



# BIOETHICS CARIBE

## BSEC's NEWSLETTER

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Newsletter of the Bioethics Society of the English-Speaking Caribbean – May 2020

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## **FROM THE DESK OF THE PRESIDENT**

Dear BSEC Members,

It gives me immense pleasure to write this message during the release of our BSEC's Newsletter for 2020.

We have tried to put together some important current issues in Bioethics for your reading and feedback. Please feel free to record your comments on the website.

I wish to express my sincere gratitude to the contributors, to Dr Grace Sirju-Charran for her review and editing and our most efficient secretary Ms Kamille Williams for putting it all together

Thanks to all of you for your continued support for BSEC.

Best Regards,

Professor Hariharan Seetharaman

President, Bioethics Society of the English-Speaking Caribbean

## **FROM THE DESK OF THE EDITOR**

I am pleased to share with you the links to two documents now available on UNESCO's website. The first is a joint **IBC and COMEST Statement on COVID-19** co-authored by the [International Bioethics Committee](#) and the [World Commission on the Ethics of Scientific Knowledge and Technology](#) while the second is for UNESCO's press release on an update of the process of the elaboration of UNESCO's **Recommendation on the Ethics of AI**:

1. <https://unesdoc.unesco.org/ark:/48223/pf0000373115>
2. <https://en.unesco.org/news/unescos-international-expert-group-begins-work-drafting-first-global-recommendation-ethics-ai>

In addition to the UNESCO's IBC / COMEST statement on COVID-19, this issue has four further articles on this pandemic, authored by BSEC; Hariharan Seetharaman, Shakel Henson and Donald Simeon. Other articles are by Derrick Aarons who discusses the ethics of the latest developments in Assisted Reproductive Technologies; Shakel Henson develops a Case study on Research Ethics Committees in St. Vincent while Athene Aberdeen's piece is a reflection on Subjective and Objective Ethics. Cheryl McPherson has provided information on CREEi's programme for 2020-2024 and Derrick has written a review of the book by Prof. Sir Errol 'Mikey' Walrond entitled: "A Question of Ethics: Case Conferences in Everyday Ethical and Legal Issues"

We look forward to your "blogs" on any or all of these articles.

Be Safe and Stay Well.

Grace Sirju-Charran  
Editor and Vice-President

## **MEMBERS' ARTICLES**

### **“A QUESTION OF ETHICS: Case Conferences in Everyday Ethical and Legal Issues” – Book Review by Derrick Aarons**

MB.BS.(UWI), M.Sc.(Bioethics), PhD (McGill)

**AUTHOR:** Prof. Sir Errol ‘Mikey’ Walrond

The Preface of this book aptly captures the challenges faced within the medical field when seeking to persuade health care professionals to discuss and deliberate on the ethical issues associated with the technical work they do in various health care arenas.

In this book, Professor Sir Errol Walrond, Emeritus Professor of Surgery and Former Dean of the Faculty of Medicine at the University of the West Indies, Barbados, addresses some of the most important ethical issues that present within clinical settings, including issues of consent and confidentiality, counselling and alternatives in medicine, end of life issues, professional conduct, resource allocation, child abuse, issues of culture and religion, legal jeopardy, and some ethical issues in public health.

The plethora of ethical issues that are raised within the varied ethical cases to be found within this book can lead the uninitiated medical practitioner to wade through the numerous ethical conundrums, sometimes with no clear ethical signposts of which matters should be given greater ethical weight. To mitigate this, Professor Waldron provides guidance by identifying some of the important issues raised within each case, explains the technical issues to be considered in the analysis of each case, and discusses some of the important considerations to be done within the context of each topic.

With such an approach, the health care professional is provided additional insights into each ethical challenge, while members of the lay public can obtain insights not only into the sometimes tortuous deliberations that health care professionals should carry out, but also may more fully understand the outcomes of these issues when they are presented to them within the clinical setting.

Some very thorny issues are discussed, such as the responsibility a doctor may have, to act against a parent’s wishes in the best interest of the child, or whether religious considerations can override the law in the diagnosis of brain death, or whether psychiatric assessment is the final determinant in assessing mental competence. Issues of patients’ vulnerability, such as being mute and unable to express one’s preferences are also explored, as are matters relating to the consideration of individual rights and same sex spouses.

This collection of cases also explores the critical issues of the impact of social media on medical practice, and the conundrum that occurs in HIV infection where the age of consent, pregnancy in a young woman with more than one sex partner, and extra-marital relationships are fundamental

considerations. The ethical requirement of developing the skill of delivering bad news is also among the issues raised by cases within this book, as is a case that pits proffered allopathic treatment against treatment and recommendations made by an alternative medicine practitioner.

Does the unborn have rights? What are the rights of a father? Do health professionals have rights to carry out treatments that may cause harm? All these issues are found within one of the cases outlined in this book. Should patients be offered surgery when the outlook is poor? What are the considerations in Do Not Resuscitate (DNR) orders? Should supportive therapy be withdrawn when there is no hope of recovery? These ethical issues are discussed in the chapter “*To Live or Die.*”

The chapter on ‘*Allocating of Resources*’ stimulates the reader to consider whether doctors should do all that is possible without considerations of the costs and resources involved. Further, it considers whether it is ethical to demand payment first before treatment. The challenges posed by childhood sexual abuse are also illustrated by cases reported in the chapter on this issue, while issues such as the impaired physician, incorrect diagnosis, and restraining a patient are discussed within the chapter on “*Patients at Risk.*”

Issues such as a patient allegedly threatening a nurse and how such a threat be handled; whether fear can justify a normally inappropriate action and ethical issues raised in the treatment of prisoners are all to be found in the chapter on “*Criminal Cases.*” This book then ends on the very important matter of Public Health which includes the critical matter of public notification of a patient’s illness and its purpose, and whether authorities can break the confidentiality of a patient without their consent.

“*A Question of Ethics: Case Conferences in Everyday Ethical and Legal Issues*” thus brings together a wide array of clinical cases that will be profoundly educational for all health professionals that work within the clinical arena, as well as for members of the public who would normally not have access to such insights into these challenging issues with various clinical settings!

*Review by:*

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**Of Artificial Gametes, Exploitative Surrogacy, and Post-Mortem Reproduction:  
Has Advanced Technology Gone Awry? - Derrick Aarons  
MB.BS.(UWI), M.Sc.(Bioethics), PhD (McGill)**

**A Presentation to the 11<sup>th</sup> Annual Bioethics Forum, QEH & BSEC, Barbados – Oct. 27, 2019**

**Introduction:**

Advanced technology refers to new or developing Information Technology( IT) innovation that promises to provide significant value in the future. Advanced technology is being used in several environments, including artificial intelligence, digital medicine and health care, autonomous robots, and spacecraft.

