

## Medical Practice in the COVID-19 Crisis, an Unsafe Practice

### Ejercicio Médico en la Crisis de COVID-19, una Práctica Insegura

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#### Abstract:

The situation that humanity is currently experiencing is an unforeseen event for which we were not prepared. Undoubtedly, the health systems in the world collapsed at the same time as the increase in the number of positive cases of COVID-19. Medical personnel and members of other health care disciplines did not have and do not have the information, but above all the precise training to carry out the necessary protection when dealing with infected patients. However, it was a job that "had to be done". The death of the first doctors was the turning point, at which it became evident that high security measures were required, as well as sufficient training for them to continue their work. Despite the measures implemented, contagion continued to be a reality. Added to this, at least in our country, is the response of the population, which in many cases has been negative, accompanied by aggression towards personnel, damage to infrastructure and violation of the fundamental rights of other patients. The aim of this article is to present the current situation and to help raise awareness of the risk that physicians and other health workers have been experiencing on a daily basis since the beginning of this pandemic.

#### Keywords:

Bioethics, pandemic, medical crisis

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#### Resumen:

La situación que está viviendo actualmente la humanidad, es un hecho imprevisto para el cual no estábamos preparados. Indiscutiblemente los sistemas de salud en el mundo colapsaron a la par del incremento de los casos positivos de COVID-19. El personal médico y miembros de otras disciplinas de atención a la salud, no tuvieron ni tienen la información, pero sobretodo la formación precisa para llevar a cabo la protección necesaria al momento de tratar con pacientes infectados. Sin embargo, era un trabajo que se "debía" hacer. La muerte de los primeros médicos fue el punto de inflexión, en el cual fue evidente que se requerían altas medidas de seguridad, así como capacitación suficiente para que éstos continuaran su trabajo. A pesar de las medidas implementadas el contagio siguió siendo una realidad. A esto se suma, al menos en nuestro país, la respuesta de la población, que en muchos casos ha sido negativa, acompañada de agresiones hacia el personal, daño a la infraestructura y violación de los derechos fundamentales de otros pacientes. El objetivo de este artículo es plantear la situación actual y ayudar a crear consciencia del riesgo que viven los médicos y otros trabajadores de la salud en su día a día, desde el inicio de esta pandemia.

#### Palabras Clave:

Bioética, pandemia, crisis médica

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## **INTRODUCTION**

The COVID-19 pandemic put the world to the test in many ways, from identifying the vulnerability of the human race, to economic, social and cultural aspects.

The health situation that has been happening since the beginning of 2020 has already become a pandemic, it is a health crisis that is accompanied by a humanitarian crisis, but above all a social crisis.

It is a fact that the health contingency is largely due to the state of insufficient infrastructure and human capital capable of dealing with the pandemic, that is, the collapse of the medical system as such, which in turn, gives rise to a myriad of social and ethical situations, involving both patients and their families, as well as medical personnel.

Patients and family members have to deal with the grief, and the surrogates of losing their health or a loved one, and they are the ones who directly perceive the deficiencies of our health system. Even how complicated the treatment and convalescence of the infection has been, in which the patient is no longer seen practically from the moment of diagnosis, generating an atmosphere of stress and little emotional support. This, it would seem then that turns doctors into the object of venting the emotions of both relatives and patients, even the doctor's own family, this is largely due to the influence or social burden that doctors have in specific, so that on many occasions they cannot and, moreover, it is not up to them to solve (Castro, 2018).

All these situations generate stress, above all, separation between those involved, that is, the loss of the doctor-patient relationship, which in all processes is to be of utmost importance to achieve a better attachment and even prognosis of the treatment, a relationship that has been fractured, being violence towards medical personnel, the maximum degree in which this separation has been expressed (Castro, 2018).

Health professionals, particularly doctors, maintain a relationship of sociological ambivalence in their daily performance. Merton in the 1980s defined sociological ambivalence as the coexistence of two incompatible norms that regulate a given social status. In the case of medical personnel, he pointed out: "For each norm there tends to be at least one other coordinated norm that is, if not incongruent with the first, then sufficiently different to make it difficult for the student and the physician to put both into practice, referring to the social norm and the health norm that at some point become part of a whole to form an equitable society (Merton, 1980).

