Postmodern Openings
ISSN: 2068-0236 | e-ISSN: 2069-9387
Covered in: Web of Sciences (WOS); EBSCO; ERIH+; Google Scholar; Index Copernicus; Ideas RePeC; Econpapers; Socionet; CEEOL; Ulrich ProQuest; Cabell, Journalseek; Scipio; Philpapers; SHERPA/RoMEO repositories; KVK; WorldCat; CrossRef; CrossCheck

2020, Volume 11, Issue 1 Supl. 2, pages: 141-160 | https://doi.org/10.18662/po/11.1sup2/147

Bioethics of Public Policies. Ethical Standards in Crisis Situations

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Abstract: Due to the fact that the value of public health and the value of individual health take precedence in health policies that respond to the pandemic created by the SARS-CoV-2 virus, there must be a number of limitations on autonomy and informed consent, equity in access to health, etc., and the limits of these measures must be clear to both decision-makers and the public, so the measures must be taken and implemented from an ethical perspective. This lecture will address a number of ethical features that should be taken into account during the pandemic. Public health measures must take into account a number of ethical principles, namely: the intervention should be based on research and be proportionate to the threat to public health posed by that infection, or that the public health hazard, in general, represents for a particular society in one area or another of the world. The purpose of the intervention must be dimensioned in such a way that the intervention is based on the scientific results and the professional judgment of the public health experts in the respective region. The results and goals of health policies as well as the reasons why the intervention takes place must be clearly communicated to the public and be understood accordingly (Cook, 2020).

Keywords: *bioethics; public policies; crisis situations; ethical standards.*

How to cite: Sandu, A. (2020). Bioethics of Public Policies. Ethical Standards in Crisis Situations. *Postmodern Openings, 11*(1Supl2), 141-160. https://doi.org/10.18662/po/11.1sup2/147

Introduction

Focusing[1] on the bioethics of the pandemic is a new topic in bioethical discourse, which responds to unprecedented challenges in recent human history and this is because we all witness moments in which the principles of bioethics are strongly confronted with the need to manage a more restrictive reality, from the point of view of respecting autonomy but also of resolving conflicts of an ethical nature.

Michael Cook (2020) shows that the measures that society must take in the face of imminent public dangers, such as the case of Covid-19 infection, should be proportionate to the threat to public health. The case of requests for people to stay longer at home or only inside, respectively, the fact that a series of treatments that are not considered urgent must be given up and that there are such indications of closing hospitals, suspending dental treatments (Ministry of Internal Affairs, 2020a, 2020b), or the fact that some non-emergency cases will be postponed, the fact that family doctors treat as much as possible through remote interaction, through telemedicine, the fact that a person no longer decides on his own health condition and may be required to be quarantined or to be treated are such restrictions on the right to autonomy and the requirement for informed consent from the patient.

These deviations from ethical standards should be made only to the extent that the threat is immediate and be adopted gradually, as the imminence of adverse effects increases, and those who take them are obliged to explain to the public the need for such measures, the population having thus the possibility to understand the situation faced, in such a way that the measures are clearly understood.

The measures adopted by the states were based on the results obtained in the field of scientific study of this infection, both from a medical and social point of view, and from a public health perspective. However, some authors show that both public health and treatment decisions are based on a number of incomplete studies. In this sense, Professor Vasile Astărăstoae (2020) laments the lack of autopsies of people who died with the diagnosis of Covid-19 infection (Andreiana, 2020). In the opinion of the mentioned author, such necropsies could lead, based on the anatomopathological examinations, to significant information regarding the

[1] This chapter is based on the lecture entitled "Bioethics and professional deontology", held online on 26.03.2020, in the course of Bioethics and professional deontology for students of Balneo-physio-kinetotherapy and those of Nutrition and Dietetics within the "Ştefan cel Mare" University of Suceava, in which all interested persons were invited to participate.

development of the infection and the lesions that it causes, which can contribute to a better knowledge of the specific pathology of Covid-19.

Both prophylactic and therapeutic measures are based on the results of previous research. Among the preventive measures, we welcome those related to the need for isolation, but we cannot fail to emphasize those that should be adopted regarding the need to equip patients with protective equipment, medical masks, protective suits, transport of people with isolation vehicles, etc. The most worrying is the situation of doctors, medical staff across the country, who are put at risk, especially as the decline in the number of doctors who are able to be in the forefront puts public health at risk, because it is they need medical staff who can be involved in the care of patients at any time and, in order to be able to take care of them properly, they need medical equipment, tests, etc.

