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Ethics in the Time of Coronavirus: Engaging the Conversation In Reply to Hai and Colleagues



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We appreciate the feedback and thoughtful discussion offered by Dr Hai and colleagues. We are pleased our paper is generating meaningful conversations as we all move through this uncharted territory of ethical conundrums created by the COVID-19 pandemic. As Dr Hai and colleagues point out, we are certainly aware of the differences

between the HIV/AIDS epidemic of the 1980s/1990s and the current COVID-19 pandemic. The COVID-19 pandemic exceeds what any of us have seen, and therefore requires learning from all similar healthcare crises in history. We chose to focus on the AIDS epidemic because it is timelier than the 1918 Spanish Flu pandemic. In addition, we wanted to reference an ethically suitable precedent rather than a clinically similar disease process, although both would have been ideal points of reference. The H1N1 flu did not disrupt clinical care to the same extent as COVID-19, and the Spanish flu was sufficiently long ago that current ethical standards would be quite different from those at the time. Neither public health nor medical ethics had been institutionalized in either medical practice or in residency training a century ago. From a public health perspective, however, both are instructive.

Dr Hai and colleagues raise an important distinction when they point out different expectations of duty for medical students and trainees. We wholly agree that medical students are under no obligation to provide care to COVID-19 patients. Residents, however, have formally entered the learned profession of medicine, having implicitly and explicitly dedicated themselves to prioritizing patients' interests above their own. There are certainly limits to such expectations. The same argument that protects attending physicians from attempting "suicide missions" holds true for trainees. Trainees should not be expected to provide care without appropriate personal protective equipment (PPE) or without sufficient safety training. We agree that when the availability of PPE is limited, minimizing the number of encounters with a patient makes practical sense, and therefore might guide institutional measures. One more consideration with regard to the possibility of requiring less of residents than of attendings would be that residents do not yet have the financial security of attendings, and therefore represent a vulnerable sub-group among physicians. We counter that the federal government, the source of funding for residents in training, should take actions like the programs enacted to protect injured first responders after the September 11th attacks on the Twin Towers.

We share the urgency expressed by Dr Hai and colleagues in defending a cautious introduction of off-label medications in caring for COVID-19+ patients. We did not intend to suggest any ulterior motive in doing so. However, we did intend to encourage researchers and caregivers to resist a "What have you got to lose?" promotion of therapy or prevention minus reliable scientific foundation. Analogous to keeping one foot braced on solid ice while testing the thinness of the ice ahead, we

must not sacrifice our still fragile research standards in our efforts to help frightened patients. Expedited approval—which is established for research that is known not to put participants at risk—is inherently dangerous when the result is relaxed research accountability. One guard against serious therapeutic misconception would be to focus patient discussions on what is not known more than on what might result. We must not forget the failed polio vaccine and the thalidomide tragedies.

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Beware of Time Delay and Differential Diagnosis when Screening for Symptoms of COVID-19 in Surgical Cancer Patients



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We read with interest the original paper by Forrester and colleagues¹ and would like to congratulate the authors on producing an operational algorithm for operating room team members' protection. At the National Institute of Oncology of Rabat, we share the same guiding principles for team safety. However, we would like to draw attention to time-delay risk on screening symptoms for novel coronavirus (COVID-19), especially in cancer patients.

Indeed, we consider breast surgery a low-risk procedure. When surgical side effects occur, it becomes an urgent operation, which allows a delay of few hours, to admission to the operating rooms as an urgent low-risk procedure.

We report a case of a young woman in need of urgent operation for surgical site infection with negative screening symptoms at admission to the surgical ward. When she was admitted to the operating room, a fever was discovered and linked to the breast disease, and surgery was allowed with standard surgical attire and protective equipment for the operating room team. Afterwards, in the recovery room, there was a de novo worsening clinical respiratory condition, in addition to a thorough anamnestic investigation, at which time the patient revealed a contact situation and exposure to a COVID-19-positive patient in the family.

This case illustrates 2 problems. First, frequently in urgent surgery, a delay (sometimes of several hours) may occur between diagnosis and admission to the operating

room. Second, many urgent surgical diagnoses can occur with fever or respiratory difficulty linked to infection, inflammation, or bowel distension.

In conclusion, in low-risk COVID-19 urgent surgical procedures with an initial negative symptom screen, we recommend carrying out a new symptom screening before each patient movement. Second, during phase 2 of the COVID-19 outbreak, we recommend considering COVID-19 as a differential diagnosis, especially within risky conditions like urgent surgical procedures in cancer patients.

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Gun Violence and Lawful Self-Defense



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The article by Manley and colleagues¹ has laudably analyzed FBI files concerning gun-related homicides during a 37-year period ending in 2016. They advocate that surgeons, as healers, should support ongoing research aimed to reduce firearm-related violence.

The authors imply that because only 1.8% of gun-related homicides (239 per year) were categorized officially as justifiable, that is, with a felon killed by a private citizen, presumably in self-defense, that more vigorous research is needed to validate the argument of the pro-gun lobby that “good guys” with guns are needed to protect against “bad guys” with guns. Although gun-related deaths in self-defense events are few compared with overall gun deaths, the Department of Justice reported that between 2007 and 2011, 235,700 victims of nonfatal violent crime (47,000 per year) used a firearm in self-defense.² Surgeons should support law enforcement and public health interventions aimed to reduce gun-related deaths, but firearm policy must not dismiss defensive gun use as insignificant.

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