B.S.E.C.

BIOETHICS CARIBE
COVID-19 NEWSLETTER
Secretariat: St George's University (SGU) Grenada. www.bioethicscaribe.org
Newsletter of the Bioethics Society of the English-Speaking Caribbean – Jan 2021

Table of Contents

FROM THE DESK OF THE PRESIDENT

January 25, 2021

The Bioethics Society of the English-Speaking Caribbean (BSEC) has been continuously striving to increase the knowledge and understanding of Bioethics through promoting and fostering deliberations across the English-Speaking Caribbean nations.

BSEC has the tradition of releasing E-newsletters and blogs every year focusing on important global events. The Covid-19 pandemic has disrupted nations and communities in so many ways and it is only appropriate to raise awareness and educate people on the ethical issues raised by this pandemic.

I thank the contributors, Dr Grace Sirju-Charran for her usual editorial reviews and Ms Kamille Williams for her consistent support to the Society.

Professor Hariharan Seetharaman
UWI St. Augustine, Trinidad & Tobago
President, Bioethics Society of English-Speaking Caribbean
Email: Hariharan.Seetharaman@sta.uwi.edu
Tel: 1-868-662-2002 Ext: 82003 (Office)

EDITOR'S NOTE

This special edition of the newsletter consists of four articles dealing with the COVID-19 pandemic.

- *The submission by Raymond Jagessar (University of Guyana) gives an overview of the disease and its impact on Humanity with reference to the various sectors in society and suggests some ethical guidelines to manage the impact.*

- *Tomlin Paul and co-authors (UWI, Mona) reflect on the challenge faced in teaching lab-based courses and clinical training for medical students and the ethical dilemma it presents.*

- *Nakita Francis(CREEi candidate) explores the ethical issues in the care of COVID-19 patients and the management of the pandemic in Grenada.*

- *Shakel Henson (St Vincent and the Grenadines) focuses on the ethics of the COVID-19 vaccine distribution.*

- *Also included is a letter of "reconnaisance" from the founding President, Dr. Derrick Aarons, which gives some insightful history of BSEC, which is helpful moving forward..*

Grace Sirju-Charran
Editor and Vice-President

MEMBERS' ARTICLES

Impact of COVID-19 on Social, Economic Health and Education Sectors and Ethical Issues - R. C. Jagessar

[1] Department of Chemistry, Faculty of Natural Sciences, University of Guyana, South America.

Abstract

Coronavirus disease 2019 (COVID-19), is a contagious disease induced by severe acute respiratory syndrome coronavirus 2 (SARS-COV-2). The first case was identified in Wuhan, China, in December 2019. It has since spread worldwide, and became a pandemic in March, 2020. Added to this, is the emergence of a mutant SARS-COVID-2-viral strain (B.1.1.7) in the UK in December, 2020. COVID-19, is spread between people during close contact via small droplets, produced by coughing, sneezing, talking and singing. Its also airborne, requiring particulate matter for transmission. A person can become symptomatic or remain asymptomatic. COVID-19 can be prevented by social distancing and the wearing of cloth face masks, surgical masks, respirators, or other face coverings to control droplet transmission. Even though a vaccine, manufactured by Pfizer and Moderna and approved by FDA, is now commercial. The entire world awaits widespread inoculation. COVID-19 has affected humanity in many facets: health, socially, economically and in education. In health, tremendous burden has been placed to save patients life as the number of mortality and morbidity cases increases across the globe. To date, 89,603,838 million cases have been reported with over 1,926,228 deaths with 49,708,126 recovered cases. The economy of every country has been affected, as there have been severe job cuts, lockdown, decrease in world trade, border shut down etc. Production and productivity have significantly fallen across the globe in every sector. In the education sector, many universities, primary and secondary schools around the globe have resorted to online teaching, as opposed to " Face to Face" teachings. While this, to a large extent, is effective at the University level, it's not so at primary and secondary schools. Covid-19 has dramatically changed the social fabric of societies around the globe. Social gathering is prohibited, as denounced by the World Health Organisation(WHO) and the United States Centre for Disease Control (CDC). Many restaurants and other business places, have been operating within the curfew periods. Church gathering have also been prohibited. At the moment, we must adhere to protocol enacted by WHO and CDC, whilst we await the confirmatory use of the vaccine.

Keywords: COVID-19, SARS-COV-2, health, social, economic, health sector

1. Introduction:

COVID-19 is an infectious new disease induced by severe acute respiratory syndrome coronavirus 2 (SARS-COV-2), a novel virus[1] and a mutant of SARS-COV-1. The outbreak was first identified in Wuhan, China, in December 2019, though there is speculation that the virus could have originated elsewhere[2-3]. The outbreak was declared a Public Health Emergency of International Concern on 30th January 2020 and a pandemic on 11th March by the World Health Organisation (WHO). As of 15th November 2020, more than 54.1 million cases have been confirmed, with more than 1.31 million deaths[4-5].

The virus is primarily spread between people during close contact via small droplets, produced by coughing, sneezing, talking and singing. The droplets usually fall to the ground or onto surfaces, rather than travelling through air over long distances. As of June 2020, research has shown that speech-generated droplets may remain airborne for tens of minutes, providing the opportunity for the virus to be further spread by particulate matter in the atmosphere [6,7]. People may become infected by touching a contaminated surface and then touching their face Airborne transmission can also occur indoors, in high risk locations, such as in restaurants, choirs, gyms, nightclubs, offices, and religious venues, often when they are crowded or less ventilated. It also occurs in hospitals, often when aerosol-generating medical procedures are performed on COVID-19 patients.[6-7].

Since, the ACE-2 receptors permeate several organs in the body, and the virus binds to ACE-2 receptors via its spike S proteins, it has resulted in several complications such as acute respiratory distress syndrome (ARDS), cytokine storm, multi-organ failure, septic-shock, pneumonia, and blood clots, with eventual death, unless the immune system can produce the requisite antibodies to kill the virus. Some of the common symptoms experienced are: fever, chills headache cough, fatigue, shortness of breath and loss of sense of smell and taste, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, muscle or body aches. In health, a person can become symptomatic or asymptomatic[8-10].

COVID-19 currently can be diagnosed on the basis of symptoms and confirmed using reverse transcription polymerase chain reaction (RT-PCR) testing of infected secretions. Chest CT scans may be helpful to diagnose COVID-19 in individuals with a high clinical suspicion of infection[11-14].

