Q10

Case study. The coronavirus disease (CoVID-19) pandemic has quickly spread to various countries. As on May 8th, 2020, in India 56342 positive cases of corona had been reported. India with a population of more than 1-35 billion had difficulty in controlling the transmission of coronavirus among its population. Multiple strategies became necessary to handle this outbreak. The Ministry of Health and Family Welfare of India raised awareness about this outbreak and to take all necessary actions to control the spread of COVID-19. Indian Government implemented a 55-day lockdown throughout the country to reduce the transmission of the virus. Schools and colleges had shifted to alternative mode of teaching- learning-evaluation and certification. Online mode became popular during these days. India was not prepared fora sudden onslaught of such a crisis due to limited infrastructure in terms of human resource, money and other facilities needed for taking care of this situation. This disease did not spare anybody irrespective of caste, creed, religion on the one hand and have and have not' on the other. Deficiencies in hospital beds, oxygen cylinders, ambulances, hospital staff and crematorium were the most crucial aspects You are a hospital administrator in a public hospital at the time when coronavirus had attacked large number of people and patients were pouring into hospital day in and day out. - What are your criteria and justification for putting your clinical and non-clinical staff to attend to the patients knowing fully well that it is highly infectious disease and resources and infrastructure are limited? - If yours is a private hospital, whether your justification and decision would remain same as that of a public hospital?

UPSC Civil Services Mains 2021 · GS IV · 20 marks · Ethics Case Studies

Case Studies on above issues.

Core demand of the question

- **COVID-19, May 2020:** India has limited beds, oxygen, staff and crematoria. You are a hospital administrator in a public hospital as patients pour in

- (a) Criteria and justification for putting clinical and non-clinical staff to attend patients knowing the disease is highly infectious and resources are limited
- (b) If yours is a private hospital, would justification and decision remain the same? Duty of care, justice in scarce beds, PPE, rotation, informed consent, ICMR triage; private hospitals cannot dump the poor at the gate

Revision summary

Public-hospital staff may be deployed into COVID risk if PPE, training, rotation, informed consent and fair sharing of exposure are real.

Beds follow ICMR-style clinical triage, not VIP pull.

Closing the hospital is not the ethical alternative.

- **A private hospital keeps the same non-abandonment ethic:** stabilise, then coordinated referral, not a pavement dump.

Profit and packages may differ; dumping the poor may not.

Introduction

The virus does not read the pay scale. A public hospital administrator still has to send people into risk with scarce PPE and beds. Dumping the poor at a private gate is not a business model. Duty of care and justice in scarcity are the same ethic; the funding story is not an exit from non-abandonment.

Body

Stakeholders

- COVID and non-COVID patients, including those who will be triaged away from a ventilator.
- Clinical staff, sanitation workers, ambulance crew, and their families.
- You as administrator, the State health department, and ICMR protocol authors.
- Private hospital owners and insured versus uninsured patients, if the second limb applies.

(a) Public hospital: criteria and justification

- **Duty of care:** a public hospital exists to treat; staff accepted a profession that includes epidemic risk, not a suicide order.
- **Justice in scarcity:** beds, oxygen and ICU cannot be sold by pull. Criteria must be clinical need, likelihood of benefit, and published SOPs - ICMR and Ministry of Health triage - not VIP WhatsApp.
- **Non-maleficence:** do not send staff without the best available PPE, training, and a fit-test as supplies allow.
- **Informed consent of staff:** explain the risk, the protocol, and the right to report unsafe deployment; conscription by humiliation is unethical even in a pandemic.
- **Rotation and rest:** burnout kills patients too; cohort teams, limit continuous COVID weeks, and vaccinate when doses exist.
- **Equity among staff:** do not dump all exposure on contractual sanitation workers and interns while seniors stay in the committee room.
- **Pregnant, immunocompromised and older workers:** redeploy to lower-exposure tasks where the roster allows; this is fairness, not cowardice.
- **Non-clinical staff:** they are not disposable. Same PPE logic for a cleaner as for a consultant at the bedside, graded by exposure.

• **Transparency:** a public board of occupancy, so rumours of hidden VIP beds do not destroy trust.

• **Justification:** the alternative - closing the gate - abandons Article 21. The ethical path is risk that is shared, equipped, rotated and triaged by protocol, not by caste, cash or party.

• Mental health and family housing for staff who cannot go home to elderly parents.

• **Crematorium and ambulance gaps:** coordinate with the district; the hospital's duty does not end at a body left in a corridor as policy.

(b) Private hospital: same core, different cash, not a dump

• The decision does not flip to "we treat only those who pay in advance and we turn the poor away at the gate".

• Private hospitals remain bound by medical ethics of non-abandonment, emergency first aid, and the law of the day - State COVID requisition orders, the Clinical Establishments framework where notified, and consumer duties.

• **EMTALA in the United States is a useful ethical analogue:** screen and stabilise an emergency, then transfer with acceptance, rather than dump.

• **Profit does not cancel justice:** a dual queue of oxygen for cash and denial for the uninsured is the food-company dual standard in a ward.

• **What may differ:** elective non-COVID work, hotel-style rooms, and pricing within a government-capped COVID package where the State has fixed rates.

• **What must not differ:** triage by medical need inside the facility; PPE and rotation for staff; no punishment of a nurse who asks for a gown.

• **If beds are full:** documented, medically escorted referral to a public or listed COVID facility, with oxygen in the ambulance - not a poor patient left on the pavement.

• Coordinate with the State war-room for occupancy, so private capacity is part of the public surge, not a gated island.

• **Staff justification remains the same:** equipped, rotated, informed. A private employer who hides PPE costs in a bonus for silence has failed twice.

• If the board orders gate-dumping, the administrator refuses in writing. A licence to practise is not a licence to abandon.

Flow diagram

COVID surge -> PPE rotation consent rotation consent

COVID surge -> ICMR need-based triage

Public hospital -> Article 21 no closed gate

Private hospital -> Stabilise and refer

Dump poor at gate -> Abandonment

Conclusion

Send staff with PPE, rotation, honest risk talk and ICMR triage, sharing exposure instead of hiding seniors. In a private hospital the poor still get emergency care and a real referral. Scarcity explains hard triage. It does not explain a pavement.

Facts & figures

ICMR and MoHFW COVID protocols

The operational source for testing, isolation, PPE grades and clinical management that an administrator should not invent in a panic.

Article 21, Constitution of India

The public hospital's ethical and constitutional reason not to shut the gate on a surging epidemic.

EMTALA-like ethic

The US Emergency Medical Treatment and Labor Act forbids dumping uninsured emergencies; a useful benchmark for Indian private emergency ethics even where the statute is foreign.

State COVID requisition of private beds

Many States in 2020-21 lawfully listed private beds and capped rates; private ethics then includes obeying that public surge design.

Contractual sanitation workers

Often the highest exposure and the weakest contracts; equity requires PPE and hazard support, not only slogans for doctors.