The future of advanced technology currently has no limit, with the stated aim to advance the personal lives of consumers and their families (Anahi, 2018). Reportedly, it will make services and processes simpler and more affordable. Innovations such as self-driving cars, Virtual Reality (VR) through the use of powerful computer processors creating life-like experiences which can be used, for example, by psychiatry professionals to treat conditions such as post-traumatic stress disorder - PTSD, and Artificial Intelligence (AI) utilizing emerging algorithms, robust computers, and massive data collection, are some examples of this.

The Internet of Things (IoT) is helping to make all these a reality through the interconnection of smart computing devices in everyday objects like a thermostat, dishwasher, and refrigerator, and so it is possible to wash dishes using a simple voice command, or be reminded to eat fruits and vegetables that will soon go bad.

This article addresses three derivatives of this advanced technology and some of the ethical issues they pose for us. The derivatives are: i) The production of artificial gametes ii) Surrogacy utilizing assisted reproductive technologies, and iii) Post-mortem reproduction.

**Artificial Gametes**

Assisted reproductive technologies (ARTs) have evolved at great speed in the recent past, and ARTs may technically be used by single persons, same sex couples, or heterosexual couples utilizing various modalities (IBC, 2019). The ARTs may be used in fulfilling the wishes of some persons by overcoming some of the biological constraints on procreation.

However, across various societies, there are many economic, cultural, scientific, ideological, ethical and religious implications that are derived from the use of this technology, as they may challenge the traditional beliefs a society has about procreation, the institution of family, marital relations, parental relationships, the human body, and life itself.

Up to this point in time, gamete donation, whether in the form of sperm donation by a man, or egg donation by a woman, has been the only solution to remedy the lack of functional gametes in either sex partner. So, gamete donation may be used by heterosexual couples to treat medical infertility.

However, gamete donation can also be used by lesbian couples, single women, gay couples, or single males – these latter two utilizing a surrogate womb being provided by a willing female.

New challenges are now being posed by the possibility of the production of artificial gametes. Research scientists are currently exploring several pathways to creating gametes in-vitro and plausible biological routes towards the production of artificial sperm in men and artificial eggs in women have been described in the literature. Further, if the technological mechanisms are successful, it could also be possible to find biological routes for the development of sperms in females, and eggs in males. However, the state of knowledge on the functionality of all this, as well as safety concerns about the key methods are limiting the process and thus presenting a major challenge to those who wish to proceed towards new discoveries.

On the other hand, possible future use of artificial gametes could increase the availability of gametes for fertility clinics, where natural gametes are in short supply, and for gamete biobanks. When the gametes are produced from the same person (utilizing, for instance, autologous stem cell techniques), it may be possible for infertile persons who now use donated gametes to actually have a child who is genetically related to themselves.

The 1<sup>st</sup> successful report of the process was through the creation of viable offspring using cells from two male mice, and this was published in the journal *Stem Cell* in October 2018. The offspring was created by genetic manipulation of stem cells from the two male mice using the CRISPR-Cas 9 technology, without using any female cells. Although those died within 48 hours, the research team was further able to produce an offspring using cells from two female mice that were healthy (and able to reproduce).

#### Ethical concerns:

The production of artificial gametes and same-sex reproduction however pose a fundamental challenge to many assumptions we currently have about the limits of human reproduction. Further, these techniques raise issues related to how infertility, gametes and parenthood are now understood, as well as ethical concerns such as the commodification of human reproductive materials; the question of whether further research on the whole process is warranted or should be shelved; possible genetic or psychological harm to the offspring; and gender and parenthood issues

This matter will also influence legislation and regulation. Further, artificial gametes raise issues that will prove particularly difficult to solve or resolve e.g. possible gamete theft and the prospect of unwitting parenthood

#### Surrogacy

A surrogate is a woman who bears a child on behalf of another, either by having her own egg fertilized by the other woman's partner, or from the implantation in her uterus of a fertilized egg from the other woman (Oxford Dictionary). However, with the advanced technology, surrogacy has gone beyond the traditional two-parent, male-female constellations.

Many issues surround the notion of surrogacy in many jurisdictions. In some states, surrogacy is regulated under specific conditions, while in others the activity is expressly forbidden. In some situations, citizens have opted to travel overseas to access the service in states where the practice is legal.

Arguments in support of surrogacy include:

- a. Surrogacy may represent the last opportunity to become parents (e.g. a woman who has lost her uterus due to cancer), and so altruistic surrogacy i.e. without economic payment should be permitted.
- b. Surrogacy should be perceived as being morally equivalent to the donation of organs between living donors, in which no money changes hands.
- c. Surrogacy should be allowed with specific regulations to protect the parties involved, with the welfare of the child being the most important; and
- d. In cross-border surrogacy, the territorial distance between the child and the woman who gave birth is great/desirable? and convenient, since it is a potential way to avoid any relationship of the child with the woman who provided the gestation for nine months.

Arguments against surrogacy include:

- a. Most surrogates' decisions are made under duress, and so surrogacy is often said to be a form of exploitation of women. Surrogates are often women with few options for meeting compelling financial needs, which thus make them vulnerable to exploitation by intermediaries. Examples of this social injustice arise in poor countries, where women are exploited by intermediaries for intended parents coming from wealthy countries where such surrogacy is prohibited.

In these cases, there is often a 'market' of particularly vulnerable women who are for the most part partly illiterate, and in disadvantaged socio-economic conditions and not able to fully understand and grasp the essence of the ethical issues involved in their action. Alternately, they may understand, but cannot choose to act differently due to their dire circumstances. Further, even in some wealthy countries, the social differences and the existence of disadvantaged social classes could allow similar market forces to exist, wherein genuine consent does not play its real role.

- b. The lack of real informed consent, as women entering surrogacy are often unable to anticipate the substantial risk that they run in the process. They may not understand that they are likely to form an emotional bond between themselves and the foetus during pregnancy, which may render relinquishing the child at delivery extremely difficult.
- c. Surrogacy constitutes an expression of commodification of the woman through her social role as a mother. Thus, surrogacy transactions are inherently degrading to women and violate their dignity.
- d. Gestation comes with endless decisions about lifestyle, as this may have a direct impact on the foetus. When it involves an undertaking by contracted parties (as in surrogacy), the risk of conflict between the surrogate mother and the intended parents is very high. The surrogate's workday, lifestyle and diet, the treatment for any illness from which she may suffer, will all be evaluated by the intended parents

who may seek to dictate these circumstances. They may well state that she undertook to gestate on their behalf, and so they are the ones who should decide in the best interests of the child. Surrogacy therefore also risks entailing an intrusion into the private life of the surrogate.

e. There is the risk of possible abandonment of the child at delivery by the intended parents if it does not meet their expectations for which it was acquired. They may have been pre-natal diagnosis, and careful selection of donor gametes in an effort to get the 'best product' or the 'best child', with the belief that perfection can be determined at birth.