COVID-19 can be prevented by social distancing and the wearing of cloth face masks, surgical masks, respirators, or other face coverings to control droplet transmission. Indoor transmission may be decreased with well maintained heating and ventilation systems to maintain good air circulation and increase the use of outdoor air [6-7].

2. Effects on humanity:

COVID-19 has affected humanity in many sectors: health, social relations, the economy and education. This is compounded by greater transmissibility via the emergence in the UK of a new viral strain of SARS-COV-2, resulting from mutation. Even though, a vaccine has now been manufactured by Pfizer and Moderna and is being dispersed around the globe, we wait to see the effect of mass vaccination.

In the health sector of every country of the world, Covid-19, has resulted in dramatic high mortality and morbidity and presents an unprecedented challenge to public and private health sectors. Globally, as of January, 10th, there are 89,603,838 confirmed cases, 1,926,228 deaths and the number of recovered cases being 49,708, 126. The country most seriously affected are the United States, followed by Brazil. In the USA, the state of California seems to be the most highly affected. In Guyana, the number of confirmed cases is 6,510 with 167 deaths and 5,900 recovered cases. These figures are ascending daily. It has resulted in hospital being flooded with patients, increasing number of ICU beds, increasing number of mechanical ventilators, which are very costly, and has put tremendous strain, financially on the health sector [15-17].

COVID-19 has destroyed the social fabrics of societies around the globe. Socialization is prevented as WHO and CDC imposed a 6 feet social distancing to prevent transmission of the virus. The initial response to COVID-19 was a total lockdown. Non-essential services have been terminated in many countries of the Caribbean and the rest of the world. Hospitals, fuel production, electrical power, public sanitation and law enforcement are part of the essential services that haven't been suspended across the Caribbean and most countries of the globe. Many restaurants, bars etc. , supermarkets can only operate within the curfew periods. Restaurants and other dining places have been operating on a "take away" service. In many countries of the Globe and in the Caribbean, the 6pm to 6am social curfew has been imposed, whereas in some countries, its 10pm to 4 am. In addition, churches around the globe have been closed, with church services online. Covid-19 restrictions have also, resulted in civil unrest in the USA, with the loss of lives.

The education sector of every country has been affected to a very large extent. Many universities across the Caribbean and around the globe have resorted to online delivery, rather than the "face mode" delivery to see the realization of their curriculum. Most have been using the zoom/moodle platform. While this has worked well for courses with theoretical components, it presented a challenge for courses that have a practical component. Thus, students have had to pursue virtual laboratory sessions and thus not been able to have the actual " hands on" experience. It is the nursery, primary and secondary schools that are affected seriously, in comparison to the universities. Nursery schools are closed across the Caribbean, whereas students in primary schools are taught online to some extent. In Guyana, only forms four (4) and five (5) students are allowed to go to secondary school, so that they can complete the CXC curriculum, in preparation for exam in May/June/2021. Thus, COVID-19, will create an education vacuum in societies in years to come.

Economically, COVID-19, has affected the economy of all countries across the globe. Many jobs have been decimated in the developed world and developing countries. Millions of livelihoods are at risk. Countries, like the USA have seen the most job loss, followed by European countries. Companies and manufacturing industries have been operating on a "skeleton staff". Job loss/cuts are also seen in the Caribbean, but not to that extent seen in the developed countries. Production and productivity across the various sectors have declined significantly. Due to the closure of several companies operating across the globe, there has been a decrease in world trade. Border closures, trade restrictions and confinement measures have been preventing farmers from accessing markets, including for buying inputs and selling their produce, and agricultural workers from harvesting crops, thus disrupting domestic and international food supply chains and reducing access to healthy, safe and

diverse diets. Tens of millions of people are at risk of falling into extreme poverty, while the number of undernourished people, currently estimated at nearly 690 million, could increase by up to 132 million by the end of the year. Millions of enterprises around the globe face an existential threat. Nearly half of the world's 3.3 billion global workforce are at risk of losing their livelihoods. Informal economy workers are particularly vulnerable, since the majority lack social protection and access to quality health care and have lost access to productive assets. Without the means to earn an income during lockdowns, many are unable to feed themselves and their families. For most, no income means no food, or, at best, less food and less nutritious food. . As breadwinners lose jobs, fall ill and die, the food security and nutrition of millions of women and men are under threat, with those in low-income countries, particularly the most marginalized populations, which include small scale farmers and indigenous peoples, being hardest hit [15-16].

Internationally, millions of waged and self-employed agricultural workers, while feeding the world, regularly face high levels of working poverty, malnutrition and poor health, and suffer from a lack of safety and labour protection as well as other types of abuse. With low and irregular incomes and a lack of social support, many of them are forced to continue working, often in unsafe conditions, thus exposing themselves and their families to additional risks. Income losses, have also forced them to resort to negative coping strategies, such as distress sale of assets, predatory loans or child labour. Migrant agricultural workers are particularly vulnerable, because they face risks in their transport, working and living conditions and struggle to access support measures enacted by governments. Guaranteeing the safety and health, as well as better incomes and protection, of all agriculture food workers, from primary producers, to those involved in food processing, transport and retail, and including street food vendors, will be critical to saving lives and protecting public health, people's livelihoods and food security.

Countries in the Caribbean, depend heavily on tourism for their economic sustenance and growth. This has been severely hampered, since the onset of the pandemic in March, as governments across the Caribbean region and around the globe, restrict air travel and pursue intermittent closure of airports to prevent the spread of the virus.

Jamaica is urging its citizens to be concerned and to remain vigilant about COVID-19. The government is keeping close check on those who arrived by plane in mid-to-late March and will make sure they are quarantined. The country is trying to strike a balance between economic activity and managing the spread of COVID-19.

Mexico's federal government is suspending all nonessential government activities to try to prevent the spread of the virus. Hospitals, fuel production, electrical power, public sanitation and law enforcement are part of the essential services that won't be suspended. The country's public health crisis is seen not only in hospitals but also in homes.

Health officials in Brazil say coronavirus cases are now reported in all regions of the country. Brazil's president says the country will now utilize the armed forces 24 hours a day to fight the virus. It is pouring more resources into battling coronavirus including an expansion of tests, more laboratories to diagnose COVID-19, and increasing the number of ICU beds. 23 members of

Brazilian's presidential delegation that came to Florida two weeks ago later tested positive for coronavirus.

Cuba is enforcing strict measures in an attempt to stop the virus from spreading. The government is banning citizens from leaving the country, schools are closed, tourism is shut down, and local transportation services are no longer running. Large gatherings are banned, and only Cubans abroad and foreign workers living in Cuba can reenter the country.