Another issue is respect for equity as a principle of bioethics when it comes to mass testing. This is especially important in situations where the incidence of positive diagnosed cases is higher, and where there is a risk that the infection will be transmitted to the community. Mass testing should be done in proportion to the size of the localities or the risks in those localities, highlighted by tests already performed, which would be a fair decision and a justification for allocating more resources in large urban areas, precisely due to the high volume of the population of these localities compared to other inhabitants of medium or small communities.

1. Autonomy and respect for privacy

Another principle promoted by Michael Cook (2020) is that intrusion into the privacy of individuals through restrictive or coercive measures should be minimized so that they are consistent with the intended purpose. We are in fact talking about a conflict of values between the principles of charity - represented by the public good - and respect for autonomy. By opting for the public good, the aim is to reduce the risks to public health, even with the risk of the occurrence of particular situations in which restrictions, although imposed, require derogations from them - such as traveling for business or humanitarian purposes, etc.

When there is a public danger, its size must always be balanced against the negative effects felt by the population, there must be a balance between the public good concerned, the public danger to be eliminated and the severity of the rights restrictions that occur. In fact, as the authorities of several states did, in the first stage the restrictive measures appeared only as

recommendations, and where they were not understood and applied voluntarily, they were defined as mandatory.

Also, a series of public project initiatives aim at violating the right to privacy of quarantined persons, through mandatory monitoring and without informed consent of other parameters than those absolutely necessary for public health. Restricting their other freedoms - for example, obligatorily monitoring their temperature, blood sugar, etc. - is a violation of autonomy and individual freedom that exceeds the public interest, representing an undesirable intervention in privacy and violating both individual rights recognized by conventions and rules as well as the constitutional freedoms specific to each state, as the case may be.

2. Maximizing the public good - how do we choose who dies?

Individuals should be treated as morally equal and respectable (Cook, 2020). However, there may be situations (insufficiency of artificial life support devices) in which choices are needed between people who will or will not benefit from a particular therapy, when the equal moral value of each individual should be taken into account. There are opinions that insufficient medical technologies should benefit young people who have a longer life expectancy and a better estimated quality of life as a priority. The mere fact that a person is elderly should not exclude him from a certain treatment, because his life expectancy is lower, even if healing is achieved. From a utilitarian point of view (Mill, 2014), a series of indicators related to life expectancy and its estimated quality are calculated: QALY (years of life adjusted for quality of life) and DALY (years of life adjusted for present disabilities) (Gemene et al., 2017). These indicators measure the quality of life from a health perspective and can be used in deciding whether or not to give a certain expensive or hard-to-reach therapy, but from our point of view, the mere fact that a person is elderly should not exclude them from treatment.

There is a tendency to classify certain people as less respectable, especially when they put their own health at risk. For example, smokers or obese people are considered to be responsible for their own health and then there are opinions in bioethics that they should benefit less from health care if the diseases prove to be due to their own exposure to agents. pathogens and self-neglect of health (Butler, 1993; Thirlway, 2019). Even if there should be a series of compensations that individuals who adopt risky behaviors bring to society, for the efforts that it makes to provide them with

treatment, these compensations should not go to the point of lack of treatment or diminution. the chances of survival / healing of these people.

For example, in the case of smokers, this compensation is precisely the excise duty (stamp duty). If indeed this is the argument for ethically justifying the existence of a surcharge (vice tax), these additional revenues for the state should be directed to the budgets of the Health Insurance Houses and not generally distributed to the state budget. The solution would be in line with other similar ones, such as excise duties on fuel or ecotaxes related to traffic on public roads.

We all have the right to life, this is an inalienable right, it is part of the fundamental human rights. In practice, however, we need to talk about the protection of this right and how states and public health systems can and do ensure this right, as long as there is a limited number of specific equipment needed in this situation. No matter how much is invested in the public health system, there will be cases that could be treated from a medical point of view, but there are no material, human, technological resources, etc. allowing treatment. So what are the ethical criteria that justify access to these devices?