### **Post-mortem reproduction**

Reproduction after a sexual partner has died may be possible through three mechanisms:

1. The procurement of sperms by harvesting them from a recently deceased man for immediate or future use by the remaining sex partner.
2. Using frozen eggs, sperm, or embryo obtained from a deceased partner, so that the remaining partner can have a child when they wish.
3. Using donated cryo-preserved eggs, sperms, or embryo after the death of the donor in a gamete or embryo donation procedure, which may also be combined with surrogacy.

### **Ethical concerns:**

We should note however that post-mortem use of sperms, eggs, or embryos invariably raise complex ethical and legal dilemmas related to autonomy, informed consent, privacy, inheritance,

as well as child welfare and child dignity, children's rights, issues related to the dignity of the deceased person, and a respect for their wishes (Bahadur, 2002; Batzer et al., 2003).

### **Complex Ethical Issues**

The technological imperative is with us, and its positive impact on medicine and health care is undeniable. However, some still have unknown long-term consequences, while others raise the ethical issue of distributive justice – whereby not all persons can access the technology due to high cost factors, and resource allocation and distribution across the society are unresolved and perhaps intractable issues in some cases.

Has advanced technology gone awry? Has it created more problems than we are able to solve? Is it forging ahead without any consideration of ethical issues that affect society? Consider that in post-mortem reproduction or in post-divorce, any use of cryo-preserved gametes or embryos for gestation may present a wide complexity of biological, social, and psychological factors that involve ethical considerations of matters such as autonomy and the voluntary consent of the donor.

Should utilitarian approaches be the only consideration whereby consequential market forces determine the outcome of motherhood, and gestation can be sold subject to a legal regulation of the market? Where the amount of compensation to a surrogate for the costs of pregnancy and disturbance of her working and family life depends solely on her capacity and ability to negotiate a beneficial contract?

In the ethical consideration of artificial gametes, surrogacy, and post-mortem reproduction, where does the notion of the best interests of the child fit in? To further complicate the issue, does everyone not have a right to procreation? Is advanced technology seeking to satisfy wishes, but only for those who can afford it?

At the heart of all these questions is the matter of human dignity - dignity of both adult and child. This refers to the intrinsic value of every human being. The implication is that any commodification of the human body should be rejected, as the human person should never be treated merely to serve someone else's goals. Hence payment for human cells or body parts should never be accepted, nor should payment for using a woman as the carrier of someone else's child in surrogacy.

### **Recommendations**

Vulnerable people should always be protected, as economic vulnerability renders persons open to exploitation. This may require legislation and regulations in certain countries.

Health professionals who administer ARTs should be especially conversant with all these matters, particularly in the ethical and legal implications that underlie the process. The principle of utility, which would include an assessment of benefits versus risks, is also critical to the process, as is the principle of justice involving fair access to any beneficial treatment.

All of these technological advances with their attendant challenges are occurring within society and will invariably impact the members of society, whether for the good or the bad, therefore representatives of society should be present from the conceptual phase of any research into developing technologies, to help determine whether they are ethically acceptable or desirable.

Governments, sponsors of technological research, and civil society should help ensure the safety of advanced technologies, particularly regarding their short and long-term effects on women, men, children, and the family.

National governments should also ensure distributive justice, by supplementing and providing access to beneficial technological developments to those having the greatest need, and not to those who can best financially afford the technology.

Further, professional organizations and health professionals should promote constant evaluation of the safety of these advanced technologies, and develop ethical guidelines for their use, unequivocally focusing on medical ethics over business interests.

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## **Reflecting on Objective and Subjective Ethics in Bioethics**

**Athene Aberdeen**

**BA, English; MPhil. Linguistics; BA Theology; MA Theology;**

Mindful of the fact that there is no single approach to bioethics that can answer all the questions of the human heart and heal the human body and, also mindful that every single ethical problem about health care ethics is ultimately reduced to the conception of what it means to be human and to actualize personhood, the following is a brief reflection on the topic. A short definition of subjective and objective ethics is first presented; while ideas of moral agency, of whether actions or patterns of behaviour or structures are right or wrong and, the question of ultimate value will be mentioned since these are points of reference for normative ethical theory.

An objective ethic means that a good is recognized and does not change. This good is universal, and based on it, ethical precepts do not change either. This good is external to the human person in utilitarianism and in social biology theories, but in personalist and virtue ethic approaches it resides in the intrinsic dignity of the person. A subjective ethic on the other hand considers each value/good as mutable and ends in the autonomic desire of the patient. Such an understanding of the ‘good’ which often changes is the basis of liberal thinking. Both objective and subjective philosophical approaches largely determine the kind of policy found in politics, economics and healthcare in democratic states today.

Basically, the subjective approach to healthcare ethics decree that what cannot be measured qualitatively does not exist or, is not of interest to the ethical enterprise. In this sense, only facts or propositions-empirical evidence out there in the natural world (socio-biologism/utilitarianism) and not human beings per se count. Even healing -Beneficence is scored on a materialistic level, so that there is often a political solution to a moral challenge. Within this view, truth means verified moral statements such as ‘good’, ‘bad’, ‘right’, or ‘wrong’. The question for whom also varies in different contexts. Since there is no universal conception of the good which is presupposed as wished for by a normal human person to thrive, some people in society will be left out. Furthermore, truth is created by men and not discovered; the basic theory of Act Utilitarianism. The value of the autonomy of the human person who creates ‘truth’ is found in liberalism and its variants and especially in healthcare ethics, as one of the four key principles embodied in the ethical theory of Principlism.

In practice, a subjective ethics sees the human person as separated and not connected to his family or to society. Not that family or society are not acknowledged but the acting person as a moral agent is sufficient unto himself or herself. Autonomy is considered above all other values even life itself. So

that we have legal structures in the Western liberal state sanctioning in medical ethics, requests for euthanasia or Physician Assisted Suicide (PAS) by persons deemed as rational and free, i.e. unimpeded by external pressure to make decisions on their life plan. This practice is very questionable since in order to be achieved, autonomy needs life! When morality is left to the intention of the person doing the action, conflicts must arise, for one's autonomy will often clash with the expression of another person's autonomy. The door is also open to persons who can exercise a deleterious power on the rest of the populace who are not educated enough or, sufficiently mobilized to resist such advances. Above all else, a subjective ethics leads to moral relativism since my truth has equal weight with yours, once it allows life in society without sacrificing personal desires.