Haiti continues to deal with food shortages amid the coronavirus outbreak. The country remains under a state of emergency, shuttering schools, churches, and factories. The country's borders are closed, and a curfew is imposed to prevent the spread of virus. Haiti is one of the 51 countries the United Nations will help through a USD2 billion global humanitarian fund.

3. Ethical framework:

Despite this COVID-19 pandemic, certain ethical guidelines must be followed. There has always been an ethical tension in medicine between a doctor's concern for the health and welfare of the individual patient and concern for the health of populations. In dangerous pandemics the ethical balance of all doctors and health care workers must shift towards the utilitarian objective of equitable concern for all, while maintaining respect for all as 'ends in themselves'. WHO, CDC and other international bodies must issue an ethical framework, designed to help people think through strategic aspects of decision-making during a pandemic, as well as providing ethical directions for clinicians[17-20]. Several guiding principles as outlined below must be followed:

1. Equal respect: everyone matters and everyone matters equally, but this does not mean that everyone will be treated the same
2. Respect: keep people as informed as possible; give people the chance to express their views on matters that affect them; respect people's personal choices about care and treatment.
3. Minimise the harm of the pandemic: reduce spread, minimise disruption, learn what works.
4. Fairness: everyone matters equally. People with an equal chance of benefiting from a resource should have an equal chance of receiving it, although it is not unfair to ask people to wait if they could get the same benefit later.
5. Working together: we need to support each other, take responsibility for our own behaviour and share information appropriately.
6. Reciprocity: those who take on increased burdens should be supported in doing so, Keeping things in proportion: information communicated must be proportionate to the risks; restrictions on rights must be proportionate to the goals.
7. Flexibility: plans must be adaptable to changing circumstances
8. Open and transparent decision-making: good decisions will be as inclusive, transparent and reasonable as possible. They should be rational, evidence-based, the result of a reasonable process and practical in the circumstances.
9. All decisions concerning resource allocation must be reasonable in the circumstances; based on the best available clinical data and opinion; based on coherent ethical principles and reasoning; agreed on in advance where practicable, while recognising that decisions may need to be rapidly revised in changing circumstances; consistent between different

professionals, as far as possible; communicated openly and transparently and subject to modification and review as the situation develops.

10. If medical services are overwhelmed during this pandemic, health providers will put in place or expand systems of triage. Triage is a form of rationing or allocation of scarce resources under critical or emergency circumstances, where decisions about who should receive treatment must be made immediately, because more individuals have life-threatening conditions than can be treated at once.

Health professionals would find decision-making, during this pandemic, ethically challenging. Such extreme situations bring about a transformation of doctors' everyday moral intuitions. The obligation to persevere in the face of an extremely ill patient would be challenged by quantitative decisions based on maximising the overall reduction of mortality and morbidity, and the need to maintain vital social functions.

Doctors would be obliged to implement decision-making policies which mean some patients may be denied intensive forms of treatment that they would have received outside a pandemic. Health professionals may be obliged to withdraw treatment from some patients to enable treatment of other patients with a higher survival probability. This may involve withdrawing treatment from an individual who is stable or even slowly improving but whose objective assessment indicates a significantly worse prognosis than that of another patient who requires the same resource.

If there is radically reduced capacity to meet all serious health needs, it is both lawful and ethical for a doctor, following appropriate prioritisation policies, to refuse someone potentially life-saving treatment where someone else is expected to benefit more from the available treatment

4. CONCLUSION:

COVID-19 has affected humanity in many sectors: health, social relations, the economy and education, in a devastating way. In health, tremendous burden has been placed to save patients life as the number of mortality and morbidity cases increases across the globe. Added to this, is the increasing economic burdens imposed on the health sectors. More finance has to be allocated to fund hospital settings. The economy of every country has been affected, as there has been severe job cuts, lockdown, decrease in world trade, border shut down etc. Production and productivity have significantly fallen, globally. In the education sector, many universities, primary and secondary schools around the globe, have resorted to online teaching, as opposed to " Face to Face" teachings. While this, to a large extent, is effective at the University level, it's not so at primary and secondary schools. An education vacuum have been created world wide. Covid-19 has also destroyed the social fabrics of societies around the globe. At the moment, the entire world populace must follow the COVID-19 protocols denounced by WHO and CDC, whilst we await the confirmatory use of the FDA approved vaccine to eradicate this planet threatening disease. Amidst, this pandemic, we need to operate within the ethical framework.

5. REFERENCES:

1. Naming the coronavirus disease (COVID-19) and the virus that causes it". World Health Organization (WHO").
2. Novel Coronavirus, China". World Health Organization (WHO). Retrieved 9 April 2020;
3. Huang C, Wang Y, Li X, Ren L, Zhao J, Hu Y, *et al*. (2020). "Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China". Lancet. 395.
4. "Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV)". World Health Organization (WHO). 30 January 2020. Archived from the original on 31 January 2020. Retrieved 30 January 2020;
5. "WHO Director-General's opening remarks at the media briefing on COVID-19—11 March 2020". World Health Organization. 11 March 2020. Retrieved 11 March 2020.
6. "How COVID-19 Spreads". U.S. Centers for Disease Control and Prevention (CDC). 2020. Archived from the original on 3 April 2020. Retrieved 3 April 2020;
7. Bourouiba L (2020). "Turbulent Gas Clouds and Respiratory Pathogen Emissions: Potential Implications for Reducing Transmission of COVID-19". JAMA. "Q & A on COVID-19". European Centre for Disease Prevention and Control. Retrieved 30 April 2020.

8."Symptoms of Coronavirus". U.S. Centers for Disease Control and Prevention (CDC). 13 May 2020. Archived from the original on 17 June 2020. Retrieved 18 June 2020.

9. Grant MC, Geoghegan L, Arbyn M, Mohammed Z, McGuinness L, Clarke EL, Wade RG (23 June 2020). "The prevalence of symptoms in 24,410 adults infected by the novel coronavirus (SARS-CoV-2; COVID-19): A systematic review and meta-analysis of 148 studies from 9 countries".

10. "Clinical characteristics of COVID-19". European Centre for Disease Prevention and Control. Retrieved 29 December 2020.

11. "Symptoms of Coronavirus". U.S. Centers for Disease Control and Prevention(CDC). 13 May 2020. Archived from the original on 17 June 2020. Retrieved 18 June 2020.

