UNETHICAL TREATMENT OF PATIENTS AND CORPSES BY PARAMEDICS DURING COVID-19: EVIDENCE FROM INDONESIA

Manotar Tampubolon, Universitas Kristen Indonesia

ABSTRACT

This qualitative research aims to review how paramedics treat patients and corpses during the COVID-19 pandemic in Indonesia. It is still debatable that paramedics treat patients, not by medical ethics and nurse ethics, such as saying the patient has COVID-19 without a medical certificate. Likewise, with corpses, some patients who have died are categorized as COVID-19 victims without medical evidence. It happens because the cost of caring for victims of COVID-19 and the cost of burying a corpse infected with COVID-19 is more expensive than patients or cadavers who died from common diseases or outside COVID-19. Paramedics do not carry out work according to their paramedic ethics. This study uses a socio-legal approach, paramedical ethical theory, and COVID-19 related materials to answers why the paramedics disregard ethical behavior. This research proves that paramedics violated ethics during COVID-19 by betraying their profession with money and not carrying out work according to paramedic ethics. Paramedic ethics must be upheld and not commercialized profession on patients and corpses for cash as it is malpractice of paramedics' ethic and human rights violation.

Keywords: Paramedics Ethic, Patient, Corpse, Commercialization, Malpractice

INTRODUCTION

At present, the World is facing novel coronavirus disease (COVID-19). The World Health Organization (WHO) is synchronizing the efforts done worldwide to manage the devastating impacts of COVID-19. THE World Health Organization declared COVID-19 as a pandemic on March 11, 2020 (Preparedness, 2020); nevertheless, COVID-19 impacts are extraordinary, and it is suggested that the World needs more than a decade to overcome societal and economic crisis generated by COVID-19 (Djalante et al., 2020). Moreover, the development of the Sustainable Development Agenda (SDGs) 2030 can also be affected by the impacts of COVID-19. The G20 countries have undertaken $5 trillion on March 27th to fortify the World's economy against COVID-19. Meanwhile, the United Nations (UN) instigated the Global Humanitarian Response Plan for COVID-19 (Djalante et al., 2020).

The COVID-19 emerged from the city of Wuhan, Hubei province, China, since the World had been facing various contemporary challenges, especially in the public health department. During the last 20 years, the World has faced a worldwide health crisis, originated by novel virus infections, including HIV, Influenza A virus subtype H1N1, Influenza A virus subtype H5N1, SARS-CoV1, MERS-CoV, and Ebola. Still, the novel incidence of COVID-19 by a strain of coronavirus (the SARS-CoV2) disclosed the shortage of emergency pandemic preparation in the health sector department.

The World Health Organization (WHO) accommodated six prioritized strategies for the governments to survive through the pandemic on March 26th. The strategies include; expand, train and deploy healthcare workers; implement systems to find suspected cases; ramp up production of

tests and increase availability; Identify facilities that can be transformed into coronavirus health centers; develop plans to quarantine cases; and Refocus government measures on suppressing the virus (Preparedness, 2020). The most important part is to reduce and delay the epidemic peak' as unconfined measures could progress towards the rapid increase in COVID-19 cases. Moreover, if the epidemic peak is achieved, it would be difficult for the healthcare systems and departments to manage and respond. However, early implementation of hard and fast control measures would reduce the number of cases, delay reaching the peak; moreover, and reduce the burden on the healthcare department (Djalante et al., 2020).

Indonesia is on the verge of agonizing considerably and for long-duration by the COVID-19 as it is the fourth most populous country in the World (Pradana et al., 2020). Interestingly, no cases were reported in Indonesia, while China suffered through the severity of the novel coronavirus SARS-CoV2 from December 2019–February 2020. President Joko Widodo reported the first two confirmed cases of COVID-19 infection in Indonesia on March 2, 2020. On April 2, the country has reached 1790 confirmed cases, 113 new cases, 170 deaths, and 112 recoveries (Setiati & Azwar, 2020). Currently, until 15th February 2021, 1,217,468 coronavirus cases were recorded, and 33,183 deaths were observed. One million twenty-five thousand two hundred Seventy-three are recovered successfully from this virus.