Unlike the above, an objective ethics begins with a clear understanding of who the human person is. In Personalist and in Virtue ethics the philosophical meaning of the person as a unity of a material body and a spiritual/rational soul is understood. This meaning has come down to us from classical, medieval and modern thinkers. What is often not well understood is that the spiritual soul is the active principle of the superior activities like thought and liberty, as well as the vegetative-sensitive activity of the organism- that is growth and healing, which is part of the person. Both aspects express the concreteness of personhood. This ontological understanding based on reason, is found in the philosophy and theology of Judaism, in Islam and in Hinduism, but more precisely Christian theology. In the latter, the person is also understood as made in the image of God, and, is thus expected to live a life that leads back to this unity in God as described in Revelation. As a result, the human person has an intrinsic dignity which is the ultimate reference point for any decision-making process. Concentrating on the body alone, or on the capabilities the person acting can demonstrate in the society, always reflect a dualistic understanding of the human person. Men and women are rational, exercise free will and responsibilities but always in reference to their intrinsic dignity. That is why Conscientious Objection is so fraught with legal and constitutional challenges in the nation state, because the concept of conscience implies the idea of human dignity: it implies seeing man as a "meaningful whole", a self-contained totality. Healthcare professionals who act or fail to act in relation to certain practices manifest dissent towards the order of authority or legislated norm. In so doing, they can invoke their fundamental rights and request that they not be allowed to fulfill the legal commands contrary to their conscience. Human dignity though contested at times, is enshrined in international law and ought to be respected whether the ethical approach is subjective or objective.

The maximum respect observed when dealing with human beings shows up with the personalist approach in ethics. Even when the rationality of the moral agent is compromised through illness or, the person is gravely and persistently hindered in the application of his or her cognitive powers, this respect is due. Human dignity must be acknowledged, for the spiritual soul, the vital principle of life is still present. Persons in the vegetative state are still human beings with their intrinsic dignity intact until death: the Karen Quinlan case comes to mind. Cost benefit calculations should never be used to pressure doctors and caregivers to end the life of such patients. Largely absent in modern bioethics but found in the personalist approach, and to a certain extent in virtue ethics is recognition of the social dimension of the human person as a critical aspect in the healing process. Virtue ethics define character traits of the moral agent, as discovered by reason, acquired by practice within a community of character- family, friends, hobby groups and church etc. –provided they are not dysfunctional. However, one is very

much aware that moral training in virtues of prudence, justice, fortitude and temperance is necessary not only for physicians and caregivers, but for everyone in the society. Such training is needed to counteract the individualism that is so pervasive in all aspects of modern life. Unlike Personalist ethics, VE does not state an ultimate purpose in life for the moral agent so that action can be compromised by emotion, feelings or, even interests like the market. Finally, an objective ethic underscores the freedom in social life; a freedom that is tightly linked to justice and the common good. Even as we interact with our groups and communities, we have the responsibility that we owe to each other to procure each other's development and health. I believe that this awareness has been lurking in the bioethics field for some time, since there have been in the recent literature, topics on vulnerability, also on solidarity and, on the need for a sociological explanation of disease causation rather than relying on the exaggerated human agency that exists in research priorities and health policy.

Which is better, a Subjective ethic or an Objective ethic? The idea of Justice is not sufficiently developed in either ethic. A clearer conception is demanded by our recognition of global bioethics today. However, in my understanding of myself as a social animal, my Catholic Christian faith, and my awareness of the confusion and anger that can be caused by moral relativism, especially outside the biomedical field as seen in recent populist uprisings in Western democracies lead me to prefer an objective ethic. It does take care of more areas of human life than the subjective approach. At the heart of ethics is a concern about something or someone other than oneself. In medical intervention, seeing the patient as subject worthy of our respect, rather than as an object to be manipulated according to cultural trends, ought not to be taken lightly.

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# **Research Ethics Committees – Are they Equipped to Execute their Roles? – Case Study from St. Vincent - Shakel Henson**

**BSc, MD, MPH, MSc, MSc, MSBioethics, FRSPH, FRSTMH.**

## **Introduction**

Research Ethics Committees (RECs) have “*inter alia*” the significant role of protecting the welfare and wellbeing of research participants. They have a duty to ensure that ethical principles are adhered to, so that research participants are not exploited nor subjected to unnecessary risk of harms but rather have their rights protected while they participate in studies (Zarowsky, Haddad and Nguyen 2013). Guidelines to support RECs executing their roles are clearly outlined and readily accessible from various sources such as The Council for International Organizations of Medical Sciences (CIOMS), an international ethical guideline that was specifically designed for low-resource settings like low- and middle-income countries (LMICs) (CIOMS 2016). Although it is expected that RECs will execute their functions, it is essential to note that not all RECs are monitored, and some ethics committees may be operating without any proper standard operating procedures in place or sufficiently trained ethics committee members.

Researchers like Lorenzo et al. (2010) and House, Marete and Meslin (2016) have reported that LMICs face the challenge of weak oversight and monitoring systems. In light of the aforementioned, the effectiveness of RECs in LMICs like St. Vincent and their ability to genuinely protect research participants comes into question. Given my personal experiences with two RECs in my home country St. Vincent, I strongly believe that there is a need for continual monitoring of the RECs in this country.

## **Monitoring of Research Ethics Committees**

Dhai (2005) reported that the members of RECs in LMICs tend to be overworked as these RECs are often understaffed. Based on my experience with an ethics committee in St. Vincent, I concur with Dhai’s (2005) report. It is therefore recommended that ethics committees should be staffed adequately since there is a need for research participants to be protected. Notably, these research participants tend to be especially vulnerable in low-resource settings (Zarowsky, Haddad and Nguyen 2013; CIOMS, 2016).

With the establishment of RECs, however, measures must be implemented to ensure that these ethics committees are functioning effectively. One would not encourage countries with weak or non-existing monitoring and oversight systems to dismiss RECs but rather I deem it extremely important for a system to be implemented for these RECs to be monitored on a continual basis.

High income countries like the United States of America (USA) have witnessed cases of unethical practices in research in the past, as evidenced by the Tuskegee Syphilis Study (Pence, 2015). Lessons were learnt from such cases, however, to the extent that there have been guidelines published, The Belmont Report, and some improvements in the ethical conduct of research (The Belmont Report, 1979; 45 CFR 46 2018). St. Vincent lacks the resources that the USA possesses but that does not mean

that it is incapable of implementing effective oversight and monitoring systems for the RECs that exist in the country.