A first such criterion would be life expectancy. This is a utilitarian criterion, but if due to other comorbidities it is possible for the person to die anyway in a short time, the continuation of therapy can be considered a therapeutic ferocity (Ameneiros-Lago et al., 2006; Casella et al., 2018). It is a dramatic choice that is put in front of doctors, but in most situations a waiting list is made, as is the case with the transplant list.

There were also situations in which public persons were considered more important than others (Sandu, 2013). We believe that any patient deserves to benefit from therapy that can save his life equally compared to any other person. Unfortunately, in many cases the ability to financially support the therapy must also be taken into account. When there is the ability to pay in full for medical services, without resorting to health insurance, patients receive high quality treatments, in much better conditions and much faster, often in private clinics. When the resources come, at least partially, from the health insurances, waiting times may appear due to the agglomeration of medical institutions, especially public ones.

3. The principle of solidarity and the future of the EU

Another principle formulated by Cook (2020) states that solidarity is crucial both at the international level - between governments, in support of the states that bear the highest cost of interventions - and between

individuals. Practically at the moment we are witnessing a global shutdown, in which the states appear to act each for themselves, because each state has closed its borders, limited the export of medical and sanitary materials retaining them for the use of its own population. Basically, solidarity must also mean the creation of humanitarian cords across borders, especially within the European Union, whose philosophy is "borderless!", But they have reappeared and each state is managing its own crisis and there does not seem to be an answer. unite in the EU to this crisis and to show European solidarity in the face of common problems. The transit measures adopted and the creation of a humanitarian corridor for people waiting to transit a country that has closed its borders are more like the situation of people who would have a status similar to that of refugees and not that of full citizens, of the European Union. Of course, the countries of the world are at risk together, which means that the aid that one state can offer to another is limited, but at least the information must circulate and it must be up-to-date and correct. Many question the information that originally came from China and say that the size of the Chinese pandemic has been greatly underestimated, as have other countries such as Iran, Korea and Russia - undemocratic countries (”Did China Hide”, 2020; Ebbs, 2020; Ilyushina, 2020; ”Is Covid-19 a Game-Changer”, 2020; Moritsugu, 2020).

However, there is a lack of solidarity at EU level and many European citizens challenge the role of the European Union in this emergency, appreciating that the European Union is not taking enough action at the general level for a coherent health policy between the states of the Union. questions arise about the future role that this Union will play in the post-crisis society („Coronavirus: Is Europe”, 2020; Palombarini, 2020).

In our opinion, in the post-crisis period, three scenarios regarding the fate of the U.E. are equally possible. and globalization: the first aims at an accelerated dissolution of the Union, a resurgence of nationalism and an overwhelming impact of nation states on international politics, against the background of mutual distrust between states. It will return to a Europe and a world of borders, a new Iron Curtain appearing to separate the East - dominated by China and Russia - from the West - divided between the former member states of the U.E. and competing for areas of influence. This trend seems similar to that of the interwar period, and in the case of accentuating the revengeful tendencies between states, tendencies that were "asleep" during the functioning of the EU, these tendencies can, in the most tragic scenario, culminate in a new World War - most likely the latter, due to the use of the chemical and biological nuclear arsenal.

The second extreme scenario concerns the federalization of the European Union and the emergence of a federal state in the manner of the United States of Europe, which will take over the prerogatives of sovereignty from nation states and act unitarily and independently in the international concert dominated by declaration war and trade war. United and China - helped by Russia's wide competition. This scenario envisages an increasingly accentuated globalization, at the limit - through authoritarian policies, argued by the need for public health and protection of populations, which will be indefinitely suspended a number of civil and political rights.

Finally, the third option, the optimistic one, aims at relocating the centers of influence in international politics in a multipolar world, in which regionalization and sustainable development will be key elements of social and political stability, in a globalized world, in mainly through the virtualization of social relations and global communication. Much of the social interactions, especially economic, but also cultural, scientific and, in part, even religious, will be virtualized so that much of the lives of individuals will take place in the online environment, a supranational one, which we want to see it preserving its virtual democracy and the freedom of the internet despite policies that favor censorship already evident on certain social networking sites and search engines, but which for the time being are justified by the primacy of interest in public health. The physical Coronavirus pandemic will be replaced by the virtual *fake news* pandemic, which is already used by states but also by transnational bodies in total hybrid warfare to control this new dimension of existence: virtual space.

