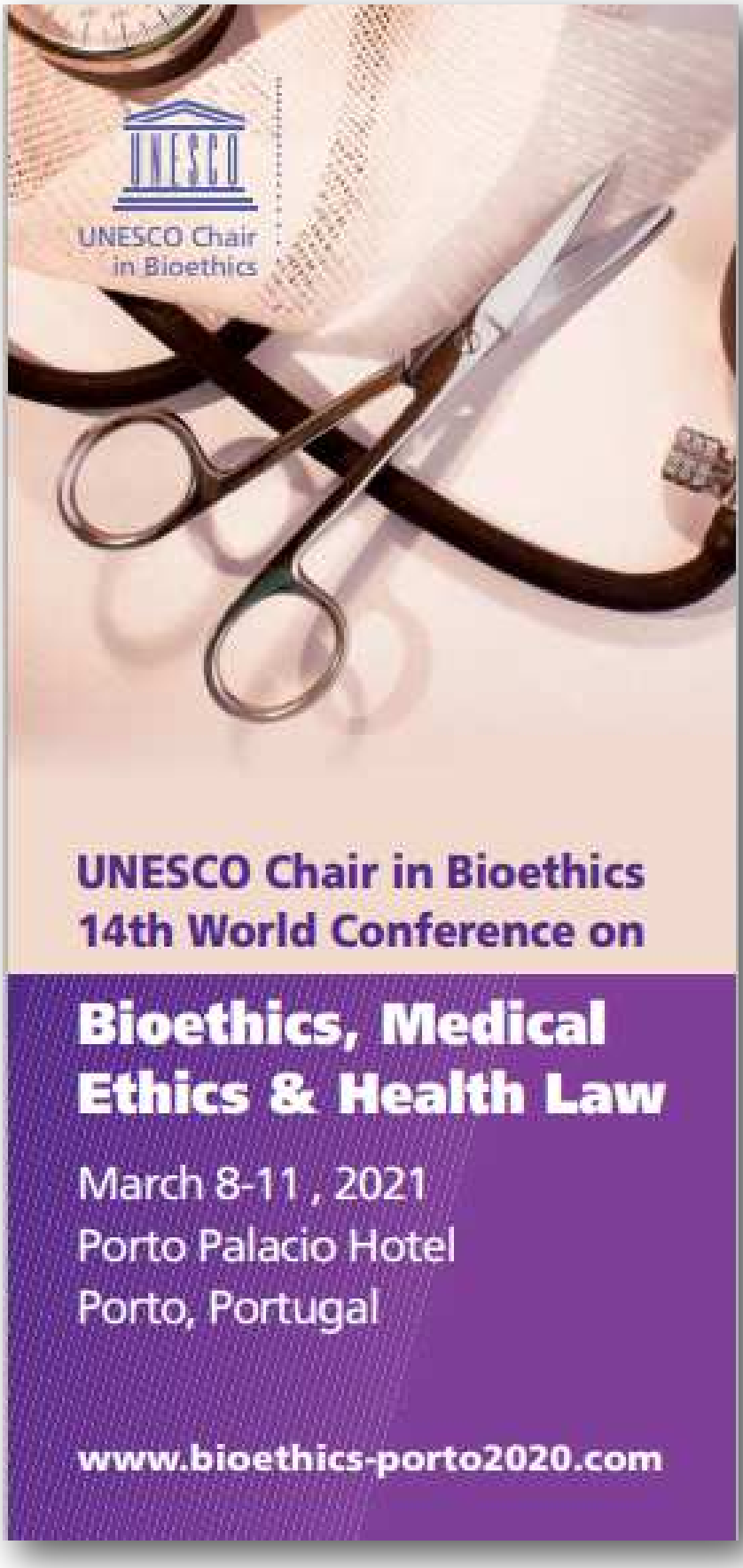

LIMITED SLOTS AVAILABLE
UST Faculty of Medicine & Surgery
Department of Medical Ethics
ALLOCATION OF SCARCE RESOURCES
In the time of COVID 19
A VIRTUAL TOWNHALL MEETING
Dr. Angeles Tan-Alora
and the
USTFMS Medical Ethics Faculty
UNESCO
United Nations Educational, Scientific and Cultural Organization
uniTwin
UNESCO Chair in Bioethics University of Haifa
APRIL 6, 2020
8 to 10 AM
USTBLACKBOARD
Painting by Dr. Mutya Bernardo
http://Bit.ly/USTMedEthics

UNESCO CHAIR IN BIOETHICS WORLD CONFERENCE 2021



The UNESCO Chair in Bioethics is pleased to invite you to become an active participant at the *14th World Conference on Bioethics, Medical Ethics & Health Law*, to be held in Porto on March 8-11, 2021. The Conference is designed to offer a platform for the exchange of information and knowledge and to hold discussions, lectures, workshops and exhibition of programs and databases.

