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Article

Medical Ethics and Mental Health during COVID-19

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Abstract

Anxiety and despair have spread like wildfire with the COVID-19 pandemic. Studies on mental health undertaken during the pandemic have revealed rising rates of suicidality and indications of acute stress and depression. The national laws on travel and quarantine have made attending these routine checkups harder and less practicable. The fast use of telehealth during the epidemic has accelerated the need to address the moral difficulties of using electronic treatments for mental illness. However, the urgent need for socially detached mental health care should not be used to weaken regulations and practices that safeguard individuals from receiving inadequate mental health care or having their personal information misused, raising several ethical concerns for the professionals providing these services. This study aims to provide a theoretical analysis of some of the pressing ethical concerns surrounding online healthcare delivery during COVID-19, which include privacy and data protection, safety and accountability, and access and fairness. Consequently a robust moral framework will be searched for solving some moral dilemmas in this context.

Keywords: Covid-19, Pandemic, Mental Health, Telehealth, Privacy.

INTRODUCTION

Due to the societal and psychological pressures coming from the pandemic, such as widespread unemployment, fears of getting the virus, sleeplessness, exposure on social media, and the mounting death toll, COVID-19 is posing a mental health crisis of unparalleled proportions. Acute stress and depression are common reactions to the coronavirus, and these reactions are more common in those who already struggle with mental health issues (Tayag, 2020). More specifically, the presence of a mental disorder is the most reliable indicator of the presence of symptoms of depression. Emotional reactions of young people during the epidemic were connected to prior victimization - such as bullying, inadequate financial resources- such as the loss of a job or income, may also lead to severe stress and depression. Exposure to media about the Covid-19 epidemic, especially media with contradictory information, is a substantial predictor of acute stress due to the pandemic, a conclusion that is both interesting and eye-opening.

These negative impacts, as is so frequently the case, have a disproportionate impact on the most vulnerable members of society, such as the elderly, persons from underrepresented racial and ethnic groups, those with disabilities, those with abnormal brain development, children, and the homeless (Martin *et al.*, 2020). When a patient's condition is critical enough to warrant admittance to an intensive care unit, both they and their caregivers face immense stress. Cognitive decline, drug misuse, and other mental health issues are all exacerbated by attempts to isolate oneself from others.

The issue caused by COVID-19 has sped up the process of using technology into mental health treatment. Increasing accessibility to mental health care both before and after COVID-19 will be much easier with the use of technology (Figueroa & Aguilera, 2020). Individuals of varying ages, technical skills, languages, and level of literacy will each need a different kind of intervention due to the fact that people engage with technology in their own unique ways.

Many of the ethical responsibilities that are associated with mental health treatment stem from the conventional connection that exists between the therapist and the patient (Martin & Kreitmair, 2018). However, what happens to the professional ethical responsibilities when the psychiatrist is replaced by an automated system

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(Martin & Kreitmair, 2018)? The ways in which disruptions in mental health treatment may also cause disruptions in the relationships and commitments that are designed to create a sense of trust, openness, and safety need to be brought to people's attention.

ETHICAL ISSUES

During this state of public health crisis the necessity to protect individuals from infection by developing means for socially distant care might undoubtedly be perceived as having a larger weight than the need to preserve privacy or carefully oversee the safety or efficacy of treatments. Despite this, it is still very necessary to investigate the costs, as well as the advantages, and evaluate whether or not the concessions that are being made to enable greater digital mental health treatment are justified.

The term "privacy" refers to an individual's right to control how much of their personal information is known and accessible to others (Milica & Bart, 2016). That is to say, privacy is the privilege of displaying one's unique self to others. While individuals disregard the law when attempting to explain or comprehend privacy, the term is often used to describe the universal acceptance and disclosure of personal information, especially sensitive information. This is a brief description of the kind of privacy we have in the medical industry. Identity protection also include health data, location data, and mobile phone data.

The disadvantages of paper medical records, such as illegible handwriting or obscured data, are mitigated by the convenience of electronic medical records. However, the medical field's reliance on digital equipment or new technologies means that not only the confidentiality and sensitivity of medical data might be a worry, but also dangers of identities frauds and other problems, when the cell phones are stolen or the technical gaps occur. This may often result in the unintentional spread of sensitive data (Lupton & Lupton, 2016).

In the United States, adjustments are being made to the HIPAA (Health Information Portability and Accountability Act) Privacy Rule, which governs the handling of individuals' protected health information. Telehealth technologies including the applications that gather information directly from users, are not afforded the same safeguards under HIPAA as covered entities like hospitals and clinics. The scope of the new regulations is restricted to healthcare services delivered through private communication platforms like Zoom (Zoom Video Communications, Inc). It has been shown that mental health app developers engage in deceptive privacy practises. Information about a person's behaviour and health may be derived from seemingly unrelated digital data, such as location data recorded on a smartphone. Ads preying on people's fears about COVID-19, for instance, might be based on conclusions about their behaviour made from their personal data.