There are an endless number of conflicting norms, for example: doctors should allocate time for further training, but should devote as much time as possible to their patients; physicians should distance themselves emotionally from patients, but should not be insensitive to them. According to the above, positions with clear premises and ambivalent parts are established, identifying the following paradigm: "Doctors, as

members of the general society, aspire to the protection of the State since they provide attention and care to other citizens, but on the other hand they must protest when their safety is threatened, but, as members of the medical field, they must accept, incorporate and naturalize the violence inherent to their training and professional practice" (Merton, 1980).

Violence can be external or internal. External violence refers to those forms of violence or hostility that are exercised against actors in the medical field by agents external to the field. In contrast, internal violence is exercised between actors in the medical field itself, including health personnel (students, doctors, nursing and social work personnel, among others) and patients. However, the health contingency has generated and propitiated a very marked external violence towards health personnel (Castro, 2018).

The external violence that different health professionals have suffered during the contingency derived from the COVID-19 pandemic, is considered to range from marginalization to threats and physical aggressions towards personnel; as well as, damage to the health system infrastructure, which have endangered the safety of medical personnel, patients and the general population through epidemiological risk (Castro, 2018). The World Medical Association (WMA) unreservedly condemns these abuses that constitute a flagrant violation of international humanitarian and human rights law, in addition to collaborating with other health, humanitarian and human rights organizations to create alliances, combine forces with the objective of advocating for the highest possible standards of health for all. Since 2012, the WMA has been a member of the Health in Danger (HCiD) project led by the International Committee of the Red Cross (ICRC) (World Medical Association, 2017).

In the context of the Covid-19 pandemic, global organizations have joined their voices in a call to protect health workers from violence: 13 global medical and humanitarian organizations representing more than 30 million health professionals have issued a statement condemning the increasing incidents of attacks against health workers and facilities.

## **LEGAL FRAMEWORK**

In Mexico there is no precise regulation of assaults on medical personnel; if they occur, they must be followed up through an ordinary criminal process contemplated in the Federal Criminal Code; however, due to the background of different violent circumstances, the medical profession is fighting for a stricter regulation of this type of conduct.

At present, the existence of the rights of physicians is recognized in its essence, but they are not legislated. At the international level, the rights of doctors are recognized, including the right to practice medicine in a free, not coerced and safe manner. The World Medical Association recognizes that the first duty of a physician is to his or her patient and that, in a situation of generalized violence or armed conflict, no human being loses the right to health; however, it recognizes that the provision of the

service may be obstructed and, in general, recommends governments to guarantee the safety of medical personnel and the sites of care, in order to provide an optimal service to those who require it (DOF Agreement: 23/03/2020).

This seems to be a matter of culture, education, respect and ethics of the profession and the actions of physicians within the community, especially when it is the first in the line of combat before the COVID-19. But it seems to be of no importance, when there is not even a legal framework to protect the guild.

It is important to point out that the practice of medicine in Mexico is different in ordinary situations and in contingency situations, such as the current pandemic of COVID-19, where the administration of health resources is given according to the convenience of the General Health Council, which is contrary to the postulate of non-coercion towards the medical practice.

A point that jumps out in this situation is the figure of conscientious objection, which is a measure that raises the possibility that a physician, because of his personal beliefs and values, refuses to perform any activity that opposes them, as long as this does not endanger the patient's life; however, on this occasion, due to the extraordinary nature of the circumstances, the life that is in danger is the life of the physician (DOF Agreement: 30/03/2020).

By way of use and custom, the Mexican population has the perception that health personnel must practice their profession even in adverse conditions merely out of a sense of vocation, without considering that although it is a humanistic issue, this is not necessarily ethical and the physician is not legally obliged to do so if there are any circumstances that justify it.

