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Review Article

Others Section

The Three "R"s-Rights, Roles and Responsibilities of Healthcare Workers during COVID-19 Outbreak in India

MONALISA BISWAS[1], VIJETHA SHENOY BELLE[2]

ABSTRACT

This article addresses the rights, roles and responsibilities of Healthcare Workers (HCW) who are frontline warriors in any pandemic outbreak. Coronavirus- 2019 (COVID-19) pandemic has emerged as international public health emergency in March 2020, and exposed the weak/failed healthcare system preparedness to respond to the pandemic threat and controlling the community spread. In India, huge population, poor economic growth and unacceptable doctor to patient ratio made swift response to emergence of pandemic, safeguarding HCWs, ability to provide care without mental and physical burn out challenging. This review emphasises the need for safety of HCW and patients, infection control, security to the family, psychosocial and mental well-being, proper allocation of medical supplies, medical ethics and communication.

Keywords: Coronavirus 2019, Ethics, Medical profession, Oath, Psychology

INTRODUCTION

Coronaviruses (family-Corona viridae) have long been considered as relatively inconsequential pathogens often causing mild cold to a Severe Acute Respiratory Syndrome (SARS). Coronavirus has challenged the world and humanity by the emergence of a highly pathogenic novel coronavirus (nCoV-2019) causing SARS in millions across the world [1]. The outcome of this global pandemic is impossible to predict, while what remains certain is that the healthcare sector is the only hope and our HCWs form the indispensable frontline warriors to help the society deal with the pandemic in the best possible way. The doctors while being responsible for combating this novel COVID-19 outbreak are exposed not only to virus but have also been challenged by trying circumstances of long working hours, physical and psychological stress and violence [2].

According to the Global Health Security Index (2019), India ranked 57 in pandemic preparedness, which emphasises the presence of various pitfalls and challenges in its healthcare system [3]. India's meagre investment in the health sector (1.3% of total Gross Domestic Product (GDP)) is now making it vulnerable to COVID-19 in contrast to other developing countries [4]. India has a severe shortage of HCWs. There is one doctor for every 1,445 Indians as per the country's current population estimate of 135 crores, which is lower than the World Health Organisation (WHO) prescribed norm [5,6].

As the emaciated Indian healthcare system attempts to break the tide of the 2019-nCoV pandemic, the frontliners face a dual challenge of playing the key role of administering healthcare to COVID-19 as well as non-COVID-19 patients along with a sea of challenges the pandemic at large and the society in specific has thrust upon them [7]. Thus, faced with debates encompassing two sides of a coin, that is overwhelming physical, mental and professional stress at one and roaring and soaring sentiments on reports of medical negligence and treatment delays on the other, this is probably the most appropriate time to revisit and redefine the current scenario of a role, rights, and responsibilities of HCWs.

RIGHTS OF DOCTORS/HEALTHCARE WORKERS (HCWS)

"So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time" [8].

The sacred Hippocratic Oath too highlights and secures the rights of the medical practitioners to lead a normal social life, a life of dignity and respect, and a life that ensures protection as well as fulfillment in all aspects.

a) Violence against HCWs

It is well acknowledged that the HCWs form a ray of hope for the patients and their families. HCWs have been perceived as the DIVINE with eternal/magical capabilities of saving and normalising lives and bringing solace to the suffering humanity. This very unrealistic perception emerges as the major reason of violence meted out to doctors and results in compromised rights of doctors to lead a normal human life.

As the doctors and HCWs are battling a vigorous fight against the unprecedented and unchartered terrains of the current global health crisis, unfortunately they are also challenged by their increasing vulnerability to violence and public frustrations. A few glaring examples include being assaulted by patient relatives/relatives of deceased to stigmatisation as the 'newer untouchables' and assault by neighbours/landlords (in the fear of contracting COVID-19 infection) and even denial of burial/last rites in events of COVID-19 deaths in doctors/HCWs.

The violence against doctors and other medical personnel has increased over the past few decades, with upto 75% doctors facing this during their practice in India [9,10]. Doctors attribute the surge in violence against HCWs to a mix of ignorance and fear, which is amplified by the pandemic [11]. The lockdown has exaggerated the problem, with patients unable to access healthcare due to transport suspension, fear of law enforcement and frustration following quarantine or containment zone restrictions. Fear, anxiety, misinformation and social media induced panic are some of the factors. Government hospitals in India are overwhelmed by the public health crisis, owing to a shortage of sufficient facilities, supplies, and infrastructure. People found it difficult to reach medical aid because the hospitals had shut down its non emergency services.