12. Grant MC, Geoghegan L, Arbyn M, Mohammed Z, McGuinness L, Clarke EL, Wade RG (23 June 2020). "The prevalence of symptoms in 24,410 adults infected by the novel coronavirus (SARS-CoV-2; COVID-19): A systematic review and meta-analysis of 148 studies from 9 countries". PLOS ONE. 15 (6):

13. "Clinical characteristics of COVID-19". European Centre for Disease Prevention and Control. Retrieved 29 December 2020.

14. Bénézit, François; Le Turnier, Paul; Declerck, Charles; Paillé, Cécile; Revest, Matthieu; Dubée, Vincent; Tattevin, Pierre (2020). "Utility of hyposmia and hypogeusia for the diagnosis of COVID-19". The Lancet Infectious Diseases. 20(9): 1014–1015.

15. https://www.medicalnewstoday.com/articles/covid-19-global-impact-how-the-coronavirus-is-affecting-the-world. Retrieved January, 11th, 2021.

16. The human impact of COVID-19 – and how business can help | World Economic Forum (weforum.org); Retrieved January, 11th, 2021.

17. COVID-19: Here's how one pandemic will change our lives, forever | ZDNet; Retrieved January, 11th, 2021.

18. Wilkinson, D., and J Savulescu. 2012. A costly separation between withdrawing and withholding treatment in intensive care. Bioethics 26 (1):32-48.

19. Vink, E. E., E. Azoulay, A. Caplan, E. J. O. Kompanje, and J. Bakker. 2018. Time-limited trial of intensive care treatment: an overview of current literature. Intensive Care Medicine 44 (9):1369-1377.

20. Wilkinson, DJC, E Butcherine, and J Savulescu. 2019. Withdrawal aversion and the equivalence test. American Journal of Bioethics 19 (3):21-28.

Protecting health care professional students during a pandemic: A brief ethical reflection – Tomlin Paul et al.

Tomlin Paul (Dean of the Faculty of Medical Sciences, Mona Campus, The University of the West Indies, Jamaica), Marjan de Bruin (Chair of the Equity, Diversity and Inclusion Technical Working Group, Mona Campus, The University of the West Indies, Jamaica) and Anna Kasafi Perkins (Senior Programme Officer, Board for Undergraduate Studies, The University of the West Indies, Regional Headquarters, Jamaica).

Introduction

When the COVID-19 pandemic struck the Caribbean in March 2020, educational institutions in the region went into reactive mode, either initially closing their doors or significantly reducing face-to-face education and training. After a few months, many, having assessed their operations, retooled to allow online teaching or emergency remote learning (ERL). The necessity of such a workable strategy to allow for continuity of education and training is well understood, as the sustainability of the region's economies, health care services as well as individual, family and community livelihoods are tied to the education sector (Perkins and Landis 2020).

Some disciplines were able to pivot more smoothly into ERL. However, the clinical and other lab-based disciplines faced particular challenges, which require ethical consideration. Students have less opportunities to obtain clinical skill as many surgical procedures and routine appointments are either cancelled or delayed. In discussions on the ethics of care in the context of a pandemic, issues such as managing very ill patients with limited resources in intensive care have been given, perhaps unsurprisingly, a lot of attention in the literature (Robert et al., 2020). However clinical training for

medical, nursing and other health professional students which presents unique challenges, with ethical implications such as how to protect students from harm, patient safety in the face of asymptomatic students and informed consent for levels of risk mitigation, have received much less attention. These ethical issues may well be exacerbated in the Caribbean where education for health professionals is significantly under-resourced even as efforts are made to deepen the use of technology. What is clear is that the disruptions caused by the pandemic may well have changed the face of health professions' education for the future.

This contribution describes, from a personal and anecdotal perspective, the context and ethical challenges inherent in managing such training in the Caribbean during the pandemic. It also seeks a pathway for resolving the ethical issues.

The clinical training framework pre-Covid-19

For centuries, training of physicians, nurses and other health professionals has benefitted from an apprenticeship model with the student being given full exposure to the clinical environment, (oftentimes the hospital), and working as a member of an inter-professional health team, carrying out duties and engaging in analysis and discussions of cases. While constrained somewhat by the curriculum, clinical training has very permeable boundaries and allows for an exploration of the space and learning environments fuelled by exuberance and scientific curiosity. While preceptor supervision is important and offers a structure for receiving students (Ekstedt et al., 2019), peer learning and exploration no doubt contribute to confidence-building and independence which are important in future practice. Nonetheless, the formation of the students' professional identity relies significantly on the instruction and modelling that take place in clinical settings; students learn to value patients as human beings and develop a passion for care and health that appears to require self-sacrifice and altruism. Pre-COVID-19, there was an implied freedom in clinical training which would have made it appear that trainers and students were oblivious of or willing to entertain risks, for the greater good. It goes without saying, however, that a clinical environment where the mission is the treatment of illness comes with a lot of potential risks with a range of severity to both clinicians and clinicians-in-training.

Training during the COVID-19 pandemic

The Caribbean is highly susceptible to natural and man-made hazards, including hurricanes, fires and earthquake, which give rise to disasters resulting in major human and environmental loss. During such disasters, students of the health professions have generally continued their education and helped in caring for those affected. Indeed, during the COVID-19 pandemic, Jamaican medical students have served in call centres as part of the government's national emergency response. However, given the highly contagious nature of SARS-CoV-2, should students be allowed into the clinical setting since they may transmit the virus without knowing or contract the disease themselves? What level of risk should be contemplated and consented to? Other factors to consider in limiting the role of students in the clinical environment include availability of COVID-19 testing, lack of adequate personal protective equipment (PPE) as well as the inability to properly maintain sanitizing and physical distancing protocols.

If, in an initial thinking about clinical training, one applies the basic containment strategies used by the public, we will expect at the very least that students wear a mask, sanitize and ensure safe distance

from other practitioners and patients. This is a tall order in many clinical settings where the nature of patient care and space limitations push the practitioner or the student to work in an environment with a higher than usual risk. Additionally, the hospital or clinic given the concentration of ill persons will in theory be a higher risk zone for COVID-19 than the public square. What of students and practitioners with underlying conditions? Should their obligation to secure the health of others put their own health at risk, knowingly? Unsurprisingly, several studies have shown that frontline workers are facing a much higher risk of reporting a positive COVID-19 test. These findings do suggest that health-care systems have an ethical obligation to ensure adequacy of PPE and appropriate strategies to protect health care workers and students from COVID-19. Protecting them also protects the patient.