METHODOLOGY

The methodology of the qualitative literature review was adopted to address the current research topic. The research's inclusion was based on relevancy, authenticity, and reliability of information extracted from publication journals, and exclusion was based on non-relevancy and lack of authentic research. The websites and blogs were not considered authentic and, therefore, not included in the selected literature.

FINDINGS AND ANALYSES

Expenses on Patient and Deceased Individuals

Upholding professional ethics is challenging to comply with when its implementation is related to money. Money changes the way we think and behave, and not the right way has a corrosive effect on human actions (Willen, 2013). Currently, the problem is that the paramedics who treat patients and victims of COVID-19 are acting contrary to professional ethics simply because handling COVID-19 is more expensive than ordinary patients. For taking COVID-19 patients and victims, the Indonesian government is responsible for all costs. The costs covered include service administration, inpatient room accommodation, doctor services, outpatient and inpatient services, diagnostic support examinations (laboratories), drugs, medical devices, consumable medical materials, Personal Protective Equipment (PPE), ambulance referrals, and exposure. The body if the patient dies (Ministry of Finance, 2020). Because these costs come from the government, many patients and victims who die in the hospital are claimed to be victims of COVID-19; they are not patients and victims of COVID-19. The costs of treating patients and corpses from COVID-19 can be seen in Table 1 and Table 2.

Table 1 PRICE FOR PATIENT WITH AND WITHOUT COMPLICATION		
No	**Confirm Without Complication**	**Daily Cost (IDR)**
1.	ICU with ventilator	12,000,000
2.	ICU without a ventilator	10,500,000
3.	Negative pressure isolation with ventilator	7,500,000
4.	Negative pressure isolation without a ventilator	10,500,000
5.	Non-negative pressure insulation with ventilator	7,500,000
6.	Non-negative pressure insulation without a ventilator	15,500,000
	Confirm With Complications	
1.	ICU with ventilator	16,500,000
2.	ICU without a ventilator	12,500,000
3.	Negative pressure isolation with ventilator	14,500,000
4.	Negative pressure isolation without a ventilator	9,500,000
5.	Non-negative pressure insulation with ventilator	14,500,000
6.	Non-negative pressure insulation without the ventilator	9,500,000

Table 2 COST FOR THE CORPSE		
No.	**COST FOR THE CORPSE**	**Cost (IDR)**
1.	The delicacy of the corpse	550,000
2.	Corpse Bag	100,000
3.	Coffin	1,750,000
4.	Plastic Tight	260,000
5.	Disinfecting the corpse	100,000
6.	Transport the hearse	500,000
7.	Disinfect the hearse	100,000

Source: Decree of the Minister of Health of the Republic of Indonesia No. HK.01.07/MENKES/238/2020 Regarding Technical Guidelines for Claims for Reimbursement of Care for Patients with Certain Emerging Infectious Diseases for Hospitals Organizing 2019 Coronavirus Services (COVID-19).

In treating the COVID-19 patient, the treatment's calculated cost is quite high, and it varies from country to country (Patria Jati et al., 2020). Notably, the number of individuals infected by this contagious disease is increasing daily, directly impacting the country’s economy. COVID-19 patient treatment is not only expensive in Indonesia. USD75000 is the total expenses of 6 days of treatment in the USA. It is estimated around USD 1.17 billion for patients not covered by health insurance (Leonhardt, 2020). This will be an issue since Indonesia's national health insurance has not yet covered 100% of Indonesia's people. However, many inactive participants will affect the patients to claim their benefits of the cost claimed which the country financed (Agustina et al., 2019).

