LETTERS

Urgent need to tackle Covid-19 impact on academic research in India.

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The government of India imposed a strict nationwide lockdown on March 24, 2020, to arrest the spread of Covid-19 (1). Abiding by the government regulations, several educational institutions including those in healthcare, postponed or cancelled several academic activities to curb the spread of the virus (2). Considering the high risk of infection transmission, several academic research projects involving human participants were paused. This has posed serious challenges in managing academic tasks such as teaching and learning activities related to research, participant examination and follow-up, field work for data collection, face-to-face discussion with colleagues, students and supervisors. Many academic healthcare research activities involve human subjects as research participants; but because of the lockdown, final year post-graduate students may not be able to complete their research projects within the stipulated time frame. Healthcare students are in a vulnerable situation because of the pressure to submit their research projects for the successful completion of the courses. Given this situation, it is probable that students may resort to unethical or fraudulent research activities such as data manipulation or fabrication to complete their research projects before the existing deadline. Such research, if published in the future, can damage the credibility and validity of the scientific evidence.

Therefore, there is an urgent need to proactively evaluate this delicate situation, supervise, and recommend alternate best practices. The major responsibility rests now with medical universities and apex bodies such as the University Grants Commission, National Medical Council, Dental Council of India, Ministry of AYUSH, and Indian Council of Medical Research which directly or indirectly regulate academic research activities in the healthcare institutions of India.

Anticipating the high probability of fraud in academic research projects of healthcare students, we would like to make a few recommendations to tackle the situation.

- Universities and research regulating bodies should extend the dates for research projec t submission. Already a few universities have issued a notice of extension of deadline for dissertation submission (3, 4).
- They should allow the submission of incomplete research projects (especially projects requiring human participants) for final year students who are on the verge of completion of their courses. This may lead to poor quality research submission, but it will increase transparency and reduce scientific misconduct in research projects. Though such research may not add any quality evidence to science, we should be happy that this will not harm science by publishing fraudulent research in the future.
- Universities should permit newly-admitted healthcare professional students to switch their research projects if they have already submitted the protocols and feel that it may not be possible to implement those projects in the near future, considering the uncertainty of the current pandemic situation.

These measures may not be sufficient, but are definitely necessary to reduce possible future scientific misconduct in academic research in India. We suggest that this serious issue should be debated and evaluated thoroughly by involving all stakeholders such as educationists, scientists, experts in research ethics, the relevant government authorities, policymakers, and finally healthcare students, to formulate strategies which are beneficial and also implementable.

These amendments will not only reduce the unwarranted pressure on students but will also help them in developing the sense of research integrity they need to practise in the future. We believe that, in this era, where we observe the prevalent scientific misconduct such as predatory publishing, retractions because of data manipulation, and other fraudulent practices which are very damaging to scientific evidence, we need competent researchers who are more aware of ethics and will practise research integrity.

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The Covid-19 uncertainty and ethical dilemmas in dental practice

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The Covid-19 pandemic has affected dental practice globally. Proximity with patients and predominance of aerosolgenerating procedures has raised concerns regarding the safety of dentists and patients alike. The near-total, yet inevitable, suspension of dental practice has raised several

ethical issues.

Guidelines provided by various dental bodies have opined that triaging of patients based on the urgency of dental treatment is essential (1, 2, 3). With the lockdown extending for over eight months and full-fledged dental practice yet to resume, many on-going advanced dental procedures like root canal treatments, gum surgeries, etc. which require follow-ups, have been abruptly halted. During lockdown, general dental practice has been largely restricted to provision of emergency services for acute problems, in the form of pharmacological management and tooth extractions. After delaying elective treatments during the period of lockdown, the demand for definitive dental care is now on the rise.

Guidelines from regulatory authorities and professional bodies have maintained that aerosol-generating procedures and elective dental procedures be deferred till the situation normalises or that such procedures be performed with higher levels of personal protective equipments (PPE) (1,2, 3). In such a scenario, many are forced to prescribe repeated regimens or higher grades of antibiotics for unresponsive cases, well aware that it goes against the policy of antibiotic stewardship. Also, triaging of patients or categorising of procedures as urgent and elective is generally based on the dentist's perspective (normative need). In many instances, problems deemed not urgent by the dentist may be perceived as urgent by the patient. The gap between the normative need and perceived need is a dilemma dentists face today.

Covid-19 has brought an unprecedented emphasis on infection control measures in dental practice. Recommendations by professional organisations call for several structural and work practice controls and additional investment on PPE, which may be challenging for a singledoctor or small clinics to implement immediately. Fear among dentists and unpreparedness regarding infection control measures has also contributed to delayed re-opening of dental practice.

During the lockdown, extreme caution exercised, by deferring treatment, was viewed as an ethical barter for the larger good of the community. Avoiding high-risk dental procedures and postponing elective procedures was akin to controlling the spread of Covid-19. It was also viewed as a contribution to ensure no wastage of PPEs, a precious resource already in short supply. With no definite endpoint in sight, and the harm arising from indefinitely postponing any healthcare intervention, the importance of nonmaleficence (doing no harm) and patient's rights needs to be weighed and deliberated.

Justice is a principle that has perhaps been violated ever since dental practice has been suspended. The moral and ethical duty to provide dental care for patients irrespective of age, sex, caste, disease status has been compromised. The dental safety net in India, comprised of public sector hospitals, dental schools which offer services at discounted rates, outreach programmes and budget dental clinics (4), usually meets the needs of the underprivileged,. The need for strict infection control in the form of PPE, has added to the cost of care in these places, pushing economically backward populations further away from seeking care. The added burden on the existent inequality in provision of care to the poor violates the principle of equality and justice.

The issue of autonomy or patient rights is frequently encountered in dental practice due to the availability of alternate treatments for common conditions. For example, in managing a severely infected tooth, root canal treatment (RCT) has been promoted as a better alternative in terms of post-treatment morbidity while removal of an offending tooth (extraction) has been the traditional option. RCTs are aerosol-generating procedures while extraction produce comparatively less amounts or no aerosol. The principle of autonomy is at stake if the patient demands an RCT, but the dentist wishes to perform an extraction in the best interests of the current situation and protecting himself. There is a conflict between patient preferences and dentist concerns in performing a high-risk treatment. However, in the larger realm of public good, individual benefit may be overlooked. In cases of public health emergencies, individual autonomy may be lost (5,6).

Thus, ethical decision making is a difficult proposition in these trying times. Deliberations on the ethics of dental care during the Covid-19 pandemic should impact and evolve the way we make our decisions.

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