Of course, this perspective only takes the immediate physical protection of persons into account. But healthcare workers, as other studies have shown, also seem to be more psychologically vulnerable compared to the general public. They showed more post-traumatic stress, were less happy in general, and reported "more anger, annoyance, fear, frustration, guilt, helplessness, isolation, loneliness, nervousness, sadness, worry"– hidden emotions which cannot be prevented by the best PPE.

It would be expected that, similarly, for medical students, the enforced transition from the clinical and/or medical school setting to home leads to isolation and struggles with establishing and maintaining boundaries between study and home. Working in the stressful COVID-19 clinical setting would also subject them to the physical and psycho-social vulnerabilities of other healthcare workers, but with little or no attention to their plight.

Summary reflections

In closing, these observations highlight some ethical concerns in training health professionals during a pandemic, which must not be ignored. Should students be exposed to this setting? Do they need to experience the "real world" in their years of training? Or is this going too far? Can they consent to the risk involved? What legal obligations should be considered in training during a pandemic?

The questions are myriad, but at least four core questions are important to dissect the ethical "marrow" of these experiences:

1. To what extent is risk an expected ingredient in medical training?
2. What are the ethical underpinnings of a framework to guide the clinical training of medical and other health professionals in a pandemic?
3. Are we, as educators, under greater obligation to protect a medical or nursing student more than a qualified health worker?
4. Are we obligated to train students in an environment with risk, similar to the one in which they will work after graduation?

Ethical issues in the training of health professionals are not new but the COVID-19 pandemic has brought with it an opportunity for re-engagement along these lines. As we become involved with management of the pandemic, we should recognize the need for a strengthening of structures within our educational frameworks which would enable consideration of these ethical issues by all stakeholders.

References

Ekstedt, M., Lindblad, M. & Löfmark, A. (2019). Nursing students' perception of the clinical learning environment and supervision in relation to two different supervision models – a comparative cross-sectional study. *BMC Nurs* 18, 49. https://doi.org/10.1186/s12912-019-0375-6

Nguyen, Long H Albert, Christine M. et al. (2020). Risk of COVID-19 among front-line health-care workers and the general community: a prospective cohort study. *The Lancet Public Health*, Volume 5, Issue 9, e475 - e483

Perkins, Anna Kasafi and R. Clive Landis. (2020). *Ethics Amidst COVID-19: A Brief Ethics Handbook for Caribbean Policymakers and Leaders.* Smashwords Edition

Robert, R., Kentish-Barnes, N., Boyer, A. et al. (2020) Ethical dilemmas due to the Covid-19 pandemic. *Ann. Intensive Care* 10, 84. https://doi.org/10.1186/s13613-020-00702-7

Ethical Issues in the Care of Covid-19 Infected Patient

Nakita Francis
CREEi candidate, Grenada

Introduction

Grenada is seen as a developing country where matters of health are often taken for granted, thus, a medical revival with appropriate intervention is necessary. With little or no arms, the undervalued medical fraternity is called upon to create and make magic as well as to perform more miracles than Jesus! Deeply rooted in a rich ancestral culture, the population has become very adaptive to traditional medicines over western medicine. The cry to replenish hospitals and pharmacies with medical supplies never ceases. Grenadians have long been crying wolf, wolf, and it showed its face in the form of COVID-19 Virus Pandemic. Nonetheless, the efforts have not been without immense challenges and national discomfort as the SARS-CoV-2 pandemic gained momentum within my little island. This essay, therefore, pinpoints the **ethical issues in the care of covid-19 patients in Grenada. Particular emphasis is placed on confidentiality, decision-making analysis, and resource scarcity.**

Confidentiality

CIOMS guidelines 4,11,12 and 22 speak to the need for maintaining respect for a person's personal information as well as the limits and consequences of breaches of confidentiality. Grenada is a developing country with a small population that is closely connected where word always seems to get around. An individual's personal data is shared without their consent not only by lower level staff but

also by the top-level staff. This flaw in the health systems has caused individuals to refrain from calling the COVID hotline to report any symptoms. There was a case in Grenada whereby an individual who was tested positive breached the quarantine protocols and his picture, as well as personal information relating to his family, was circulating on social media island-wide. It is clear these **situations blatantly disregard the need to respect one's privacy and thus disseminate information without obtaining consent.** The lack of confidentiality that exists within the country also has an adverse effect on the true count of the COVID 19 community cases because the number of persons who actually contracted the virus is not reported.

Decision-making analysis

The unexpected outbreak of COVID 19 has placed clinicians, healthcare workers, lawyers, and governments under immense pressure requiring them to find novel ways to deal with conditions beyond their ordinary daily operations. Applying the principle of nonmaleficence, the clinicians are mindful that they should not cause harm to the patients in their care. Therefore, decisions relating to the category of patients who should be given priority is critical. In this case, the health care worker in his/her quest to save as many lives as possible ensures that the decisions made are fair and just. In a press briefing, the Minister of Health of Grenada advised that the persons who are severely sick will be given first preference. This statement warrants an ethical intervention to determine if this decision is ethically sound. It will require assessing the timeframe within the detection of positive cases and also determining what symptoms that should be present to categorize the patient as severely ill. In conforming with the principle of beneficence, the risk involved in saving that severely ill patient should not result in severe harm to the entire population. With that being said the patient who has a higher risk of spreading the virus to other members of the community should be given preference instead of the severely ill who may not be the most likely to have multiple interactions. This utilitarian rule would result in a lower spread of the virus and act in the best interest of the patient and by extension the state.

Decision-making analysis also looks at whether or not a patient should be treated in a healthcare facility or at home. Hence a positive patient is treated at a state quarantine facility if their symptoms are mild however severe symptoms would require one to be hospitalized in the ICU unit at the General Hospital.

Resource scarcity

Not enough space and ventilators in the hospitals

Amidst the panic and uncertainty that surfaced with the pandemic, the infrastructure in Grenada gained additional spotlight as fear triggered a clamor for adequate space to cater for COVID-19 patients. There is a tradition of persons having to spend long hours outside/inside clinics to be treated for minor cuts or sickness. Some even return home without being able to see a doctor or nurse. Unfortunately, the onset of the pandemic triggered even more lack of trust and fear in the health care system as a level

of indecisiveness ensued concerning the availability of space to check, house, or quarantine patients or suspected patients. The hospital has even been the place of choice with particular allocation of space for quarantine. However, it was not too long before the public clamour for change of this policy of accommodating both COVID -infected and non-infected patients in the same building, fueled by fear for their lives and that of others already housed in the General hospital. The medical team found itself in a quagmire struggling to find the ideal place to be named the designated quarantine point.