4. About credibility - between credible scientific studies and scientific fake news

Support between states must also be linked to the freedom of scientific discoveries and free access to medical information on these issues, and scientific publications on Covid-19 to be open access - free for all. Indeed, there are, in the large medical databases and beyond, sections for research on the Covid-19 issue that have turned private access into open access precisely because these articles, in particular, help the scientific community around the world to cope. together with this challenge. Open access can also bring some inconsistencies, such as the misallocation of the authorship of an idea, the publication of unfinished research or the publication in the form of a preprint of articles subsequently rejected in the peer-review process, but which significantly influenced treatment schemes. We mention here the example of a company from Timişoara that claims that

its affiliated researchers were the first to discover a vaccine for Covid-19 and that practically the vaccine proposed by this company was plagiarized by researchers from China (Duţă, 2020) in the context of a collaboration between the Timişoara Research Institute and the Chinese Ministry of Health and widely used in China. At the time of publication, the Chinese colleagues assumed all the merits, except that the therapeutic scheme for the vaccine was practically a Romanian invention, according to the statements of the management team of the Research Institute from Timişoara.

A major issue with the speed with which medical information on Coronavirus is made available to the public is that studies in the intermediate stages, against which there is not yet a definitive opinion of the scientific community, are presented in the form of pre-publications (public exposures). online before publication and the peer-review process). This is the case of a study (Archip, 2020) on the drug Remdesivir, initially promoted in the treatment of the Ebola virus and which passed clinical trials in human subjects, being recommended in anti-Covid-19 therapy, but which seems to be ineffective in this fighting the new virus and, moreover, a study withdrawn from publication on the WHO page shows that it could also have significant side effects (Dunn, 2020).

Also, the Hydroxychloroquine drug was promoted and introduced in the treatment regimens against Covid-19 in many countries (Lepădatu, 2020), including in Romania, but the article that originally promoted this drug and on the basis of which the states introduced it in the scheme was withdrawn from publication, as it did not meet the peer-review criteria, considering that in the elaboration of the paper the ethical standards necessary for research on human subjects were not observed and there is not enough evidence to support the conclusions of the article and the use of hydroxychloroquine. in anti-Covid-19 treatment (Raoult, 2020).

On March 27, 2020, a study was published in the Journal of Medical Virology (Zikuan et al., 2020) in the form of a literature review of 434 clinical trials of Coronavirus, conducted through March 15, 2020 in China. We cannot but welcome the scientific community's ability to respond quickly to a problem of common interest, which allows us to talk about a globalization of responsibility. Without intending to diminish the merits of Chinese researchers, we find that due to the need for rapid publication, even the article reviewing the 434 clinical trials was sent to the journal and published as a Letter to the Editor (Zikuan et al., 2020) - type of article that generally goes through a much shorter peer-review process, or, in some cases, such articles are published without peer-review, having the character of making public important and urgent information before they should be

processed into complex articles, subject to the peer review process which can take, in some cases, more than a year. Probably the large number of studies is determined by the topicality of the studied problem, but also by the consistency of the funds allocated to this topic. We draw attention to the fact that especially in terms of clinical trials it is absolutely necessary to comply with ethical rules (CROS NT, 2018; European Commission, 2014; National Agency for Medicines and Medical Devices of Romania, 2020), namely: scientific value, estimation the relationship between the benefit to society and the progress of knowledge versus the risks to participants, the reduction or elimination of financially or materially stimulated participants where possible, voluntary participation, ethical advice, etc.

The large number of studies and the areas covered may raise suspicions about the quality of the resulting publications, when they are made in a hurry, in the desire to be among the first to announce a series of results and implicitly to receive citations in the field. However, the fact that clinical trials are in an official Register of an open nature, accessible to any researcher, is important for the possibility of verifying the results by other research teams and reporting to them in the design of similar studies.