For a covered agency to use or share a person's Protected Health Information, that individual must provide written consent in accordance with the Privacy Rule. A valid authorization needs to have the following basic aspects: a description of something like the relevant data to be used or made known, the names of the individuals who have permission to conduct the suggested use or disclosing, the names of the individuals whom the public body may make the release of information, a description of the purposes for which the disclosure will be made, and an expiry date for each purpose. Since an authorization is not synonymous with a fully informed permission, persons should be made aware of the potential uses and disclosures of their personal data before giving their approval (Bassan, 2020).

Unlike HIPAA-regulated telehealth services, those that are not part of the HIPAA umbrella are not subject to any kind of statutory oversight (Bassan, 2020). Telecom providers are free to collect whatever health data they see fit. It is very improbable that existing privacy regulations will be revised to accommodate the growing popularity of telehealth. Data on public health collected during a pandemic is likely to be sold or otherwise exploited for a high price. HIPAA only applies to "covered entities," which include health plans and providers that electronically communicate protected health information in the course of patient care or business. When HIPAA applies, covered organisations must assume responsibility for implementing appropriate technological safeguards. However, applications that consumers use to track their own health are not included in this definition of telehealth. When data is transferred from its original custodians, the providers, to other custodians, such as technology and communications businesses, including those who offer health-related commodities and services, the data loses its HIPAA protections. In other words, even if the data is just as sensitive, HIPAA does not protect information or analytics produced from sources that are not covered by the law. One scenario is a doctor conducting patient consultations through an internet content and chat portal provided by a firm like Facebook. Health information given through Newsfeed may be governed by Facebook's privacy policy and hence subject to loosened rules, despite the fact that the care provider may be normally subject to HIPAA.

However, the modification to the HIPAA regulation raises larger issues about whether it is acceptable to impose the duty on consumers and patients to ascertain how technologies are exploiting their psychic health data and react accordingly (Martin *et al.*, 2020). It is unreasonable to expect patients, particularly ones who may have pressing health care needs, to fully comprehend and weigh issues such as additional medical conclusion drawn from their information, the third stakeholders to whom the data may well be sold, and the alternative arrangements and consequences of having their own data sold. In the context of customers, the claim that the utilization of these services is often not required for the wellness and well-being of both the user has sometimes been used to justify the lack of openness that exists in privacy regulations as this isn't the situation in a clinical setting. If patients have no option but to utilise consumer technologies to seek medical services, then they have no alternative but to consent to the exploiting privacy practises of technology businesses. This is because patients have no alternative but to use consumer technologies. In addition to concentrating on consent as well as transparency as methods for addressing shortcomings in data protection, additional regulations to limit what data can be used for direct advertising, actions taken by the Federal Trade Commission to address deceptive or unfair practises, and additional rules that have replaced of HIPAA may be required to protect patients.

Even while some individuals may feel more uneasy about the government utilising their data than they would about corporations or academics using their data, many epidemiologic applications of new data sources may not involve protection of personal data to a larger level than present commercial and research activities (Mello & Wang, 2020). Many usage carry a greater risk of invading a person's privacy than others. Using a person's location and the contents of their text messages, in particular, goes further than what people living in democratic countries are used to. The usage of public and confidential data in day-to-day life often does not include the attachment of personally identifying information. In addition, data are not often utilised for the aim of trying to locate and inflicting penalties on the individuals whose data are being collected, with the exception of the use of data by law enforcement. In contrast, for instance, the form of contact tracing that is now being conducted in Israel entails quickly enforcing public health directives on people who have been tracked.

In general, showing respect for the autonomy of persons includes obtaining their consent before accessing their personal data and making specific uses of such information (Mello & Wang 2020). Users are asked to provide their informed consent to the industry's scheduled uses of their personal data in the Terms and Conditions agreements that must be accepted in order to make use of apps and websites. This "informed consent" is a fundamental ethical principle that underpins both medical care and research ethics. Because then at least three available regimes; opt in, choose to out, and mandatory, are feasible, and distinct nations have made different choices, the issue of consent has particular significance for contact tracing though the phone records. This is due to the fact that there are at least three plausible alternative regimes. Even though it's okay to share private information during a pandemic so that people can find their contacts, it's less okay when the societal threat isn't as urgent (Martin *et al.*, 2020). In view of the idea that the administration or businesses don't track people's data in a way that isn't right, rules and guidelines need to be made about tracking personal information for health research. The guidelines and regulations should make it clear what kinds of data can be tracked, how long they can be stored, and who can access them.