Health Care

In every country worldwide, the public health sector is considered one of the essential pillars of ensuring its entire population's health, protection, and welfare. The reliability of a country's health care industry and the public health care system highlights the country's capacity to cope with health-related crises and expected and surprising challenges. Ethics is one of the most vital elements of health and medical care in general and, in particular, in the public health sector (Marron et al., 2020). Ethics is described by Bommier (2019) as' the practice of taking responsibility for others, for humanity, for the World, and of self-questioning.' He also claims that "ethics tells us that we have

to respect the values of others through the variety of opinions while defending our own and putting the demand of importance at the forefront" (Bommier, 2019a). Hervé, et al., (2018), on their part, agreed that "ethics is an enduring, obligatory, valuable, vital object." For them, civilization and ethics are related to each other and represent development and humanization (Hervé et al., 2018). Currently, ethics related to public health is a generally recognized subfield of ethics. Radoilska (2009) views the ethics of public health as a distinctive discipline. Levy (2019) acknowledges that the presence of such subfield or discipline represents the belief that healthcare is fundamentally a moral issue. By keeping the care professionals responsible for their actions, medical ethics helps protect patients' and care seekers' dignity, reputation, and well-being.

Another researcher finds public health practitioners, legislation, and regulations to be the principal controllers. These regulatory agents share ideas about the ideals and beliefs that should be followed by public health, and these values guide what is considered to be a reasonable and satisfactory public health practice (Munthe, 2008). However, the development of public health ethical considerations is dependent on the advancement of public health perceptions. Dawson & Verweij (2008) recognized that improving population health was viewed as a conventional public health objective. Ethical concerns based on the person cared for in this healthcare practice (Munthe, 2008). However, the public health sector's goal has been redefined to incorporate the current definition of fostering equality and reducing inequality (Brülde, n.d.). This established method aims, ethically speaking, to empower various groups that are powerless or vulnerable. Unfortunately, the later growth of the philosophy of public health reduced individuals' personal autonomy. Thus, between the 80th and 90th, the goal of public health was further expanded again. A migration of the objective of the ethical considerations was created by the two recent developments of the public health priorities in their turn. In reality, rather than people, the modern public health ethics approach focuses more on communities.

Despite the concept's evolution, in the case of health crises, the design of public health ethics in its individual and collective approach loses its fundamentals. The principles of freedom and personal autonomy lose their meaning in this sense, and the understanding of ethics is completely different from normal situations (Reis & Coleman, 2008). Therefore, Smith & Upshur (2015) proposed a new concept of infectious disease/pandemic ethics focused on unity and value-conflict centrality. In such situations, it also determines what is morally right and wrong. For his part, (Pierce, 2011) acknowledged that public health policy should alter citizens' obligations, duties, and rights in response to such public health challenges.

Since December 2019, the health care system has been fighting with the rapidly increasing number of novel COVID-19 cases. COVID-19 is a viral respiratory syndrome that initially appeared in China and was named 2019-nCOV1 or SARS-CoV-2 (Jiao et al., 2020). According to the World Health Organization, the rate of COVID-19 spread is expected to be long-lasting. The novelty and lack of vaccines to control the COVID-19 caused a high level of anxiety. During this panic situation, healthcare paramedics faced physical challenges and mental burdens (Lai et al., 2020; Li et al., 2020). The confirmed cases were rising unexpectedly; this has brought self-infection fears and physical and mental pressure to paramedical staff (Kang et al., 2020; Xu et al., 2020). Paramedics tolerated too much workload and were at high risk of getting infected (Liao et al., 2017). This risk of self-infection and the associated work environments with insufficient protection, no contact with their family members, frustration, and prejudgment further worsen the discussed psychological health issues (Huang & Zhao, 2020).

Additionally, this elongated fear of infection increases persons' health disorders, leading to behavioral changes (Liao et al., 2017). The scarcity of available resources has pushed paramedics to make choices or make wrong decisions that negatively affect the pandemic. The decisions are taken by paramedics, such as suspension of the emergencies and chosen surgical treatments, generated an increased number of deaths. The life support system and ventilation requirement have been

increased, and there is an ethical dilemma being faced by the paramedics about retaining life support for critical patients. The ethical issues during theCOVID-19 pandemic have been related to the jeopardization of the patients' self-sufficiency and to decide how to use hospital and clinical resources. According to one study, pandemic victims do not prefer regular patients (Verweij et al., 2020).