Another fact that undermines trust in science is the citation in the media, without prior control of the sourcesm of a pseudo-scientific literature on Coronavirus, which is based on opinions rather than empirical results and which confuses the public with the contradictory nature of the messages. obviously interested in one direction or another and not respecting the basic rules of ethics of research and publication - namely axiological distancing, untruncated presentation of results, refraining from excluding those results that seem to indicate the invalidation of hypotheses, etc. The interest of the media seems to be to use seemingly legitimate sources from a scientific point of view but which accentuate the emotional impact of the message, its controversial character.

These slippages from research ethics put bioethics in a crisis situation related to the contemporary value of science and scientific methods in the face of politics and especially populist tendencies. The discount from scientific requirements strengthens distrust of research and undermines the ethical and axiological foundations of the knowledge-based society.

5. Research on human subjects in a pandemic situation

An ethical tool in the Covid-19 crisis situation is proposed by UNESCO and is entitled "*Ethics in Research in Times of Pandemic*" (Association of UNESCO Centers, UNESCO's Network of National Bioethics

Committees & Commissions of Latin America, 2020). The guide discusses biomedical research, if and how it can be conducted on vulnerable populations, especially those from regions with endemic poverty such as Latin America. In these areas there is an even greater risk that the use of experimental treatment or vaccination methods will be applied in violation of ethical standards in clinical research on human subjects, especially when it comes to such an emergency situation. states as well as researchers themselves are tempted to relax ethical standards.

Research ethics on human subjects, especially in the case of conducting clinical experiments, involves compliance with clinical principles (Ahmad & Moeen Al-Sayed, 2018; European Commission, 2014; National Agency for Medicines and Medical Devices of Romania, 2020; Nardini, 2014) such as:

• The benefit of clinical research should be judged at the level of humanity, while at the level of those involved should focus primarily on non-malice, ie the results should benefit all humanity, but the actual implementation of research, clinical trials, must not harm research participants.

• Research involving human subjects should therefore consider therapeutic efficacy in favor of people who will be infected in the future, even if those who participate directly in the clinical trial may also have a number of benefits - these are not excluded, but not are necessarily followed directly, because the clinical trial includes a number of people who are part of the so-called control group, who do not actually benefit from the active substance, these people being treated by *placebo*, or by conventional therapy already existing for that disease.

• Another principle is that in research, patients cannot be left without treatment. They must benefit from the current treatment in force. An exception is the research on vaccines, which can be performed on healthy populations, the volunteers participating in the research not being affected at the time of the research by the respective pathogen. In this situation, the benefit-non-harm ratio must be taken into account and as many risks as possible that may affect the person participating in the research[2] must be eliminated. If the therapy is successful, participants will

[2] At the time of preparation for the publication of the text (26.04.2020), the media published a news item that turned out to be false, according to which the first participant in clinical trials for an anti-Covid-19 vaccine had died. The news was denied and proved to be wrong, apparently a product of anti-vaccination circles (Turnnidge, 2020).

benefit from the positive effects of the vaccine. The principle of non-malice must take precedence in the selection of people participating in research.

There is only one derogation from this principle: *compassionate use programs for experimental drugs* (Raus, 2016). This idea of compassionate participation in research programs on innovative therapies and new active medicinal substances is aimed at people who are particularly severely affected by the pathogen on which clinical trials are being conducted and who are in the terminal phase, who receive that therapy without participating in the research itself, in order to give them an extra chance to survive and possibly heal. The European Commission, through the European Medicines Agency (EMA), has advised EU member states that they may derogate from the principles of research ethics by offering patients in a particularly serious condition - terminal - experimental therapies. , based on the principle of compassionate participation in research (European Medicines Agency, 2020). This principle has been accepted because there are no treatment regimens proven by clinical trials to be effective and because there is no standard therapy for this disease.

• Even in extreme conditions, such as the current pandemic, experiments involving human subjects are not allowed without their express consent, especially if they are vulnerable.

• It is imperative that participants in clinical research be fully aware of their situation, namely that they are participating in a clinical trial, that the outcome of the experiment could lead to the discovery or testing of a treatment regimen, vaccine or substance. that they could benefit from the active substance or could be in a control group, being randomly assigned to one or another of the groups, and those who do not benefit from the active substance will not be informed , but will not be left without treatment, as it is offered in accordance with therapeutic standards at the time of clinical trials, or with placebo if there are no such therapeutic standards. The researcher must ensure that this is voluntary participation, on which there is the express consent of the person.