Last April, the United Nations System in Mexico reiterated its solidarity with health personnel who have suffered any form of violence and discrimination related to the coronavirus pandemic. A situation that is not to be believed, considering that only in Latin American countries has this occurred. Likewise, he expressed "his full availability" to continue working in collaboration with the State and the Mexican society, with the objective "to guarantee the exercise of the human rights of all people, in moments in which more than ever we must reinforce our solidarity", referring not only to the health personnel, but also to the lack of defense of the human rights of the patients.

The different health institutions have had to implement protection measures for the hospitals, together with the Secretariats of Security and Defense, some hospitals even provided private transportation to their employees to guarantee their safety; and the government of Mexico City made hotel rooms available to health personnel so that they could rest away from their homes or as a refuge from possible aggressions.

### **CURRENT SITUATION**

In the month of December 2019, the presence of a disease causing acute respiratory involvement associated with coronaviruses, called "coronavirus 19 diseases (COVID-19)", was reported in Wuhan city, China. The coronavirus study group of the International Committee on Taxonomy of Viruses

named it as "SARS CoV 2" (Chen, 2020). By the end of January 2020 it reached the Americas, adding thousands of new infections and deaths. After the third week of June (almost six months after its origin), the World Health Organization has documented more than 9,000,000 confirmed cases and almost half a million deaths due to the disease caused by SARS CoV 2. In addition, there has been a substantial change in the way the entire world conducts itself from the economic, health, education and environmental point of view in practically all the countries of the planet, so it is part of the global agenda (Chen, 2020).

For this reason, consequences on the physical and mental health of the population are easily predictable, especially in the most vulnerable sectors, which may include increased stress (manifested by insomnia, anger, extreme fear of disease despite not being exposed to it), high-risk behaviors (abuse of alcohol, tobacco and other substances, social isolation), and health disorders (alcohol, tobacco and other substance abuse, social isolation), social isolation) and mental health disorders (post-traumatic stress, anxiety, depression and somatization, among others), and this is much more evident in health personnel who care for patients with COVID-19 due to the pressure exerted on them by their family derived from their own situation and emotional involvement that the pandemic implies (Zhu, 2020). Assaults on healthcare workers are not a new problem. Kuhen noted an increase in violence in the human health infrastructure, especially in emergency care areas, as these are groups that work in a high-intensity environment and are particularly vulnerable in many respects. Factors that influence the occurrence of aggression against staff are related to patients' fear, especially if they are going to undergo intrusive or painful procedures, or also when the patient or their family members perceive a lack of empathy from their treating physician. Some individuals might have volatile behaviors due to thoughts unrelated to treatment, just because they are sick and unclear about their prognosis since little information is available to this day about the safety of a treatment, or even the uncertainty of not being able to see their family members or little contact with health care staff (Zhu, 2020).

Along the same lines, a qualitative meta-synthesis was carried out on the experiences of violence and aggression in emergency room work teams, which we have seen to be repeated and attenuated in a situation such as that involving COVID. The review identified the following constant aspects that are reflected repeatedly during the COVID 19 pandemic:

- The first, is related to the inevitability of violence and aggression due to the frequency of incidents and the perception that there are few measures to prevent these events by the organizations for which they work, considering that aggression for health personnel during the contingency has taken place within the health spaces themselves, with no authority to protect them.
- The second is related to the staff's judgments about the reasons that lead them to face acts of violence and

aggression, so that the patient's ability to act rationally may be reduced depending on the physical or psychosocial health conditions and, therefore, be legitimized and tolerated by health workers. For example, they do not consider an aggression to be of the same magnitude if it comes from a person with dementia, alcoholic, or simply because they are annoyed by the waiting time, referring to the role that society has given to medical personnel, even taking attitudes of submission, believing that this is the act they must put up with because they are doctors.

- The third refers to the feeling of abandonment and neglect that health personnel have due to the lack of support from the team and the administration of their hospital unit when they find themselves in a situation of risk and potential danger (Collins, 2008).

Since the COVID-19 epidemic was notified by the World Health Organization, the Mexican government has kept a close eye on its evolution in order to structure a response model; therefore, as of March 23 of this year, a series of agreements and decrees were issued in the Official Gazette of the Federation describing the extraordinary measures and the protocols for their execution. In the "DECRETOS", extraordinary actions are declared in the affected regions of the entire national territory in matters of general health to combat the serious disease of priority attention generated by the SARS-CoV2 virus (COVID-19), most of them published on March 27, 2020 (DOF Decree: 27/03/2020).