Brazil is an LMIC, which has been effective in regulating its RECs (Lamas et al. 2010). This country established a national ethics committee that oversees all of the RECs in Brazil. The national committee functions to monitor these RECs so as to ensure that they are adhering to ethical guidelines and are functioning optimally to protect research participants (Lamas et al., 2010). It is able to execute its role effectively since all of the RECs in Brazil must be registered (Lamas et al., 2010). Countries, like St. Vincent, should adopt this practice, which will help to better protect research participants.

### **Experiences from St. Vincent**

About two years ago I was invited to be a member of a REC in St. Vincent. Unfortunately, there was no follow-up on this, and I am yet to attend a meeting of this ethics committee. One of its members noted, however, that there were insufficient members of the committee and persons needed to be trained so that the REC can function more effectively. Given my training in research ethics, I was asked to help teach some potential members of this REC. Like my membership, this too failed to be realized possibly because research ethics training is not high on the priority list.

Recently, one of my colleagues expressed disappointment with the manner in which her ethics committee is functioning. This REC, which is located in St. Vincent, was recently established. Members were assigned but more than 50% of these members have absolutely no training or prior exposure to research ethics. The ethics committee did not mandate training of its members but merely selected individuals from within the organization and established the REC just so that it can be documented that there is an ethics committee. No community members were selected and there were no discussions about having one become a member of the REC. The REC chair was selected based on seniority in the organization rather than competence in research ethics. Standard operating procedures were not established, and no clear guidelines were given to the members of the REC on how protocols should be reviewed. My colleague was highly concerned as the REC had started reviewing research protocols.

### **Recommendations**

As was mentioned previously, LMICs like St. Vincent have limited resources, which serve as a barrier to RECs executing their roles effectively (Dhai, 2005). However, as per my experience, there is also the problem of underutilization of existing resources. Having a system in place that can assess how RECs are functioning, like the national ethics committee in Brazil that is responsible for oversight of all research ethics committees, will help to identify gaps, weaknesses and limitations of these ethics committees to optimally execute their duties. Once the problems have been identified then effective solutions can be implemented.

Strengthening oversight and monitoring systems in LMICs is highly encouraged. A key starting point, as was done in Brazil (Lamas et al., 2010), is to mandate that all RECs in a country be registered with the national research ethics committee. Failure to do this, however, will likely lead to research participants being inadequately protected. If the REC that reviewed the protocol was ineffective in executing its duties and lacks trained personnel to correctly identify ethical issues in research proposals,

then it would be very difficult for such an ethics committee to offer protection to research participants. Assigning a designated national ethics committee to monitor all RECs in the country is recommended. There is no need for a large committee to do this monitoring, but its mere existence will encourage RECs to carry out their duties effectively.

## **Conclusion**

It is imperative to have RECs in LMICs since research takes place in these countries and participants of research will need to be protected. These RECs, however, have an obligation to function at a standard that will permit optimal protection of research participants. Although LMICs, like St. Vincent, may have limited resources, it is still possible to have a system in place that can better utilize existing resources. These LMICs can mandate that all RECs be registered nationally. By so doing, citizens, who may at some point serve as research participants, can be better protected. Hence, with the introduction of national committees that can continually monitor RECs, these ethics committees will likely strive to optimally protect and safeguard the rights, welfare and wellbeing of research participants.

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## **Caribbean Research Ethics Education Initiative (CREEi) 2020-2024**

**Cheryl Macpherson**

**BSEC Past President, Professor, SGU; Senior Research Fellow, WINDREF**

The Caribbean Research Ethics Education Initiative (CREEi) is back! Many CREEi alumni have become BSEC members and are advancing research ethics in their own institutions and countries through teaching, research, or policy work. Funding for CREEi was renewed in February 2020 (Fogarty International Center of the National Institutes of Health Award # R25TW009731) and is being held at the Windward Islands Research and Education Foundation (WINDREF) in Grenada under the leadership of BSEC's Past President, Professor Cheryl Macpherson.

CREEi remains a partnership of 3 institutions: Universidad de Autonoma in Mexico (UAQ) led by Dr Hilda Romero, Clarkson University in the USA (CU) led by Dr Paul Cummins, and WINDREF/St George's University (SGU) in Grenada. Sean Philpott-Jones who developed and led CREEi's first iteration left CU but remains involved as a new member of our Advisory Board. We are grateful to Sean for his important regional contribution and ongoing support, and to the Fogarty International Center of the National Institutes of Health for Award # R25TW009731 which provides full scholarships to CREEi fellows.

CREEi 2020-2024 retains some original Advisory Board members and adds, in addition to Sean, Sergio Litewka at the University of Miami and its online research ethics CITI program. Faculty include BSEC's founder and past president Derrick Aarons, Bob Hall, Jose Salvadore Arellano; CREEi alumni Sharmella Roopchand-Martin, Bernardo Garcia, Eduardo Farias Trujillo, and Maria Concepcion Mendez Gomez Humaran.

Like its predecessor, CREEi 2020-2024 aims to impart and strengthen expertise in research ethics and bioethics across the region and to equip its graduates to function as researchers, educators, policy advocates, or academics. The responsible conduct of research (RCR) remains a core value. CREEi will now offer only a two-year masters degree in "Bioethics and Research Ethics" (not the previous one-year certificate), with full scholarships from the NIH-FIC. The first cohort of CREEi fellows will now be able to receive masters degrees from Clarkson University (CU) upon successful completion of the two year program. A process to transition the degree granting to SGU and UAQ will be designed and implemented for the second and/or third cohorts.

A unique feature of the new CREEi is that fellows in each cohort will include those from both English and Spanish speaking countries in order to deepen cross-cultural understandings, insights, and partnerships across the region. They do not have to be bilingual as the program will have English and Spanish translations. . Also new, is the opportunity to design, conduct, and prepare a manuscript for submission to a mainstream journal over one year. Fellows are required to produce either a research paper on research ethics to submit for publication or a capstone paper reflecting a one-year education or policy project. It retains its original structure of online courses bookended by intensive onsite courses.

CREEi aims to attract those involved in research ethics committees?/IRBs or in health-related professions including medicine, pharmacy, public health, information technology, academia, law, and others.