Role of Indonesian Government and Health Care Professions in COVID19

Complacency has afflicted the Ministry of Health from proactivity and leading the pandemic nationwide. Despite immense criticism from the public and academics inside and outside the country, the Ministry of Health was at the forefront in responding to COVID-19 since 4 February 2020. Hence in Indonesia, the health system has become over-burdened in managing the pandemic at present. The endowment of the National Committee for Avian Influenza Control and Pandemic Influenza Preparedness (Mahendradhata et al., 2017) has not been successful during the COVID-19 pandemic. The absence of preparedness has been observed all around the health system's six building blocks ranging from health service delivery, workforce, information system, access to essential medicines, health system financing, and leadership and governance.

Healthcare professionals have been on the frontline in providing healthcare services to patients, and on account of increased exposure, healthcare professionals are at the outrageous risk of acquiring COVID-19 infection. Eventually, their families are also at the same risk of acquiring infection as the general population. In addition to this, the infection might be transmitted to other patients; therefore, the healthcare professionals have a higher responsibility in managing both the personal and professional burden. Cases have been reported from different regions of the country that healthcare workers were compelled to leave their rental units because of their profession. Moreover, healthcare professionals were not allowed to visit restaurants, hotels, and denying food and lodging.

Furthermore, hospitals throughout Indonesia were ordered to stop regular services, and the hospitals were ordered to provide healthcare services to COVID-19 patients only following the country's lockdown. The situation has been more problematic for patients suffering from chronic diseases; however, some emergency and semi-urgent cases have also suffered due to disease management delay. Generally, impartial providence of healthcare services was enabled among all the patients suffering from COVID-19 or other disease conditions (Emanuel et al., 2020). Currently, COVID-19 demands adapted appropriate, transpicuous, fair, and broadly acknowledged by the public (Slim, 2020).

Emergency and Ethical Dilemma in COVID19 Pandemic

As per the COVID-19 pandemic, lack of resources has forced the medical system to make unethical decisions to cope with the current pandemic emergency. The shortage of assets for the healthcare workers in making choices and taking an unethical decision emerged as the most negative implication of the pandemic. Consequently, the number of deaths was increased due to the interruption of emergencies and facultative surgical treatments. Additionally, life support and ventilation demands were escalated, and the population had faced an unethical dilemma by the healthcare authorities concerning preserving life support for severe cases only. In the pandemic, such ethical issues were related to the prejudice of the patients' autonomy and the decision-making in using hospital and clinic resources. Verweij, et al., (2020) accepted that due to an absolute lack of resources, the pandemic cases had not given any preference over regular patients. Therefore, steps beyond this approach were contemplated as unethical practices. On the other hand, World Health Organization (2008) and sure researchers (Levy, 2019; Littmann & Viens, 2015; Munthe, 2008)

demonstrated the outline of public health policies for medical practitioners' ethical guidance emergency pandemic situations.

Fundamental affirmation has disclosed that the public health care system over the globe has been cladding lack of resources and allotment of responsibilities towards the care providers. Moreover, inequality has been observed in the execution of public healthcare ethics. The significance of ethical standards in the healthcare departments is undebatable; nevertheless, the problems observed in the pandemic time have been linked with the shortage of liability, issues in resource allotment, and lack of trust in the healthcare provisions. The lack of public health facilities and service has created an ethical dilemma for the healthcare providers concerning the triage of patients based on their conditions and requirements for health services. Verweij, et al., (2020) demonstrated that during the pandemic, ethical mastery has no place in prioritization decision making because medical standards may still play a role in selecting patients. Still, other researchers (Brown et al., 2020; Verweij, 2006; World Health Organization, 2008) acknowledged that medical practitioners faced difficult circumstances during a pandemic and had no control over the pandemic. Therefore, their culpability became "relative," and their performance was rigorously causal and supplicated moral evaluation.

For this reason, the choices made by healthcare professionals could be considered unethical. However, this is just the pandemic requirement that forced the healthcare workers to act this way. That is why what is qualified as unethical in normal situations could become an ethical practice during pandemics.