Target Groups

• physicians • nurses • dentists • social workers • psychologists • psychiatrists • lawyers • judges • bioethicists • philosophers • researchers • writers • ethics committee members • teachers • educators • rectors, deans and administrators of academic institutes • hospital managers • teachers and students of medical, nursing, ethics, psychology, philosophy and law schools and faculties • professional, cultural and volunteer organizations and associations • governmental & public bodies • speech and language therapists • veterinarians • nutritionists & dietitians

Language: The World Conference will be held in English

Abstracts of approximately 200 words on any of the listed topics are invited for oral or poster presentation. All submissions must be written in English. Each participant may present only one lecture or one poster. See website for submission information.
Deadline for abstract submission: January 15, 2021

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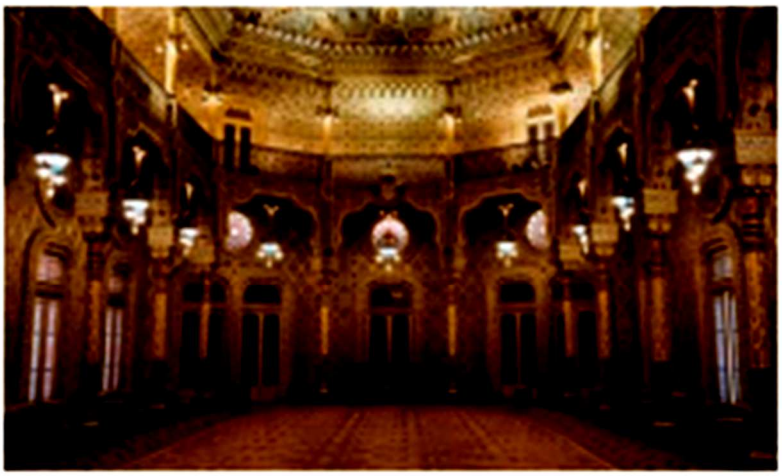
Prof. João Proença Xavier • Dr. Francisca Rego
Prof. Miguel Ricou



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Main Topics

• Alcohol, Drugs • Animal Research Ethics • Assisted Suicide • Autonomy • Benefit & Harm • Bioethics & the Holocaust: An Educational Agenda • Bioethics Education • Bioethics: Gender • Bioethics: General • Bioethics: History & Future • Biotechnological Products • Clinical Trials • Confidentiality • Cultural Pluralism • Death and Dying • Dentistry, Law and Ethics • Discrimination • Doctors' Rights • Drugs • End of Life • Environment's Protection • Equality • Ethical Aspects of E-Medicine • Ethical Aspects of Toxicology • Ethical Education: Skills & Technology • Ethics & Environment • Ethics and Immigration • Ethics Committees: Challenges & Tasks • Ethics Committees: Different Forms • Ethics Committees: Education of Member • Ethics Committees: Establishments • Ethics Committees: Evaluations • Ethics Committees: General • Ethics Committees: Platforms for Deliberations & Policy Recommendations • Ethics Committees: Procedures & Operations • Ethics Education: Tools and Methods • Ethics Education: Youth and Children • Ethics in Physical Education and Sports • Food and Death • Forensic Medicine • Genetics: Ethical Aspects • Health Challenges Faced by Children and Women • Healthcare in Terminal Illness • Healthcare Services and Costs • Healthcare: Dignified & Non-discriminatory • Healthcare: Ethical Supervision • Human Dignity • Human Life: Sacred Life, Quality of Life • Human Rights • Informed Consent • Justice • Medical Errors • Medical Ethics • Medical Ethics and Law: Patents • Medical Ethics in Times of Crisis • Medical Ethics: Globalization • Medical Ethics: Management • Medical Ethics: Surgery • Medical Ethics: The Digital Era • Medical Law • Medical Negligence • Medical Research • Mental Disorders • Neuro-ethics • Nursing, Law and Ethics • Organ Transplantation • Patients' Rights • Pregnancy: Termination • Psychiatry, Law and Ethics • Psychology, Law and Ethics • Reproduction • Solidarity • Stem Cell Research • Surrogacy • Veterinary: Ethics and Law •

For more details and registration, see
www.bioethics-porto2020.com

Schedule*

	Monday, March 8	Tuesday, March 9	Wednesday, March 10	Thursday, March 11
08:00-08:30	Registration	Registration	Registration	Registration
08:30-10:30	Opening Session	Plenary Session	Plenary Session	Plenary Session
10:30-10:45	Light Refreshments	Light Refreshments	Light Refreshments	Light Refreshments
10:45-12:15	Sessions	Sessions	Sessions	Sessions
12:15-13:45	Sessions	Sessions	Sessions	Sessions
13:45-14:00	Light Refreshments	Light Refreshments	Light Refreshments	
14:00-16:00	Sessions	Sessions	Sessions	
16:00-17:30	Sessions	Sessions	Sessions	
19:00	Optional Social Evening	Optional Social Evening	Optional Social Evening	

* Subject to change

PCO & Secretariat:
ISAS International Seminars
POB 40399, 6303 Larnaca, Cyprus
office@bioethics-porto2020.com

Under the Auspices of:

WMA IFMSA wfme WORLD FEDERATION FOR MEDICAL EDUCATION CPME

Message of Chair's Holder

We are at the beginning of a new era and in recovery from the Corona epidemic, which attacked us all a few months ago. We send condolences to the affected families, and blessings for good health to all who suffered from this disease.