To ensure a comprehensive protection of the HCWs, further incorporations need to be made in the existing laws and strict practical enforcements of the same [12].

b) Insurance Facilities to Medical Professionals

Anticipating the deaths of HCWs, the Central government announced an insurance scheme of Rs 50 lacs to cover approximately 22 lac HCWs [13]. However, the scheme does not cover treatment costs and is limited to reimbursement in event of death (that is loss of life due to COVID-19/ accidental death on account of COVID-19 related duty). It is proving hard to even access the bereaved families of HCWs across India. Struggles range from acquiring the required documents to confusion over their eligibility and rejection of claims by the insurance company. However, reports and experiences clearly suggest that settling claims is an enormously arduous task, even if one has all the required documentation [14,15].

How do we address situations, where COVID-19 positivity could not be established due to false negative reports, or it is contracted while on duty in apparent non-COVID-19 hospital settings or if the doctor/ HCWs is a private employee or an independent clinic owner?

As pointed out by a media report, it is indeed worth reflecting on the question, "Who has the last word?". "Is the word of the hospital final?" and "Since claims get forwarded to the insurance company, by the state or the central government depending on the jurisdiction, do they conduct their own investigations?" [16].

ROLES AND RESPONSIBILITIES OF DOCTORS/ALLIED HEALTHCARE WORKERS (HCW) [17]

The pandemic of COVID-19 has witnessed doctors and HCWs serve the society tirelessly jeopardising their individual and family safety. COVID-19 is a battle which was impossible to even attempt in absence or reluctance of our HCWs. The World Health Organisation (WHO) took its lead to redefine and explicitly update the responsibilities of HCWs especially relevant to the present pandemic time. The document reads as follows, HCWs should [18]:

i. Follow established occupational safety protocols ensuring personal safety as well as safety and well-being of all and participate in Government/Employer facilitated occupational safety and health training- The organisation should provide personal protective equipments or make their employees to strictly adhere to wearing masks, prevent gathering and encourage to use e technology for meetings.

ii. Use provided protocols to assess, triage and treat patients- Ministry of Health, Government of India and State Ministry have regularly updated the protocols regarding triaging and treatment process. Indian Medical Association, AYUSH and other medical fraternity have equally contributed in these phases.

iii. Treat patients with respect, compassion, and dignity- COVID-19 positive and suspects should be treated with respect, compassion and dignity.

iv. Maintain patient confidentiality- Patient confidentiality is to be maintained; this is being strictly adhered to by most healthcare facilities where disclosure of reports is done only to concerned authority and patient relatives. However, municipal boards outside residences of patients (protocol followed at the beginning of the pandemic) seeking home isolation at the pandemic onset caused significant anxiety and distress among patients and relatives due to the social stigma associated with COVID-19.

v. Adhere to the established public health reporting procedures (for suspected and confirmed cases) - Indian Council of Medical Research (ICMR) has made it mandatory to entry COVID-19 positive reports on the website and maintained confidentiality of patients by giving coded number to the positive cases.

vi. Provide/reinforce infection prevention and control information to the general public-In local languages, in newspaper, televisions, social media and in phones information about prevention and control were given to public in the presence and absence of symptoms and risks. Electronic and print media is replete with information related to all aspects of COVID-19. A few months through the COVID-19 pandemic, many hospitals have set up telemedicine facilities which ensure public and patients are able to obtain online consultations to clarify their doubts and fears.

vii. Put on, use, take off and dispose of personal protective equipment properly-Doctors were trained to use Personal Protective Equipments (PPEs) and in local languages videos were made regarding use and disposal of PPE (donning and doffing). However, the quality of PPEs and adequate supply of PPEs remain a concern in atleast few of the health care facilities.

viii. Self-monitor for signs of illness and self-isolate or report illness to managers, if it occurs-With the increasing number of cases and lack of beds for hospitalisation, doctors, HCWs and educated people have been trained to self-monitor their illness and report in case of need. Self-help groups were created and when HCWs are affected, a set of monitoring devices, necessary goods were supplied along with moral support to the family of HCWs.

ix. Advise management if they are experiencing signs of undue stress or mental health challenges that require support interventions-Due to increasing mental health issues, Indian Medical Association (IMA) Karnataka and IMA Udupi planned for mental health cell under the guidance of psychiatrists to support COVID-19 effected HCWs. However, a lot remains to be done in the domain of providing psychosocial support to our HCWs as well as our patients and public.

The authors would like to share an experience- A technician working in the clinical lab was asymptomatic and father had symptoms of COVID-19. Primary contacts were screened and this technician turned to be COVID-19 positive. Since, enough knowledge was imparted as part of teaching practice in the lab, she immediately informed the lab in-charge and 4 technicians who were in close contact with her were home quarantined and on day 5 they were screened for COVID-19.