Moreover, the struggles did not end there as the lack of oxygen has been plaguing the hospital for a number of years. This flaw has been attributed to many deaths causing public outcry on television and radio stations and with the onset of the pandemic, the cries grew louder. Who would be given access from the scarce supply? Would it be the rich or would special preferences be given to the persons who can pay? What would happen to the poor? Would they be left to die? The questions remained numerous and unanswered. Those that were answered were quite vague and elusive fueling national doubt in the health system. Further, the reliability and goodwill of the COVID-19 team received a daily dose of bashing. Nationals were afraid of getting sick. They were afraid of any possibility of going to the hospital. Many were in fear of not being able to breathe again once the virus is contracted.

Limited PCR testing

In order to combat the pandemic, it became compulsory that a recognized scientific approach be followed in order to confirm whether or not someone has or does not have the virus. This process was quickly engaged in the developed countries. Many conducted rapid tests and PCR tests for the immediate/urgent acquisition of information to guide the decision-making process. Additionally, the information served to channel the placement of victims/patients. The more developed Caribbean countries like Jamaica and Trinidad were able to effectively adopt the testing process even with closed borders. Grenada, on the other hand was challenged in this area as it depended on neighboring islands for assistance. PCR tests had to be sent to Trinidad while the nation waited anxiously for results. Moreover, the uncertainty of results amidst the declaration of false negatives and false positives have dug holes in the scientific and ethical practices of honest, valid, and reliable reporting of cases. One must not ignore here, the silence of medical practitioners and the COVID-19 team to curb panic or to mitigate the impact on the Grenadian economy. It was felt that certain persons or cases were tested while others were asked to self-quarantine without being tested upon entry into the country. It may be safe to say that the spread may have been averted or avoided due to the innate human nature of fear in Grenada's population resulting from traumatic events experienced such as the Grenadian revolution in 1979 and hurricanes : Janet in 1955 and Ivan in 2004. Additionally, one can say that the laws/rules which sought to limit movement within a stipulated time, fueled and managed the actions of the people.

Not enough lab technicians and healthcare workers

The shortage of Healthcare workers in Grenada resulted in the exploitation of the existing regular workers. The decision-makers ignored the rights of the healthcare workers and thus they were faced with significant pressures. It was necessary that they report for duty on call as well as work for an extensive period of time. The PAHO report (2020) stated Grenada Healthcare workers were discriminated against when traveling on public transportation and as such the government had to make

the decision to get private transportation to carry them around. **This however, was a short-lived service provided for the healthcare team, particularly nurses who had to eventually plead their cause on social media for assistance out of abandonment.**

The lack of human resources in the medical field has proven even more scary/critical? than before. The threat in the health sector has shown its face amidst the unforeseen pandemic leaving nationals to only hope for better. Unfortunately, the tendency here in Grenada of having one person skilled in a particular area has again emerged as risky business. The sad thing is that even when the cries are loud in the health sector the silence and inactivity or rather the lack of acknowledgement thereof poses a national threat to the nation. This painful reality engulfed Grenada as the impatience amongst the people and anxiety to know the truth gained rapid momentum. The reality that all and sundry had to accept that there was the lack of skilled personnel to assist in the efficient and effective testing of patients. **WINDREF** team at St. George's university was overwhelmed as they worked ceaselessly to meet the needs of the COVID-19 medical team and to aid reporting to the PAHO in a timely manner. The reality? There were just not enough lab technicians to meet the demands of testing. This proved even more draining during the contact tracing process. Furthermore, returning nationals and visitors were left in limbo wondering what their status or fate would be. Here it is worth noting that results from PCR tests were expected to be returned within 48 hours and that process was frequently flawed. Patience, fatigue and burnt-out challenged the scientific and ethical approaches!

Nationals prefer to use traditional medicine instead of visiting the doctor.

Supply and demand certainly affect diminishing returns and in relation to the medical field doctors too, are now a scarce commodity. However, beyond the aforementioned, people have started to take matters into their own hands. Most importantly, their healthcare and medical diagnosis is usually done at home with the assistance of family members or friends. Bearing in mind the deplorable state of the general hospital and health centres worsened by the lack of medication, even after a medical practitioner's diagnosis, Grenadians have resorted to a traditional approach to healing themselves. The lack of trust in the medical field has driven many persons to seek assistance from herbalists through face to face and online consultations. Fear of the virus and eventually fear of death have triggered immediate and most convenient acts of humanity as they depended on the herbs for protection. What is important to note however, is the silence that challenged the honest reporting and documentation of persons affected or infected. No true representation of cases could be counted since doctor visits were limited or restricted. In reality, could one honestly account for the number of persons who came into contact with infected persons? Could one really tell the exact number of persons who were likely to have been impacted by the COVID-19 virus in Grenada? The shortage of doctors and overwhelmed nurses surely have a story to tell!

Conclusion

The lack of direction plagued the Grenadian populace during the pandemic! The frequent changing of instructions, the lack thereof, the inconsistencies in instructions and reporting did not work well on

the part of the patients nor the government. Even with scarce resources discrimination found a hiding place and pop up in affluent areas. Grenada's lack of readiness and preparedness to treat serious and urgent medical issues, severely bruised the ethical path regarding scientific principles. The scarcity of healthcare workers and their lack of security even to execute their duty further challenged the positive efforts to curb infections and the spread thereof.

Bibliography

Addressing Human Rights as Key to the COVID-19 Response. (n.d.). Retrieved November 23, 2020, from https://www.who.int/publications-detail-redirect/addressing-human-rights-as-key-to-the-covid-19-response

Emanuel, E. J., Phillips, J., & Persad, G. (2020, March 12). Opinion | How the Coronavirus May Force Doctors to Decide Who Can Live and Who Dies. The New York Times. https://www.nytimes.com/2020/03/12/opinion/coronavirus-hospital-shortage.html

Ethics and COVID-19. (n.d.). Retrieved November 23, 2020, from https://www.who.int/teams/health-ethics-governance/diseases/covid-19

How Hospitals Can Manage Supply Shortages as Demand Surges. (2020, April 3). *Harvard Business Review*. https://hbr.org/2020/04/how-hospitals-can-manage-supply-shortages-as-demand-surges

Human resources for health and the covid-19. (2020, August 18) ... - PAHO/WHO. Retrieved November 23, 2020, from https://www.paho.org/en/file/71596/download?token=zUEJ6Org