The new issue of the newsletter is dedicated to the ethical dilemmas associated with the Corona epidemic. I would like to congratulate Dr. M. Vasinova and the newsletter's Editorial Board on this. The pandemic hit the UNESCO Chair by causing the postponement of the World Conference to a new date. On the other hand, the Chair seems to have never experienced such intensive activity by individuals and groups as has been shown during the last period "Every cloud does have a silver lining" The new issue of the newsletter extensively reflects this important activity. Many colleagues deserve appreciation and thanks for their welcome initiatives.

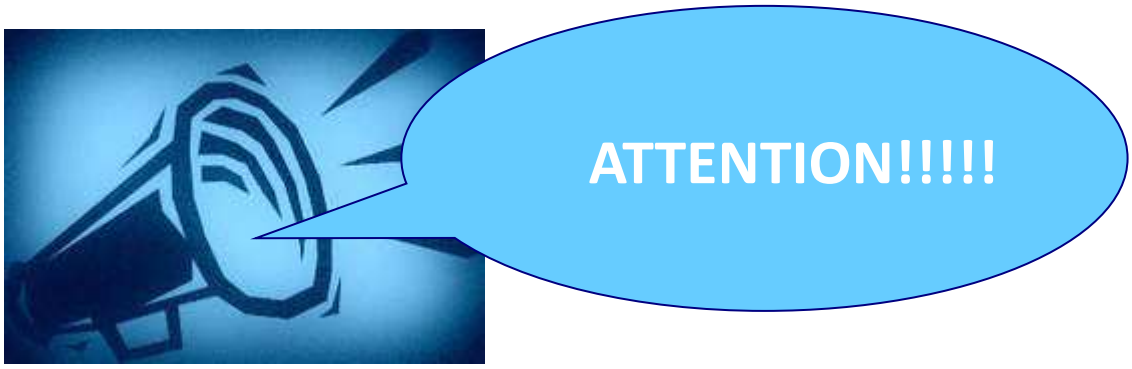
Appreciation should be shown, first and foremost to Professor Russell de Souza, Head of the Chair's Education Department. Professor Russell initiated and co-chaired with his excellent team no less than nine Webinars. For three months, dozens of scientists and ethicists from all over the world held these professional meetings, deploying before thousands of participants the variety of ethical dilemmas associated with the epidemic phenomenon. The Head of the European Division of the International Network of Units of the Chair, Prof. Vojin Rakis, deserves highly appreciation. Prof. Rakis, along with his colleagues, built and distributed a questionnaire dealing with ethical dilemmas involved in the Corona epidemic. The team will analyze the data that will accumulate and consider the EU support request for this project. Another leading colleague, Prof. Shai Lin who initiated, collected, built and disseminated current information of the best articles recently published around the world on bioethics and corona, should be highly commended. Professor Rui Nunes, Head of the Chair's Research Department, should be appreciated for his success in holding the upcoming World Conference on the new date, without prejudice to the rights of all participants previously enrolled in this conference.

As mentioned above, the Corona epidemic has caused, among other things, the postponement of the 14th World Conference to March 8-11, 2021, while keeping the original conditions of registration and the scientific program.
Postponing the conference date will allow more participants to sign up for the conference and enrich its scientific program.

I wish you all good health, and hope to meet you in Porto at the World Conference.
Sincerely yours,

Prof. Amnon Carmi, Head
UNESCO Chair in Bioethics

Editorial Board Communications



NEWSLETTER'S CONTRIBUTIONS REQUIREMENTS

The contributions for the next Bioethical Voices newsletter must be forwarded to the Editorial Board before 31 July 2020. They should to be written in good English and in Word Format, with some photos (where possible) and their contents should be of international interests. Each author is personally responsible for the contents and the language of his/her own contribution. Contributions must be signed.

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Chair Holder's Message, Editorial, Bioethics in the World, Bioethics VIPs and Institutions, About Legislation and Judgments, Bioethics and Disability, Education, Youth Bioethics Education, Research, Publications, About Units, Focus on Units, World Bioethics Day, Events, Past and Future Chair's Conference, Editorial Board Announcements. The structure of the Newsletter is still in progress.

AIM OF SECTIONS

Bioethics in the world (300 words max.): description of a concept /idea and its interpretation/ application in the different geographical contexts or a news.
About legislation and judgments (300 words max.): news from Law associations, Court decisions, developments in national or international legislations
Education (max 300 words): announcements of creation of working group or networks, list and a short description of courses, seminars, workshops (including the target, the dates and organizers), trainings, university programs.
Research: ongoing research projects: title, authors and short description.
Publications: title, authors, year of publication.

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