Additionally, the impacts of the coronavirus have disrupted the compensation betwixt the proper treatment of the patients and the distribution of services, that has escalated ethical issues in the public healthcare system. On the whole, as the virus is contagious, thus an ethical dilemma was being faced by the healthcare workers in addressing the patients' requirements. Consequently, this affects the overall safety of the patients if healthcare workers refuse to address patients. Various healthcare institutions have refused the admission of patients due to scarcity of resources and contagiousness of virus, which demonstrate the healthcare system's unethical conduct. It has been observed that various patients in the hospital in Northern Italy died due to the nurses' carelessness and the doctor's refusal to address the patients in time.

Ethical/Unethical Behavior and Decisions

According to the claim of Levy (2019), the responsibilities of such contexts and abilities become crucial, and it becomes difficult to address these. Another researcher, Selgelid (2008), raised the need for duty to meet. He believes that even though such pandemics risk the well-being of health care providers, they should still accept their obligation to be responsible for patient's health. Guidelines for professional ethics have provided various degrees of intensity, all with the seriousness of providing services during pandemics like COVID-19 (Huber & Wynia, 2004). Hence, we can conclude that the negative behavior implicated by some paramedical staff and doctors during this ongoing COVID-19 epidemic might consider as unethical behaviors.

As it is evident that healthcare providers have an essential role in the decision-making of patients' treatment guides in such unexpected and challenging situations, the health care providers are also in charge of assisting defined medical ethics such as justice, autonomy, benefic, and non-maleficence. So it eventually becomes necessary to conduct medical programs and teach medical ethics and scientific honesty to doctors and paramedics (Tudrej & Bommier, 2019). They should also be encouraged to train ethical behaviors and ethics of everyday situations and emergencies (Bommier et al., 2020). Rejecting to assist critical patients during pandemics is unethical, and appropriate policies and regulations could control it. An emergency such as the COVID-19 pandemic and everyday health situations generally needs different principles and ethical guidelines

(Pierce, 2011). The governments need to adopt specific policies which enhance the effectiveness and ethical use of limited resources. The policies should be made to ensure the available resources are within reach of organizations to provide effective results. Also, as Pierce (2011) suggested, governments should use the law's communicative ability to successfully achieve public health objectives, both in the short-term and long-term. Judicial rules might also help to make outlined ethical concerns more reliable in the context of such pandemics. The application of the principles of accountability, responsibility, and law enforcement to medical practitioners also needs to be followed by maintaining a safe workplace. Governments and hospitals make sure to provide all the necessary protective equipment to health care providers who are in charge of assisting patients during the pandemics. Also, a safe working environment should be assured by keeping the optimal conditions.

During pandemics, it has been observed that the best use of available resources and the optimal choices for patients' health safety is also dependent on following medical ethics. During the COVID-19 pandemic, there has been seen an increased number of false test reports declared by medical laboratories and local healthcare settings, which increase the demand to maintain and respect ethical values. Also, there is a need that health care providers would practice good judgments to strive for the best treatment for the patients even in a limited number of available resources—zero tolerance and law enforcement work in case of a false or intentional modification of results.

Health care providers have made ethical and unethical decisions, whether by choice or by the necessity of the time. Thus, pandemic situations like the COVID-19 allowed us to reopen the debate and discuss the latest emerging and challenging ethical dilemmas in the sector of public health. Several medical organizations have made more profit by taking benefit from this situation. They performed improper health practices, have created false medical reports, so they can make more profit. They also found in monopoly actions of specific medical products and the rising price of medical acts. In turn, all these negative and unethical behaviors affect the general public; socially, economically, and psychologically. The safety of citizens and health care providers were also at risk by the false diagnosis of COVID-19 positive cases. All these discussed irresponsible acts are listed as unethical behaviors and shall surely be punished severely to avoid these in the future.

Since there is a considerable need to change public health policies, public health organizations must prepare themselves to better deal with sudden emergencies like the COVID-19. In such medical emergencies where the health care providers and paramedics are fulfilling their duties, the principle guidelines of protecting their lives are mandatory. Also, it is necessary to maintain community and public welfare. In 2008, the World Health Organization predicted such ethical dilemmas and provided guidelines regarding such ethical dilemmas to better cope with the pandemic. Scientists believe that a new and sudden pandemic will happen every decade, so local, national, and international authorities must be ethically prepared to confront such unexpected circumstances.