International Ethics Guidelines for Health-related Research Involving Humans (2016) Geneva: CIOMS in Collaboration with WHO ISBN 978-929036088-9

Jamrozik, E., & Selgelid, M. J. (2020). COVID-19 human challenge studies: ethical issues. *The Lancet Infectious Diseases*, *20*(8), e198–e203. https://doi.org/10.1016/S1473-3099(20)30438-2

Man breaks leg after jumping out of quarantine facility in Grenada. (2020, October 12). http://jamaica-gleaner.com/article/caribbean/20201012/man-breaks-leg-after-jumping-out-quarantine-facility-grenada

(n.d.). Human Resources for Health: Overcoming the Crisis - World .... Retrieved December 13, 2020, from http://www.who.int/hrh/documents/JLi_hrh_report.pdf

Perkins, K. A., & Landis, R. C. (2020). *Ethics Amidst COVID-19: A Brief Ethics Handbook for Caribbean Policymakers and Leaders* (Smashwords Edition). Anna Kasafi Perkins and R. Clive Landis at Smashwords.

Thirty Grenadians quarantined due to COVID-19 violator. (n.d.). Retrieved December 13, 2020, from http://www.loopnewscaribbean.com/content/30-grenadians-quarantined-due-covid-19-violator
(2017, August 30). The Economics of Healthcare. Retrieved December 13, 2020, from https://scholar.harvard.edu/files/mankiw/files/economics_of_healthcare.pdf

The Ethics of the COVID-19 Vaccine Distribution – Implications for St. Vincent and the Grenadines

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

Introduction

Having first been identified in Wuhan, China in 2019, one year later, the Coronavirus Disease (COVID-19) has resulted in 71, 581, 532 confirmed cases and 1, 618, 374 confirmed deaths in 220 countries, areas or territories globally as of the 15th December, 2020 (WHO, 2020a). In response to the significantly high morbidity and mortality rates, there has been rapid progress in its management. A COVID-19 vaccine is now available and distribution has already begun among the high-income countries (BBC, 2020). For a low- and middle-income country (LMIC), like St. Vincent and the Grenadines (SVG), there are concerns regarding the accessibility, availability and affordability of such a vaccine to a resource poor country. It is possible that there will be inequalities in the distribution of this COVID-19 vaccine, such that the ethical principle of justice is defied (WHO, 2020b).

Situation in St. Vincent and the Grenadines

St. Vincent and the Grenadines (SVG), an upper middle-income English-speaking Caribbean country, has fortunately recorded only 98 confirmed COVID-19 cases and 0 deaths up to the 15th December, 2020 (Worldometer, 2020). The Ministry of Health, Wellness and the Environment (MOHWE) of SVG has been working vigorously to protect the Vincentian public and to best educate them on the ways in which the spread of the novel coronavirus, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), can be minimised (MOHWE, 2020). Despite the success achieved in controlling COVID-19 in SVG, receiving the COVID-19 vaccine will likely be beneficial to the citizens of this country, especially those who are most vulnerable.

It may be argued that concerns regarding the safety and efficacy of this vaccine are likely to surface. If the aforementioned happens, these concerns will be valid as every citizen deserves to have their voices heard and their autonomy respected. Despite this, however, there may be justifications for mandatory vaccination as the common good ought to take precedence over individual autonomy in this grave public health issue.

Given the nature of COVID-19, mandatory vaccination may be required to achieve herd immunity and to prevent harm to others (Savulescu, 2020). Some individuals, like those who are immunocompromised, will be unable to receive the COVID-19 vaccine. Mandatory vaccination of the rest of the population will thus be protective of the public's health. Undoubtedly, such protection is essential at this time of great threat to public health by a deadly infectious disease, COVID-19. The COVID-19 vaccine must, however, be safe and effective (Savulescu, 2020). If it is not, this will be detrimental to the health of citizens who will likely lose trust in a system that is expected to safeguard them. It is therefore the duty of the decision-makers to protect the public and minimise the harmful effects of COVID-19. Part of this obligation to safeguard the public ought to involve weighing of the risks and benefits that are associated with this COVID-19 vaccine, which was developed expeditiously for a disease that the world had no prior knowledge of.

The MOHWE must do their research on the COVID-19 vaccine; continue their educational campaign; and ensure that citizens are fully informed of the risks and benefits of taking this vaccine. Each citizen has a right to life and health (UN, 1948) so the threat posed to public health by COVID-19 warrants an intervention that will optimally protect life and health. It is therefore the responsibility of the Vincentian decision-makers, policy makers and public health officials to ensure that the citizens of SVG are adequately educated on the effects of COVID-19 on one's health as well as the safety and efficacy of the COVID-19 vaccine. This will help competent individuals to make truly informed decisions about taking the vaccine. They will also be better able to assume behaviours that will not only benefit them but also their neighbours, fellow Vincentians. With a positive attitude, appropriate behaviours and better understanding of the implications of their actions on the public's health, mandatory vaccination may not be required (WHO, 2020c). Vincentians may willingly volunteer to receive the COVID-19 vaccine, once it is safe, out of pure altruism. This will contribute to the common good. A potential issue, however, would be a low response rate. If an inadequate number of individuals receive the COVID-19 vaccine, this would not be sufficient to achieve herd immunity and protect the public's health.

Although there may be a delay in SVG and other LMICs receiving this COVID-19 vaccine for distribution among their citizens, that time period prior to the vaccine's arrival can be used to each country's advantage. It should be a period of verification, education and reassurance. Additionally, it ought to be a time for the decision-makers to consider factors like affordability of the COVID-19 vaccine, mandatory versus voluntary vaccination, herd immunity, allocation of the COVID-19 vaccine, vulnerability of citizens and adherence to the ethical principle of non-maleficence such that both individual rights and the common good are safeguarded (WHO, 2020c). Effective resolution of this multifaceted challenge will benefit from the inputs of a multidisciplinary team, which should include an ethicist.

Conclusion

Fears and anxiety levels are expected to heighten during this period of global distribution of the recently available COVID-19 vaccine. Promoting rational thinking and behaviour among the public at this time would be necessary to ensure public safety and protection as the world continues to battle this newly emerging and deadly infectious disease, COVID-19. Issues related to justice and fairness in the distribution and allocation of the COVID-19 vaccine are likely to affect LMICs, such as SVG.

Amidst these injustices, however, over which there will possibly be little control, it will be worthwhile for LMICs to support the ethical principles of justice, beneficence, non-maleficence and respect for autonomy. Ultimately, the decision-makers have a responsibility to act in a manner that will be in the best interest of citizens and therefore endorses the common good.