SHORTCOMINGS AND DEFICITS IN THE RESPONSIBILITIES OF HCWS

Deficits and shortcomings are an evitable reality in any system and the COVID-19 pandemic has brought forthhidden and less acknowledged fallacies of the healthcare system. The major shortcomings reported in the COVID-19 era include:

a) Circumstantial Challenges Threatening the HCWs

A pandemic of this stature reveals even the minute lacunae in the existing setups and brings to the fore several ethical questions (at different levels) without any straightforward answers. A deep insight on these grey/difficult areas and establishment a thoughtful and transparent standard operating protocol by the relevant stakeholders (keeping the greater benefit of the society as prime) to address these hurdles is essential to ensure safety and security of HCWs as well as the general population. These include [19,20]:

i) Allocation of scarce medical resources (ventilators, Extracorporeal Membrane Oxygenation (ECMO) etc.,) among COVID-19 patients

ii) Resource allocation between and non-COVID-19 patients (ICU beds)

iii) Regimen in acute/life-threatening conditions given the non availability of hospital beds in metropolitan cities

iv) Effective and transparent communication with patients/patient bystanders in the present mode of minimal contact healthcare delivery

v) Ensuring patient confidentiality and dealing with the burden of societal stigmatisation of COVID-19 (in face of the awareness notices put up by the municipal authorities in cases of home isolation)

vi) Delivering effective and holistic care at isolation settings

vii) Infringement of individual rights to seek healthcare in the present settings of restrictive or shut OPD (to prevent COVID-19 transmission)

viii) Adaptation to telemedicine technology and making the same accessible to mass

ix) Addressing the perils of teleconsultation as a means of healthcare delivery

HCWs face the risk of the patient frustrations resulting from these situations even though they do not have any direct involvement or decision-making powers in these aspects.

b) Medical Negligence, Apathy and Ostracisation [21]

While social distancing is this need of the hour, it is indeed unfortunate to witness the emotional oblivion and apathy which has gripped our society in this testing time. Reports of people being ostracised and hospitals refusing care and admission to non COVID-19 critically ill patients is rampant. Diagnostic utilities diverted solely for COVID-19 care leaves patients suffering from other equally fatal/chronic conditions feel orphaned and deprived of healthcare facilities. Are the lives of non COVID-19 patients less valuable? Where would critically ill patients go if all hospitals reject admission and treatment? Who would be finally responsible for the loss of lives due to non interventions/ treatment denial in the golden hours? This indeed has costed us the lives of many (in vain) who could be actually saved with appropriate treatment. Reports of medical negligence and communication deficits have been surfacing even in exclusive COVID-19 care centres. It is difficult is pinpoint the responsibility exclusively to HCWs or hospital administrations or public health stakeholders, a holistic cooperative collaboration directed to the welfare of all is imperative to address such trends of medical negligence and apathy.

c) Assault of COVID-19 Patients

It is indeed worrisome and shameful to witness reports of harassment and sexual abuse of COVID-19 patients. Hospitals, considered a safe haven for the ill, transforming into sites of oppression and abuse makes us question the very definition of not just civility but humanity itself. Such unfortunate incidents have been reported across the country [22,23].

It is a matter of grave concern since these incidents of assault on patients reflect our weak security systems. COVID-19 patients suffer with immense anxiety due to the isolation requirements, the anxiety of recovery and the panic of being separated from their near and dear ones. The least psychological solace we could offer is reassurance of recovery and safety. However, these events violate the essential principle of non maleficence and compels us to reassess if basic patient safety and protection of modesty are indeed luxuries which Indian patients deserve to be denied. Feelings of insecurity are enhanced as they are surrounded by staff in suits and it is difficult to tell who is who.

These unique circumstances pose several privacy and security concerns for patients. It is therefore imperative that we strengthen existing mechanisms and understand the legal framework around such issues. However, the dismal record of enforcement of guidelines is the underlying reason for rampant incidents of harassment and abuse to patients. It is imperative that hospitals/ clinical establishments are made accountable for protection of patients' rights and implement/enhance/enforce their security systems (monitor movements, ensure access control entry and exit, implement strict adherence to easy and round the clock display of identification cards/ bands by duty doctors, medical attendants and other hospital staff). There is no denying that it is important to focus our attention and resources on stopping the spread of COVID-19, however, we must not lose sight of emerging issues, which if ignored, could become a pandemic of their own.

d) Lack of Sufficient Hospital Beds and Black Marketing of Beds [24-29]