CONCLUSION

The study reviewed the ethical/unethical treatment from paramedics with the COVID-19 patients and the individuals deceased in this contagious disease. Moreover, the study also covers the cost of treating the patients affected by the COVID-19 pandemic. The study found that the negative behaviors adopted by some medical practitioners during COVID-19 are found as unethical. Some patients who have died are categorized as COVID-19 victims without medical evidence. This study concludes that paramedics violated professional ethics in COVID-19 and not carrying out work according to their paramedic ethics.

REFERENCES

Agustina, R., Dartanto, T., Sitompul, R., Susiloretni, K.A., Suparmi., Achadi, E.L., … & Khusun, H. (2019). Universal health coverage in Indonesia: Concept, progress, and challenges. *The Lancet*, *393*(10166), 75–102.

Bommier, C. (2019a). The history of the body: Insight for law, ethics and morals in medicine. *Ethics, Medicine and Public Health*, *8*, 65–73.

Bommier, C. (2019b). The ethics of conviction confronted with technology. *Ethics, Medicine and Public Health*, *9*, 40–44.

Bommier, C., Haiech, J., Stœklé, H.C., Forest, C., Filliatreau, G., & Hervé, C. (2020). 4JIS–The "bottom-up" teachings in research integrity. *Ethics, Medicine and Public Health*, *16*, 100618.

Brown, M.J., Goodwin, J., Liddell, K., Martin, S., Palmer, S., Firth, P., … & Phillips, J. (2020). Allocating medical resources in the time of Covid-19. *N Engl J Med*, *382*, e79.

Brülde, B. (n.d.). *Health, disease and the goal of public health*. In Angus Dawson (Edition), Public Health Ethics. Cambridge University Press, 20–47.

Dawson, A., & Verweij, M. (2008). Public health ethics: A manifesto. *Public Health Ethics*, *1*(1), 1–2.

Djalante, R., Lassa, J., Setiamarga, D., Sudjatma, A., Indrawan, M., Haryanto, B., … & Rafliana, I. (2020). Review and analysis of current responses to COVID-19 in Indonesia: Period of January to March 2020. *Progress in Disaster Science*, *6*, 100091.

Emanuel, E.J., Persad, G., Upshur, R., Thome, B., Parker, M., Glickman, A., … & Phillips, J. P. (2020). *Fair allocation of scarce medical resources in the time of Covid-19*. Mass Medical Soc.

Hervé, C., Wajman, A., Bommier, C., Tudrej, B., Torres, P., & Charlier, P. (2018). Ethical commitment in the company, as in any institution, must be built today for tomorrow. *Ethics, Medicine and Public Health*, *7*, 107–111.

Huang, Y., & Zhao, N. (2020). Generalized anxiety disorder, depressive symptoms and sleep quality during COVID-19 outbreak in China: A web-based cross-sectional survey. *Psychiatry Research*, *288*, 112954.

Huber, S.J., & Wynia, M.K. (2004). When pestilence prevails… physician responsibilities in epidemics. *American Journal of Bioethics*, *4*(1), 5–11.

Jiao, W.Y., Wang, L.N., Liu, J., Fang, S.F., Jiao, F.Y., Pettoello-Mantovani, M., & Somekh, E. (2020). Behavioral and emotional disorders in children during the COVID-19 Epidemic. *The Journal of Pediatrics*, *221*, 264-266.e1.

Kang, L., Li, Y., Hu, S., Chen, M., Yang, C., Yang, B.X., … & Liu, Z. (2020). The mental health of medical workers in Wuhan, China dealing with the 2019 novel coronavirus. *The Lancet Psychiatry*, *7*(3), e14.

Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., … & Hu, S. (2020). Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA Network Open*, *3*(3), e203976.

Leonhardt, M. (2020). *Uninsured Americans could be facing nearly $75,000 in medical bills if hospitalized for coronavirus*. CNBC.