Applicants must have a bachelor's degree or equivalent and be citizens of countries in the Caribbean Basin classified by the World Bank in 2020 as low- or middle-income (those eligible are listed in the Call for Applications). They must demonstrate strong interest and professional goals relevant to research ethics or bioethics and be positioned to integrate their CREEi education into their employment or career. The Call for Applications and the Application Form can be downloaded from the BSEC website <http://www.bioethicscaribe.org/blogannouncements.html> and from <http://unidadbioetica.com> and <http://filosofia.uaq.mx/ub/index.php> .

## COVID-19

### **COVID-19 STATEMENT FROM THE BIOETHICS SOCIETY OF THE ENGLISH-SPEAKING CARIBBEAN**

We are living in unusual times, with more than 173 countries globally being affected by the Covid-19 pandemic. With so much of politicisation, pointing fingers, blame-games and harsh statements from many circles, it is imperative that BSEC must express its standpoint regarding the ethical aspects of this whole scenario.

In addition to ill-health (both physical and psychological) caused by this pandemic, there are multifarious major ethical concerns with respect to personal and social responsibilities, economic adversities and vulnerability of groups of individuals.

The ethical concerns may be approached by two major areas – healthcare setting and societal setting.

With respect to healthcare, resource allocation and rationing are the major issues. Throughout the world, it is common knowledge that public healthcare systems are underfunded and this pandemic has opened the eyes of many regarding the importance of strengthening primary and public healthcare allocating more resources to this area of medicine. Until vaccines and treatment drugs are developed, the primary method of preventing this disease is personal and public hygiene, in addition to isolation.

In countries where there is a raging spread of the disease and the healthcare settings are overwhelmed, there is already rationing of services based on *ad hoc* criteria. This includes denying testing, hospitalization, ICU care, ventilatory support, etc.

Regarding healthcare providers, there have been situations where they have to attend to Covid-19 patients without proper personal protective equipment (PPE), which has introduced an ethical dilemma of whether the providers can refuse to attend to such patients. Hoarding of drugs, PPE, and use of untested drugs are other major ethical concerns.

Health research is extremely crucial at this juncture; however highest ethical standards must be adhered to, especially when new interventions and clinical trials are undertaken.

With respect to societal setting, although fraught with controversies, when it is a national shutdown, it is everyone's personal responsibility to abide by the rules, not only because it is illegal, but also because every single person may be a reason for spreading the virus. This concern for others (beneficence) is one of the major personal ethical responsibility one should display at this point of time.

Another major social responsibility is avoiding the spread of fake news, unverified claims, sensational news, protected health information of patients in the social media.

Price-hiking (gouging), hoarding essential amenities, distributing things on sectarian or other such discriminatory basis are all unethical behaviours reported during this time of pandemic.

BSEC wishes to reinforce the personal and social ethical responsibilities of every global citizen during these important times of our life in order to tide over this scourge collectively, adopting scientific and ethical strategies.

Wish you all a safe and healthy life ahead.

## **SOLIDARITY Trial – Identifying Effective Treatments for COVID-19 - Professor Donald T. Simeon**

**Director, Caribbean Centre for Health Systems Research and Development, UWI, St Augustine**

At the time of writing, there were over three million (3, 000, 000) confirmed cases of COVID-19 and over 210 000 deaths from this dreaded disease. The pandemic has affected every country on the planet, with devastating effects in many. Caribbean countries have been doing a good job in containing the spread of infections within their jurisdictions, however there is still no cure or widely accepted treatment. Researchers all over the world have been working overtime to better understand this novel corona virus (SARS-CoV-2) which causes COVID-19, identify effective treatments, and produce a safe and effective vaccine.

In order to identify pharmaceutical interventions that are effective in the treatment of diseases and to determine and measure side effects, researchers depend on randomized controlled (clinical) trials. It was therefore no surprise that health researchers have been very busy designing and conducting clinical trials to identify treatments for COVID-19. As of April 21, there are over [500 registered trials](#) investigating the effectiveness of a range of interventions, which include antiviral drugs, antimalarials, traditional medicines, stem cell treatment, convalescent plasma, immunosuppressants, and vaccines.

The World Health Organization (WHO) is conducting one of the largest trials, aptly termed the ‘Solidarity’ Trial. Countries all over the world were invited to participate giving them the opportunity to contribute to the identification of a safe and effective cure for COVID-19. Significantly, four Caribbean countries have indicated interest in participating in this Trial. Consequently, researchers at The University of the West Indies has established a regional steering committee, to support these countries in their preparation for the Trial.

The [Solidarity Trial](#) is designed to assess the effectiveness of four pharmaceutical interventions to slow the progression of COVID-19 disease or improve survival of the patients. The interventions are being compared against standard of care, which has been defined by each country and depends on best practices and availability of resources. The four trial interventions are remdesivir (an experimental antiviral drug); chloroquine and hydroxychloroquine (drugs used to treat malaria); combination of lopinavir and ritonavir (two HIV drugs); and lopinavir/ritonavir plus interferon-beta (drug with immunomodulatory properties that can cripple viruses).

A Steering Committee established by and based at WHO is managing the Trial. This Committee was charged with the responsibility of randomizing recruited patients at the various sites to the treatments, monitoring side effects, conducting interim analyses to determine *inter alia* whether there is a need to make any changes to the treatments or even to stop the study. Each participating country was also required to establish a local trial performance committee, comprising persons with expertise in pharmacy, medicine, ethics, data management as well as at least one lay representative. These committees have a critical oversight role to monitor and supervise the progress of the Trial.

Proper ethical oversight of the Trial was important. This started with approval from the relevant local research ethics committees. WHO provided each country with a copy of the standardized trial protocol and informed consent form. However, both had to be reviewed for cultural appropriateness, and amendments were made if necessary. The critical role of research ethics committees (RECs) during times of emergencies, such as this pandemic, was highlighted. Accelerated review of urgent research was required. Researchers were held at an even higher standard than usual since research subjects were likely to be particularly vulnerable. Indeed, it was suggested that a dedicated REC be appointed to conduct such urgent reviews during emergencies to fast-track the approval of research that would be required to guide urgent policy development as well as clinical and other actions. This requirement was included in the draft National Health Research Policy for Trinidad and Tobago. Unfortunately, the Policy is awaiting Cabinet approval so urgent COVID-related research proposals may have to be approved by multiple RECs before research could commence.

Another ethical issue with the conduct of the Solidarity Trial was the availability of the trial drugs. The medications being investigated may have been in stock in a country for the treatment of other conditions and using them for the Trial could have resulted in their unavailability for the patients for whom they were initially procured. Importantly, WHO indicated that they would supply the Trial drugs to participating countries to avoid stock-outs and to ensure that the health of other patients was not compromised.