Lack of hospital beds, ventilators and oxygen cylinders is by far the most reported reason for distress among the masses afflicted with COVID-19. Some private hospitals have been allegedly involved in black marketing of beds which further worsens the crisis and amounts to denial of right to equality and right to live with dignity. Data shows adequate availability of beds but in reality, patients still struggle amidst severe complications and urgent need of hospital care. Though the disappointment and frustrations generated due to failures of the healthcare system is invariably directed to the doctors and paramedical staff, it needs to be identified that this challenge cannot be addressed by the doctors or allied HCWs and doctors are unfortunate targets of misdirected frustrations.

e) Ineffective Communication/Non Acknowledgment of Psychosocial Needs of Patients/Relatives

The need for social distancing, the regulatory guidelines of prevention of overcrowding resulting in minimum staffed rotational shifts and barring of patient relatives/bystanders from hospital visit and the enormous burden of huge patient load along with long duty hours has made effective communication to patients and their loved ones a real challenge in the COVID-19 scenario. Catering to the arduous duty schedules as well as personal safety, it is indeed challenging to communicate effectively. However, unprecedented times call for unparalleled measures/efforts, the importance of clear and effective communication with patients and bystanders, identifying and resolving fears/doubts/anxieties and providing as clear a picture as possible goes hand in hand with delivering effective treatment. Ineffective communication, inadequate display of empathy and compassion and non acknowledgement of fears/ doubts of patients/bystanders is adding an enormous toll on the mental health of the patients which might account for incidents of escape from hospitals [30] or panic attacks or abuse by the family and loved ones. Basic communication skills of grief recognition, acknowledgement and bereavement support prove game changers in addressing psychological needs of the patients [31].

i) The magic pill is always hidden in communication [31]:

- To share information in a timely, clear, and precise manner with patients/families.
- To treat patients and their families with dignity and compassion
- To promote collaboration between patients/families and healthcare providers and local bodies.
- To ensure comfort, check-acknowledge-validate emotions, provide reassurance .
- To assess need for information, deliver information with empathy.
- To address anger, disappointment, respond to emotions.
- To discuss resource allocation, provide a clarity on guidelines and explain what this means to the patient (talk about what can be done and what cannot be, reassure that same rules apply to everyone).

ii) Bereavement support [31]:

Patients and families diagnosed with COVID-19 experience a profound sense of loss. Most of them are unprepared for the rapid deterioration in health. This is coupled with other losses like the sense of security, livelihood, financial security, personal freedom,

and support systems. Attending to this distress is an important component of palliative care service provision.

Importance of Observation and Identification of Grief Patterns:

- Recognising Distress.
- Recognising Grief.
- Ruling out Complications (Rule out depression, assess risk of suicide).
- Facilitating Grief interventions through hospital/local support centres.

Golden Pearls of Communicating with Distressed Patients/ Bystanders:

- Giving reliable information in bits which can be understood by laymen.
- Keeping messages simple and accurate; avoid medical jargons, repeat and re-emphasise if necessary. Be honest, avoid false reassurances.
- Maintaining calm behaviour and empathy.
- Enhancing coping skills .

Finally, HCWs need to use their judgement and report to their immediate supervisor in any situation, which they believe could present an imminent and serious danger to life or health.

f) Suboptimal Ambulance Services [32-35]

There has been a widespread complaint about lack of adequate ambulance services or undue delay in ambulance services across the country which increases patient anxiety, leads to deterioration of the health status and in extreme situations has allegedly even claimed the lives of a few COVID-19 patients. Limited ambulances, lack of adequate number of trained drivers, over worked existing drivers, shortage of equipped ambulances and the rising burden of COVID-19 cases aggravates this situation. This again is an issue to be dealt by the public and private stakeholders and calls for logistic/ infrastructural strengthening of the allied health services, HCWs directly have negligible powers to address this challenge.

While highlighting deficits might be extremely easy, it is equally our responsibility to acknowledge and attempt to ease the challenging situation of doctors and HCWs.