• Research should avoid including among participants in research participants people from vulnerable populations, as it is assumed that they can be more easily manipulated due to low living standards but also the possible additional value that incentives offered in the form of bonuses (Association of UNESCO Centers, UNESCO's Network of National Bioethics Committees, & Commissions of Latin America, 2020). It is allowed to offer financial compensation for the time spent by participating in the research and paying any expenses that would revert to the participant following his enrollment in clinical trials.

In previous research (Frunză & Sandu, 2017a, 2017b), in which we analyzed the involuntary participation of patients in clinical research - not in clinical trials, but in biomedical research - we highlighted the fact that patients are required to sign a consent to give doctors the right to use patients' data in further research, including their own biomedical data, including biological products taken, blood, tissue samples and so on, not only for therapeutic purposes but also for research. In our opinion, the introduction of these requirements in the informed consent forms is excessive for the rights of patients, as long as they can consider that if they do not consent to their data being used for research purposes, they will be denied the therapeutic act.

The opinion expressed by us can be countered with the statement that monitoring the health condition and the effects of various therapeutic approaches are not experimental, and for their use in the development of scientific papers should not be obtained a different consent for research than for treatment, because practically we are talking about a therapeutic act analyzed later on the basis of a secondary analysis. It can also be considered that the tissues and biological samples already taken belong to the medical institution, the patient being the one who gave them to be analyzed for diagnosis, and then performing a secondary analysis does not endanger the patient's life or quality. and as such should not raise the question of the possible unethical nature of such research. In our opinion, the objection is in principle correct, because the data and biological products already obtained from the patient do not produce additional stress to him, but ethical issues can arise when practically the research is the one that prevails over the therapeutic interest. An example is a study performed on some patients whose cerebrospinal fluid was extracted to establish the diagnosis, but in a larger amount than was necessary, in order to use the biological product in research, which led to the death of the at least one of the patients in question (Frunză, 2016; Hopulele, 2015).

The principle that the doctor decides for his patients, based on their informed consent, is generally valid for the therapeutic act when there is no intention to measure the effectiveness of one or another of the therapeutic schemes on behalf of his patients. When the experimental intent exists, it must be communicated, and informed consent for research must be express and patients must be informed that they are participating in a therapeutic approach with experimental valences. To validate a therapeutic method, randomized clinical trial is the most effective and the only method that allows the generalization of results by publishing them.

Clinical trials should be reported in registers specially set up and endorsed at the WHO level, which contain information on the methodology, the complete results of the research - more precisely all the data obtained in the research, both the hypotheses that confirm these results and those that refute them. , data on the admission criteria of patients in the experiment. Such studies generally comply with ethical standards because they are directly controllable by any interested person, precisely because of the public registration of research data. Clinical trials must be reported to ethics commissions from which the ethical opinion must be received. Only the data thus obtained can demonstrate the therapeutic efficacy of a specific molecule / substance or medical technology. Observational studies performed on the patient's bedside have an indirect value, they can give indications on the possible efficacy of a treatment with substances already approved for other therapeutic contexts, but such studies cannot be invoked to certify the efficacy of a therapy as long as it is not they can certainly assess the real causes of the efficacy / inefficiency of the administration of a substance.

There are, in the public space (Malik, 2020), discussions on the application of clinical trials in countries where living standards are low, where we are talking about an insufficient capacity of health systems, where innovative therapies (which are expensive) are relatively inaccessible to the population, even after these therapies are approved by the medical authorities. For these countries, it is the participation of the population in such clinical trials that can be a chance for access to such therapies as long as, say many, before the therapy reaches the clinical stage it has been analyzed biochemically and methodologically and probably has been previously tested on animals.

The article mentioned above shows that there is a trend of globalization (Thiers, Sinskey & Berndt, 2008) of clinical trials, but Kenan Malik (2020) considers that the motivation of pharmaceutical companies to conduct *offshore* tests is that in countries with low levels of income, the regulations for the application of clinical trials are less severe, the participation of medical *staff* is cheaper financially and the subjects of the experiments are much easier to find. The example of India is given here, where, although there are very well trained doctors, due to the level of poverty the costs of such experiments are 40% lower than in other countries and due to the large population the subjects are much easier to recruit. In this country the number of clinical trials increased 5 times in the period 2008-2014 (Mandal & Abrol, 2015). Kenan Malik (2020) shows that there have been situations in which the replacement of an expensive treatment

with cheaper alternatives has been tested, the control group not benefiting from the high-priced substance, which represents the global therapeutic standard and has instead been subjected to a placebo treatment.