References:

BBC (2020) *Covid-19: First vaccine given in US as roll-out begins* [Online]. 14th December. Available from: https://www.bbc.com/news/world-us-canada-55305720.

MOHWE - MINISTRY OF HEALTH, WELLNESS AND THE ENVIRONMENT (2020) *Covid-19 information* [Online]. Kingstown, Ministry of Health, Government of St. Vincent and the Grenadines. Available from: http://health.gov.vc/health/index.php/covid-19-information.

SAVULESCU, J. (2020) Good reasons to vaccinate: mandatory or payment for risk? Journal of Medical Ethics. [Online]. Available from: https://jme.bmj.com/content/early/2020/11/09/medethics-2020-106821.

UNITED NATIONS (1948) *Universal Declaration of Human Rights* [Online]. United Nations. Available from: https://www.un.org/en/universal-declaration-human-rights/.

WHO - WORLD HEALTH ORGANIZATION (2020a) *Coronavirus Disease (COVID-19) Pandemic* [Online]. Geneva, World Health Organization. Available from: https://www.who.int/emergencies/diseases/novel-coronavirus-2019?gclid=Cj0KCQiA2uH-BRCCARIsAEeef3lVuolKoKfnUit7MIyfoTyZRXsu9Nr9oQzViVFzOI9R7F2x8XastfYaAkT6EALw_wcB.

WHO - WORLD HEALTH ORGANIZATION (2020b) *Coronavirus Disease (COVID-19): Vaccine access and allocation* [Online]. Geneva, World Health Organization. Available from: https://www.who.int/news-room/q-a-detail/coronavirus-disease-(covid-19)-vaccine-access-and-allocation.

WHO - WORLD HEALTH ORGANIZATION (2020c) *The Public Health Emergency caused by the COVID-19 Pandemic – Relevant Ethical Issues* [Online]. Geneva, World Health Organization. Available from: https://www.who.int/ethics/topics/outbreaks-emergencies/Statement-CNECV-Covid19_Key-Considerations.pdf?ua=1.

WORLDOMETER (2020) *Saint Vincent and the Grenadines* [Online]. 15th December. Available from: https://www.worldometers.info/coronavirus/country/saint-vincent-and-the-grenadines/.

LETTER TO MEMBERS

Derrick Aarons – Founding President
MB.BS.(UWI), M.Sc.(Bioethics), Ph.D.(McGill)

Dear BSEC members,

As we are about to go into the 2020 Elections for a new Executive to guide our Society over the next 2 years, since I had the great honour of being the founding President of our bioethics fraternity, I thought it would be timely to share what our 'founding fathers' had hoped for, the challenges we foresaw, and the aspirations to be realized.

It seems like eons ago, in 2005, that a 'steering committee' was established and which held meetings over an 8-month period to spearhead the formation of the Bioethics Society of the English-speaking Caribbean, (BSEC). That committee, chaired by Prof. Ralph Robinson of the Dept. of Life Sciences, UWI, Mona, Jamaica, had multi-disciplinary representation, with persons like BSEC past President Prof. Cheryl Macpherson, currently Professor of Bioethics at St. George's University in Grenada; inaugural BSEC Treasurer, Prof. Donald Simeon, current Director of Research and Graduate Studies at the UWI, St. Augustine, Trinidad & Tobago; Dr. Eileen Boxill, QC, former Director of Legal Reform at the Ministry of Justice in Jamaica, who led the formulation of our Constitution; Dr. Grace Charran, current BSEC Vice-President, retired Lecturer of the Dept. of Life Sciences, UWI, Trinidad & Tobago, and current Vice-Chair of the UNESCO World Commission on the Ethics of Scientific Knowledge and Technology (COMEST); and Dr. Tony Frankson, retired Lecturer at the UWI, Bahamas School of Clinical Medicine & Research.

With the official launch of BSEC in May 2006, it was our hope that not only would we grow continually with members from all across the Caribbean who had an interest in the 'aims and objectives' of bioethics, but would also perform an advocacy role for the development of ethical policies in health care and research across our countries of the Caribbean. We also dreamed that one day we would facilitate training in bioethics, initially as a post-graduate certificate, and eventually as a Masters in Bioethics!

It is with much pleasure that our 'founding fathers' can say that all the above have been achieved, and more!!

However, some of the challenges we foresaw still remain with us. We were challenged to keep members interested in the 'cause' of bioethics, and so sought to host a Bioethics Forum every year, commencing in 2007. The plan was to host it in a different Caribbean country each year, with particular themes in bioethics specifically chosen by the host country that were relevant to them. With

this we have had varying success, with the latest Forum being held virtually in October 2020 due to the COVID-19 pandemic.

Another challenge was how to involve BSEC members in our annual Forum when it was not being hosted in their particular country. To address that, we developed a BSEC Newsletter that would publish, among other matters, all the presentations that were made at our Bioethics Forums each year.

Another was that of regular communication with members, particularly about what plans our Executive was making, and bioethics opportunities and 'happenings' around the world. So we initially developed a bi-monthly email circular "From the Desk of the President" – which sought to inform BSEC members about the significant matters being discussed at Executive meetings, as well as upcoming bioethics events in which they might be interested. That circular was eventually replaced by a 'mail-out' from the BSEC Secretariat regarding bioethics notices, educational opportunities, or other matters of bioethical interest.

Despite the foregoing, however, by far the greatest challenge has been the collection of annual membership dues from members who are widely dispersed across the various jurisdictions of the Caribbean. Our efforts at annual collection to keep our Society going, defray costs such as website maintenance, plan and execute annual forums, and other expenditures that our BSEC Treasurer reports on at every Annual Meeting of BSEC, have generally been met with poor success.

This matter also has negative consequences on both sides, incapacitating the full functioning of BSEC, as well as the status of its members. While some in-country regional representatives have made sporadic collection of annual membership fees from some members during some years, most of our members are in 'non-financial' status and consequently are limited in being able to nominate, stand for elected positions on the Executive, or vote during BSEC Elections.

I remember 'brain-storming' some years ago with our broader BSEC membership on how to improve our Society as we plan our way forward. Therefore, as a very concerned member of the group of 'founding fathers' – I am again writing to you all across the Caribbean to 'brain-storm' with us on ways in which your annual membership fees (US$20) can be sent to the BSEC Executive without the costly deduction of wire transfer bank charges.

Please send your suggestions to: BioethicsCaribe.BSEC@gmail.com

We look forward to hearing from you!