THE CROSSROAD/CHECK MATE SITUATION FOR DOCTORS/HCWS

a) Acts and Omissions

The reluctance to make certain critical decisions might be closely associated with the belief that causing harm to the patient by making an egregious error is worse than allowing harm to happen by omitting an action or delaying the initiation of an advanced treatment regime [36].

b) Identity and Expectations

As emphasised before, many COVID-19 care units are hugely managed by the interns/postgraduate students and the junior practitioners. They are overwhelmed with their new roles, often precipitated by a disparity between the level of responsibility imposed and what they feel they could handle at ease. Juniors often feet judged, unheard, disrespected, dehumanised, insulted and a target of frustration delivery (punch bag) in a highly stressed and modestly equipped scenario. This builds up anxiety, inferiority, frustration, deterioration of self-confidence, withdrawal and self-criticism, they often indulge in judging their behaviour against their expectations of themselves, what they believed a doctor should be able to do as well as judging their competence against their perceptions of the expectations of senior colleagues/teachers. This results in reluctance to call for help or clarification as they fear failing their senior colleagues' expectations, being insulted and judged. These leads to serious unresolved stress and burden among the budding doctors as well as compromising the quality of patient care due to emotional burn out [37,38].

c) Cost of System Failures

Delay in ambulance services or unavailability of hospital beds and ventilators or non availability and black marketing of drugs like remdisivir, delay in reporting from referral laboratories or exorbitant hospital bills (in private hospitals), denial of discharge till clearance of hospital bills etc., are lacunae plaguing the healthcare system. The doctors and HCWs have no role in creating these deficits and hence cannot alleviate these concerns frustrating the patients and their loved ones. Yet unfortunately, it is the doctors who bear the brunt of these system failures as the patient perceives the doctor/ HCWs as their life savior and the "all responsible representative" of the complete system.

d) Physical/Mental Burnout

Acknowledging the "human aspects" of doctors/HCWs, providing space and opportunities for their personal overall well-being and their personal and family needs has been an alien concept for the society. The HCWs need effective gateway for assertion of their rights of protection (against occupational hazards, violence, and psychological burnout) without compromising their duties amounting to patient harm. The extremely long duty hours, single handed management of huge patient loads, witnessing patient/ patient bystanders' fears, loss of patients/colleagues/paramedical supporting staff and non acknowledgment from the masses can result in post-traumatic stress disorder, anxiety and depression. It is worth emphasising that delivering the highest standards of treatment and compassion is near to impossible unless the system and the society paves way to address and heals the physical and mental burnout of its frontline warriors, the HCWs. "YOU CANNOT POUR FROM AN EMPTY CUP", individuals in need of desensitisation to mental burnout can hardly display compassion or offer psychological support, irrespective of the social and moral responsibilities levied on them.

e) Apathy Towards System

Medical students and junior doctors are faced with myriad unheard challenges (long duty hours, competing for PG entrance exams, lack of postgraduation seats, sky rocketing fees for acquiring postgraduate seats, absence/negligible stipend and source of income/long years/duration of struggle before settlement, fear of judgement and criticism from seniors, fear of family contracting COVID-19 from them and so on). The pent up suffocation is bound create a general apathy towards the entire system and compromise the degree of performance delivery, communication and compassion towards their patients [39,40].

How to Address these Deficits?

The divine and responsible role of a doctor calls for delivering the best possible at all times, alleviate the sufferings of humanity and guide humanity to the ultimate well-being. In testing times, HCWs need to turn back to their historical Hippocratic oath for inspiration. Probably the most underemphasised as well as the most important phrase of the oath reads "*I shall repeat this oath daily lest I forget that I am in a divine profession to heal the world*." The responsibility of healing the world is indeed an enormous one, more so in the face of a global pandemic like that of today. Healing is not just treating, the oath emphasises "*I will remember that there is an art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.*"

CONCLUSION(S)

As we tread the unchartered terrains of an unprecedented COVID-19 pandemic, continue to fight the virus with the tireless efforts of HCWs and dedicated scientists who explore and update our knowledge base on COVID-19 and its solutions, we ought to acknowledge, that tough times demand immense resilience and unified cooperation. The entire medical fraternity along with complete, unconditional, uncompromised and nonjudgmental support of the public and private stakeholders should mount exemplary public health measures to address the existing deficits and emerge victorious against the demonic clutches of the notorious virus jeopardising the world. The fight however is a holistic one, the society and the general public should unanimously join hands, display resilience, patience, tolerance, adherence and determination to complement and aid our HCWs and overcome the COVID-19 crisis.

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PARTICULARS OF CONTRIBUTORS:
1. PhD Scholar, Department of Biochemistry, Kasturba Medical College, Manipal Academy of Higher Education, Manipal, Karnataka, India.
2. Associate Professor, Department of Biochemistry, Kasturba Medical College, Manipal Academy of Higher Education, Manipal, Karnataka, India.

NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:
Dr. Vijetha Shenoy Belle,
Associate Professor, Department of Biochemistry, Kasturba Medical College,
Manipal Academy of Higher Education, Manipal-576104, Karnataka, India.
E-mail: vijethashy@gmail.com

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