From an ethical point of view, the scientific journals in the medical field must take into account the refusal to publish studies based on such experiments, in which there is no certainty of compliance with ethical standards and the refusal of states to accept the tested substance and the obligation pharma to additional tests.

Another trend in the current crisis situation is to shorten the period of research in terms of identification and validation of active molecules, vaccines, treatment regimens[3], etc. This reduction of time must be achieved especially by minimizing the bureaucracy involved in scientific research, the development of research projects, even approval, obtaining ethical opinions from research ethics commissions and so on, but not at the cost of sacrificing careful analysis of efficiency, especially risks, ethical evaluation, the implementation of evaluation in ethics commissions and especially not at the cost of falsifying results or applying partial results.

6. Ethical issues regarding the protection of medical staff

Another issue we focus on is that in some states (for example, Italy) the triage is performed by medical staff with secondary education, more precisely by nurses and not by doctors, an aspect that we explain precisely by the need to avoid widespread exposure of physicians to possible Covid-19 infections, in order to keep them as available as possible in the first line. Here we do not believe that it is a discrimination based on study criteria, respectively for the fact that doctors are considered much more important in the application of the therapeutic approach. However, this idea of protecting doctors is debatable, given that nurses are just as important in the application of therapy, because in most cases it is the doctor who prescribes the treatment scheme, but nurses are the ones who actually care for the patient.

There should be no discrimination in terms of the social importance of one or the other of the professions. Again, I believe that it is not necessarily a negative solution for triage to be done by medical professionals with secondary education, as long as they can easily detect the symptoms of this disease because they are relatively obvious and already described in what

[3] If in late March - early April the media talked about the start of clinical research for vaccines or therapies and predicted that they will be available in a few months, at present (27.04.2020) the appearance of a vaccine is estimated for next year (Spinney, 2020).

we might call a poor literature in the field, so that a person with average health training can detect if there is a risk of disease. On the other hand, there is likely to be discrimination, at least from what is seen, in that nurses are put in the forefront and that this requires extra effort - and there should be an additional reward for people who appear in the first line. On the other hand, the migration of doctors and nurses, of healthcare professionals in general, puts the medical system at risk even more than it is at the moment (Oprea et al., 2013).

Conclusions

Because this article is related to the specifics of informed consent, the specifics of respect for autonomy and we digressed to understand autonomy and informed consent in the context of public health issues, in conclusion we want to discuss the limits of informed consent. As I said, public health is such a limitation.

As far as the fact that, even in the same country, sometimes different treatment schemes are applied in different hospitals, as long as there is no official treatment schedule and no treatment protocols, doctors should be free to prescribe the drug or medicines which, in accordance with their own professional judgment, may lead to the best effects in the case of the patient, and the patient should, as far as possible, give or refuse informed consent to such treatment. However, there is a violation of ethics when patients are involuntarily involved in research on human subjects as long as they use the doctor's freedom to propose treatments in the absence of an approved therapeutic protocol, only to test which therapeutic scheme works more effectively.

Does the emergency situation justify, at least in part, the breach of ethics with regard to clinical trials? Or the fact that a person receives a different therapeutic regimen whose chances of producing a cure are not scientifically validated information through clinical trials and the risks of adverse effects are not known, can be considered a particular situation in which professional ethics are respected. precisely because patients are not left without treatment? Violation of research protocols regarding the exact explanation to the patient of his situation and the fact that, although he is not enrolled in a clinical trial, the results of the therapy applied to him can be used for research purposes should be justified by the need to establish as soon as possible therapeutic protocols in case of a pandemic with global effects and affecting a significant number of people.

Informed consent should be required at least in normal situations for patients or participants in experiments on human subjects before therapy but also with each change in therapeutic approach, such as a change in treatment regimen, change in medical approach, and so on. The patient must be informed of his situation, the risks to which he is subjected to the evolution of the disease in various situations, in various therapeutic scenarios, etc. It is very important that he must understand and consent knowingly.

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