The Caribbean has a proud track record of making timely scientific contributions towards the treatment of important international public health conditions. Participation in the Solidarity Trial has provided an opportunity to further strengthen the Region's image and status in the international health research community.

All the participating countries, researchers and health officials deserve our heartiest congratulations. We look forward to the timely identification of effective treatments in order to save lives and a safe vaccine to prevent new infections.

**COVID 19 – An Eye-Opener for Humanity to Care for The Underserved -  
Hariharan Seetharaman  
Professor of Anaesthesiology and Critical Care Medicine  
Director of Graduate Studies & Research, UWI, St. Augustine**

The ICU team in a tertiary-care hospital received a call at around 9 pm from a peripheral hospital informing that a patient is being referred with suspected Covid-19.

The patient was wheeled into an isolation room in the Accident and Emergency Department. There was one personal protective equipment (PPE) suit available, which was used by an ICU doctor to clinically examine and attach the patient on to a mechanical ventilator.

Regular hospitals did not have enough supply of PPE required to care for Covid-19 patients, since these were predominantly allocated to dedicated ‘quarantine’ hospitals.

The tests to confirm the diagnosis of Covid-19 were performed, but the results would only be made available from the public-health laboratory after a period of 24-48 hours.

Meanwhile, the doctor had to doff the PPE, in order to return to the ICU and provide care for non-Covid-19 patients.

The patient was on a mechanical ventilator but there was no PPE for a nurse to provide bedside care; nor for any healthcare worker to undertake cardiopulmonary resuscitation on the patient who had a cardiac arrest, early in the morning. The patient demised unfortunately without receiving the optimal care.

Although this actually happened in a developing country, the situation is not any better in the developed world.

The media is filled with similar stories, where people died because of the scarcity of amenities including (but not limited to) diagnostic tests, ambulances, N-95 masks, hospital and ICU beds, mechanical ventilators, and human resources.

It is a well-known reality that this pandemic, with its enhanced power of transmissibility, pushed every country into panic, not giving enough time to put in place adequate preparatory and counter measures. However, the personal ethical dilemma of medical practitioners, determined by their Hippocratic Oath to save patients’ lives, (endangering their own lives) is worth discussing.

The ethical questions that come to the fore are as follows:

1. Should healthcare providers risk their life in trying to save a patient without a PPE, knowing fully well that the disease is extremely contagious?
2. Can a provider refuse to provide care to a patient in the absence of a PPE?
3. If a patient dies due to suboptimal care – exclusively because of the unavailability of PPE for the health provider, is the provider deemed legally culpable for the death of the patient?

4. Can the healthcare system be an attributable causative factor for death, for not having resources required for the care of the patient?
5. What is the personal ethical responsibility of the provider in such a situation?
6. The pathology of Covid-19 consumes the patient, the system is overwhelmed, and the providers are often passive observers, unable to do anything because of the lack of resources. Does this absolve the healthcare providers of their moral responsibility?

In many countries of the developed world, the governments, systems, hospitals, laboratories, health providers, lack of medicines, etc., are being blamed when this new emerging infection started afflicting their country, albeit they were boasting all these days that their country was the ‘best’ in terms of healthcare delivery! There are calls for scientists to rush and prepare a vaccine for Covid-19!

But, isn’t this a stark reminder of how people die every day in poor, underserved areas, because they do not even have basic health facilities to address simple, preventable and curable diseases? Why has humanity for a long time turned a blind eye towards these underserved areas?

There are still horror stories out of the African continent that in some areas, people cannot even see *one* doctor, much less an ICU, in a 100-mile surrounding area!

Why the rich countries in the world and the United Nations did not see this as a priority to save lives in these regions in a war-footing, when discussions revolve around waging wars and sending armies to intimidate ideologically different countries and regimes?

Is it not shameful that the World Health Organization continues to maintain a list of the so-called “Neglected Diseases” in 2020?

Why pharmaceutical and technocratic industries did not bother to find medicines and vaccines for diseases prevalent in these areas?

Ebola was identified as early as 1976, but there was no effort to find a vaccine for decades when the disease was limited to one continent, however when it hit the shores of the developed world in 2016, within two years a vaccine was brought into use!

Covid-19 is an eye-opener to the need for solidarity with all of humanity and for treating every other human on this earth with the same compassion and diligence, which we require of our own compatriots in the wake of this pandemic. Let us take a resolve that healthcare is a basic human right - irrespective of the geographical, socioeconomic and other such factors which continuously threaten to deprive humans of this right!

# **COVID-19 – Experiences from St. Vincent and the Grenadines**

**Shakel Henson, BSc, MD, MPH, MSc, MSc, MSBioethics, FRSPH, FRSTMH.**

## **Introduction**

The World Health Organization (WHO) defined health in terms of physical, social and mental wellbeing. All three aspects of health have been greatly challenged by the newly emerging infectious disease, the Coronavirus Disease (COVID-19). This ongoing threat to global health security rapidly transformed the world and continues to severely affect the morbidity and mortality rates of countries worldwide (WHO, 2020a). St. Vincent and the Grenadines (SVG), an upper middle-income English-speaking Caribbean country, like many other countries, has not been spared the wrath of COVID-19 (WHO, 2020b). Despite the efforts of the Ministry of Health, Wellness and the Environment (MOHWE) in SVG to sensitize the Vincentian public about COVID-19, some Vincentians still possess a laissez-faire attitude towards the disease.

## **Situation in St. Vincent and the Grenadines**

The Government of SVG has been doing a remarkable job educating the public on preventive measures that ought to be implemented to minimize the spread of COVID-19 (MOHWE, 2020a). Information has been made readily available through different media including the radio, television and Facebook. Schools were closed one week earlier, following the report of a COVID-19 case, and up to the present time, which is one month after this early closure, they remain closed (API, 2020). Private and public businesses have been adhering to the advice from the MOHWE in SVG to the extent that social distancing is strongly encouraged and in some cases enforced; hand-washing stations have been set up; use of hand sanitizers have become a normal practice; the wearing of masks is heavily supported; among other gestures.

Following the closure of schools on the 20<sup>th</sup> March 2020 (API, 2020), the mode of teaching was transformed and students now have to adapt to a system of online learning. Unfortunately, as evidenced by my own daughter's experience, the online platform has been inaccessible to all students thus making the delivery of lessons challenging. Thus far, half of the students in my daughter's class have not yet logged on to the online platform and lessons have been delivered inconsistently. Teachers appear to be intimidated by the process and some classes, like Needlework, have not been taught at all because the author believes that teaching such courses will require a lot of creativity and additional teaching tools to make learning feasible for students.