With the fast spread of the COVID-19 epidemic throughout the world, the importance of digital healthcare for mental wellbeing has become readily obvious (Torous & Keshavan, 2020). Patients with anxiety and depression have been the primary focus of the recent uptick in interest and use of healthcare technology as a means to meet the needs of those in quarantine, with both social and physical distance restrictions and a lack of in-person care. For those of us with serious mental illnesses such as psychotic disorders have been largely ignored. It is becoming more important to tailor electronic health records to the requirements of those who have serious mental illnesses (SMI). Furthermore, there are new dangers associated with digital health that experts in the area must now evaluate and try to mitigate. Today's mobile health solutions sometimes need users to agree to a personal information written at such a college level of reading before they can use the app. In comparison to other medical disorders, mental health applications are particularly likely to have no privacy policy at all. Patients nowadays often use unproven commercial applications for SMI that don't even comply with industry norms. It's not a novel concept, but SMI is now making good on the promise of employing digital technology like applications to improve global mental health. That reality has been established by early experiences with COVID-19, necessitating that healthcare systems aim to fast keep up with patients' advancing technological requirements. For example, schizophrenia has a long history of pioneering work in mobile mental health, and this trend will only increase in the near future, fueled by the COVID-19 problem, until mobile and tele-digital health complement, if not threaten, the status quo.

Those who have experienced or are currently dealing with mental health disorders like anxiety or depression are the most likely to use digital mental health apps (Martin *et al.*, 2020). Some people may be more vulnerable due to experiencing both mental problems and social issues simultaneously. People in the midst of a serious emotional crisis, such as anxiety, who are currently financially fragile and who lose their jobs as a consequence of the epidemic may be more prone to forsake pricey premium in-person mental health therapy in favour of a cheaper, though frequently unvetted, mental health applications. They may be less able to evaluate or use a psychological health app efficiently if they are depressed or unemployed, or to make an informed decision about the preservation of mental privacy.

If using apps for mental health becomes more commonplace during the epidemic, then this trend may continue even after the outbreak has passed. In the event that health insurance providers follow the trend of pushing the use of health applications as a cost-efficient alternative to in-person therapy, it will be essential that apps only get reimbursement if they deliver effective care. For example, The Digital Health Act in Germany, which was enacted with the goal of increasing the utilisation of virtual care tools during pandemic, serves as a model for addressing these concerns because it mandates that businesses provide evidence of the products' safety and effectiveness before they are granted permission to receive reimbursement. A legislation that is similar to this one might assist create a more uniform framework for the assessment of digital health devices and guarantee that consumers have access to goods that are risk-free.

We are aware that the The World Health Organization (WHO) has declared the coronavirus illness known as COVID-19 a public health emergency that poses a risk to people all across the world (van Deursen, 2020). During this time of emergency, there has been a lot of discussion on the public's need for information and communication through the internet. The study conducted on the topic of digital inequality has proven that internet access does not have an equitable distribution among the general populace. A prominent worry among academics and policymakers on both the national and international levels is the existence of digital inequality. Using the continuing COVID-19 situation as a setting for empirical investigation, the purpose of this contribution was to give a more comprehensive knowledge of what would take place in the event of a global health pandemic. In a health pandemic, persons who are already more privileged are more likely to take up the information and interaction possibilities given by the world wide web to their benefit, while others who have less advantages are less likely to profit from using these resources. As a result, the COVID-19 dilemma is contributing to the perpetuation of preexisting inequality.

It is also possible that persons of various races, languages, ethnicities, and cultures may not get the most benefit from using informational and therapy applications (Chen, Szolovits & Ghassemi, 2019). The lack of multicultural and racial diversity among physicians and therapists may create hurdles to mental health treatment even when patients are connected with providers through digital means.

The unavailability of technology, low levels of digital literacy, and inconsistent internet connectivity are the main obstacles for patients to use telehealth (Velasquez & Mehrotra, 2020). Older persons of colour and those with lower socioeconomic position are disproportionately affected by the digital gap, which is the sum of these obstacles. These challenges are made even more daunting by the fact that an increasing number of physicians are opting to shut down their outpatient clinics in favour of providing treatment solely from the comfort of their own homes through electronic means (e.g., email, phone, and video chat) with their patients. In addition to the digital gap, there is mounting evidence that persons of colour and the elderly are more vulnerable to the health consequences of COVID-19. It's easy to lose sight of those who aren't a part of our high-tech culture when time is of the essence. To those of us who use computers every day, the concept of having one in one's house may seem silly, but for many Americans, it is invaluable, and it is an absolute need in a country that must work toward health care equity. Ability to utilise technology effectively is equally important. Health and community systems at the federal, state, and local levels, as well as the private sector, must work together to advance health equality by addressing issues of digital technology, awareness, and coverage. What they do now might help ensure those who are most helpless are not forgotten in this time of need.

CONCLUSION

Although there is still no final solution to the ethical problems of confidentiality, equity, openness, and responsibility, I hope to have shown through this brief analysis that why it is a matter of great importance that we take principles of justice, fairness and a deep respect for human dignity when we are trying to determine if new rules are required to preserve privacy and maintain openness, or whether current standards may be modified to achieve the same ends. And this clearly implies that the disparities in digital care delivery may be avoided if policy is created in close collaboration with those who will be directly affected by the change. Moreover, fairness demands that the our policies must reflect that we are giving high priority to the concerns of most disadvantaged groups, in our case mental patients, especially in these difficult times.

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