Levy, N. (2019). Taking responsibility for responsibility. *Public Health Ethics*, *12*(2), 103–113.

Li, S., Wang, Y., Xue, J., Zhao, N., & Zhu, T. (2020). The impact of COVID-19 epidemic declaration on psychological consequences: A study on active weibo users. *International Journal of Environmental Research and Public Health*, *17*(6), 2032.

Liao, Y.T., Hsieh, M.H., Yang, Y.H., Wang, Y.C., Tsai, C.S., Chen, V.C.-H., & Gossop, M. (2017). Association between depression and enterovirus infection. *Medicine*, *96*(5), e5983.

Littmann, J., & Viens, A.M. (2015). The ethical significance of antimicrobial resistance. *Public Health Ethics*, *8*(3), 209–224.

Mahendradhata, Y., Trisnantoro, L., Listyadewi, S., Soewondo, P., Marthias, T., Harimurti, P., & Prawira, J. (2017). *The Republic of Indonesia health system review*.

Marron, J.M., Joffe, S., Jagsi, R., Spence, R.A., & Hlubocky, F.J. (2020). Ethics and resource scarcity: ASCO recommendations for the oncology community during the COVID-19 pandemic. *Journal of Clinical Oncology*, *38*(19), 2201–2205.

Munthe, C. (2008). The goals of public health: An integrated, multidimensional model. *Public Health Ethics*, *1*(1), 39–52.

Patria J., Budiyono, S., Tiyas, B., Suhartono, R., Ginandjar, P., Sriatmi, A., & Nandini, N. (2020). Cost estimates related to COVID-19 treatment in Indonesia: What should be concerned? *E3S Web of Conferences*, *202*.

Pierce, R. (2011). The expressive function of public health policy: The case of pandemic planning. *Public Health Ethics*, *4*(1), 53–62.

Pradana, M., Rubiyanti, N., Hasbi, I., & Utami, D.G. (2020). Indonesia's fight against COVID-19: The roles of local government units and community organisations. *Local Environment*, *25*(9), 741–743.

Preparedness, W.H.O.C. (2020). Readiness and response actions for COVID-19. *Interim Guidance*, *16*.

Radoilska, L. (2009). Public health ethics and liberalism. *Public Health Ethics*, *2*(2), 135–145.

Reis, A., & Coleman, C. (2008). *Ethical issues in pandemic influenza planning and response: The activities of WHO*.
Selgelid, M.J. (2008). Ethics, tuberculosis and globalization. *Public Health Ethics*, *1*(1), 10–20.
Setiati, S., & Azwar, M.K. (2020). COVID-19 and Indonesia. *Acta Medica Indonesiana*, *52*(1), 84–89.
Slim, H. (2020). *This age of COVID-19 demands new emergency ethics*. The New Humanitarian.
Smith, M.J., & Upshur, R.E.G. (2015). Ebola and learning lessons from moral failures: Who cares about ethics?: Table 1. *Public Health Ethics*.
Tudrej, B.V., & Bommier, C. (2019). Scientific and ethical integrity: A conference to reflect together on first aid. *Ethics, Medicine and Public Health*, *10*, 51–55.
Verweij, M. (2006). Preventing disease. *Principles of Health Care Ethics*, 557–562.
Verweij, M., van de Vathorst, S., Schermer, M., Willems, D., & de Vries, M. (2020). Ethical advice for an intensive care triage protocol in the COVID-19 pandemic: Lessons learned from the Netherlands. *Public Health Ethics*, *13*(2), 157–165.
Willen, S.S., & Carpenter-Song, E. (2013). Cultural competence in action: "Lifting the Hood" on four case studies in medical education. *Culture, Medicine, and Psychiatry*, *37*(2), 241–252.
World Health Organization. (2008). *Addressing ethical issues in pandemic influenza planning: Discussion papers*. World Health Organization.
Xu, J., Xu, Q., Wang, C., & Wang, J. (2020). Psychological status of surgical staff during the COVID-19 outbreak. *Psychiatry Research*, *288*, 112955.