Adjusting to the sudden change and new way of life appears to be difficult for some individuals. Although social distancing is strongly encouraged and enforced in some business places, persons waiting on the outside to enter such places line up close to each other; constantly babble in some instances; and even criticize these places, like the supermarkets, for the measures that they have implemented. Some people go to the extent of blaming the country and the Government of SVG for the supposed "nonsense" that presently exists stating, for example, that it is only in SVG that people have to line up to go into the supermarket. Despite numerous warnings, in some cases it has been difficult to

control the number on people who attend social gatherings, like funerals. Persons still congregate to socialize and do so in close proximity to each other.

With an intention to keep the economy going so that many persons can still remain employed and be able to feed their families, the Government of SVG has not issued curfews or shut down the country. Despite these measures, however, some individuals, like those who work in the hotel industry, have lost their jobs while others have had a reduction in their salaries.

To help its citizens, the Vincentian Government has offered grants to young persons with business ideas; given money to taxi drivers and others whose incomes were severely affected by COVID-19; assisted the unemployed through its economic relief plan; and encouraged lending agencies in the country to offer moratoriums of at least three months to assist those persons who have been financially displaced (Searchlight, 2020a; Searchlight, 2020b).

### **Criticisms**

The Government of SVG has been heavily criticized for the manner in which it has addressed the COVID-19 situation. There have been criticisms about not closing the country's borders; bringing the Vincentian sailors, most of whom are stranded at sea, home; failing to shut down the country; among others. Despite such criticisms, as of the 29<sup>th</sup> April 2020, SVG has only reported 16 cases of COVID-19 (MOHWE, 2020b). There have been no deaths up to this date; 8 persons recovered; 8 active cases exist; 121 persons have been tested for the virus; 3 results are pending; and 114 individuals are in quarantine (MOHWE, 2020b).

It is believed that more persons would have been in an economic crisis if the country was shut down. Although it is not entirely business as usual in SVG, some may argue that the liberty that Vincentians have amidst the COVID-19 crisis will permit them to keep a sound mind and prevent some non-communicable diseases, like mental health disorders, from escalating. Contrarily, others may debate that the complacency that exists may result in a sharp rise of COVID-19 cases in the imminent future, especially in light of recent suspected community transmissions (iWN, 2020). Some controversy has surfaced through the media and some individuals even blame these platforms for the complacency that exists among Vincentians. The first COVID-19 case in SVG was reported on the 11<sup>th</sup> March 2020 (WHO, 2020b; MOHWE, 2020a). This case later recovered, and the country was promoted by the media as being "COVID-19 free" on the 27<sup>th</sup> March 2020 (News784, 2020a). The MOHWE in SVG attempted to do some damage control following the aforementioned and urged Vincentians to continue to adhere to the COVID-19 recommended preventive measures (facebook, 2020). Several days after this "COVID-19 free" claim in SVG, the country reported its second COVID-19 case on the 1<sup>st</sup> April 2020 (News784, 2020b). Thereafter, there has been a steady increase in the number of cases of COVID-19 in SVG but fortunately no deaths (MOHWE, 2020b).

A statement from the first identified COVID-19 case in SVG was one that criticized the manner in which the situation was handled. Initially, there was denial by some health-care workers that this was truly a COVID-19 case but thereafter the patient's complaints were taken seriously and within one day a test for COVID-19 was done. This patient who had recently returned home to SVG from the United Kingdom, tested positive for the disease but had mild symptoms (MOHWE, 2020a). According to this

patient, a young female lawyer, the worst part of being tested positive for COVID-19 was the discrimination, cyberbullying and loss of confidentiality that ensued (News784, 2020c).

It was painful to hear the experiences of this patient. Perhaps it was fear and anxiety that caused some members of the Vincentian public to react negatively toward their fellow citizen for contracting an infectious disease. The reasons, however, for reported hostility against the first COVID-19 case in SVG are unclear but the discrimination and loss of confidentiality could have been controlled to some extent. With proper education, discrimination can be minimized and at best should not occur. Loss of confidentiality though, especially through healthcare workers, must never happen.

As a medical doctor, I have first-hand experience of this confidentiality issue and was surprised that some of my own colleagues were involved in circulating the names and addresses of persons who were quarantined due to suspicions of having COVID-19.

### **Recommendations for the Future**

Lessons can be learnt from this COVID-19 experience that can help to improve the health outcomes of Vincentians and protect their safety and well-being. Fear and anxiety are likely to surface in emergency settings. However, through continual education and preparations for emergency situations, the public can have a better sense of how to prepare for severe outcomes and be optimally protected in the process. Mock exercises on how to address various health issues can be implemented. This will likely come at a cost, but the price will be worthwhile if lives can be saved and panic can be minimized when a true disastrous situation, like COVID-19, surfaces. It will certainly be difficult to predict the effects of newly emerging infectious diseases but by sensitizing the public on the possibility that such diseases can occur and having a clear plan of action in the event of these occurrences will be beneficial.

### **Conclusion**

Indeed, it was virtually impossible to predict the catastrophe that the world has experienced due to COVID-19 (WHO, 2020a). The author is of the opinion that SVG, like many other countries, was not sufficiently prepared for the magnitude of the effects that have been created by this deadly pandemic. Nonetheless, the experiences of this country and the lessons learnt from other countries can help to boost its emergency preparedness plan so that if ever such a crisis arises again in the future, SVG can be better prepared.

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## **BSEC MEMBERS' ACCOMPLISHMENTS:**



### **Dr. Derrick Aarons**

**MB.BS.(UWI), M.Sc.(Bioethics), Ph.D.(McGill); Founding President - BSEC**

#### **New Appointment:**

Head of the Health Professions Authority, Turks and Caicos Islands, West Indies

#### **Peer Reviewed Journal Publications:**

Aarons DE. *The disability-rights perspective within the bioethics agenda*. Nursing Ethics Journal. Feb.'2020

Aarons DE. *Bioethics and the environment against the violation of human rights: Redefinition of agrarian and food sovereignty*. Revista Redbioetica UNESCO 2019; 10(1): 14-22.

#### **Keynote Addresses:**

Jan. 2020: *“Ethical Issues in Infectious Diseases”* – Infectious Diseases Symposium, Antigua, West Indies

Nov. 2019: *“University-trained naturopathic practitioners: Who should regulate?”* – The Annual General Meeting of the Caribbean Association of Medical Councils (CAMC) – Barbados, West Indies

#### **International Conference Presentation:**

Nov'19: *Developing a policy and governance of gene-editing and gene drive research in the Caribbean* – The Global Forum for Bioethics in Research (GFBR) - Singapore