The decree specifies, among other things, that the necessary measures will be taken to contain the epidemic and also explains that the administration of both public and private resources will be in accordance with the needs. This decree raises the possibility that human resources may be reallocated according to the needs of the health system, which is neither a free nor a safe exercise. It is understood that this measure has no malicious character, however, it only considers the needs of the population and the system itself, never the rights of health professionals in their defense or protection, including physical aggressions (DOF Agreement: 14/05/2020).

Despite the risk, medical personnel, as well as all health personnel, especially those who are known to have contact with infected persons, or health personnel who know they work in a hospital or wear a medical uniform, despite this, all have continued to exercise their profession, which in addition to exposing them to epidemiological risk has become an unsafe situation and have been subjected to situations such as verbal threats, discrimination, physical violence or murder in many parts of our country and Latin America.

All this scale of aggressions forces us to consider the origin of these aggressions, since in the context of the pandemic, the medical sector has become a particularly disadvantaged group to be violated. Usually the conceptions of what is good or bad rest on society, this phenomenon forces us to ask ourselves why the relationship between doctors and other people is so

fragmented to the prejudice of the former and also why the population has a bad concept of the activities that health personnel perform, putting them in a disadvantaged position and even disadvantageous in many aspects, starting with the economic one. If to this, we add the fact that the protection of medical personnel is not legislated, it generates inconformity, but above all the tip of the iceberg for a series of more serious problems being ideal for impunity or at least the non-reprimand of these acts, which far from it seem to be closer to the normalization of the same.

One fact is that a large part of the population expects self-sacrificing behavior on the part of health personnel, that is, medical care despite the fact that the doctor does not have any measure or guarantee of physical or emotional safety, but they do not consider that the quality of medical care depends directly on the circumstances in which it is given, including the doctor's work comfort or even personal issues that could involve the doctor's own performance as any other worker.

This situation of pandemic, counter poses many positions, since being a health crisis, doctors are people of utilitarian value above other professions, which is a paradox, because on the one hand they are forced to work even at the risk of affecting their health and on the other hand the population perceives that this connotation of value is related to the personal characteristics of the human being who practices medicine and that generates feelings of defense and rejection by the perception of being undervalued. But this is not so, the practice of medicine is just a job, like any other, with the peculiarity that being a health crisis, physicians are the functional unit of response and contingency of the pandemic (General Health Law, 2021).

Without leaving aside the feelings of the patients, part of the negative feelings is due to the expectation of medical attention, which is by far exceeded at this time of the contingency, making communication difficult from the beginning and in many cases, why not say it, the attention and follow-up, and thus generating, in this particular case is increased by the number of patients who need to be treated. It is thought that we should be doctors before we are people, but inevitably we are people before we are doctors.

## **CONCLUSIONS**

The public health consequences generated by the global pandemic of COVID-19 also have a direct impact on the health of workers and, consequently, on the resilience and survival of companies and the economy of a country, which have been identified as aspects that do not interact or in fact have no impact on the development and care of the pandemic.

In response to the isolation measures adopted by countries to limit the spread of the virus, some economic sectors and companies have immediately implemented remote work modalities, generating that most of the workforce work from home or in virtual mode, conditions under which are not exempt from occupational hazards and, therefore, also require the adoption of preventive measures. However, this modality is not

applicable in many productive activities, in which workers continue to go to their workplaces in person, which makes them more vulnerable to contagion.

This is why, more than ever, prevention and control measures must be a priority to protect the world of work from exposure to this biological risk and prevent new infections. Exposure to the virus by all persons in the workplace, and in particular workers, including of course health personnel, must be part of the health and safety management of companies, starting with risk assessment and the adoption of preventive and protective measures, such as the application of strict work protocols, including hygiene and sanitation measures, the use of adequate and sufficient personal protective equipment, the design of workstations, work organization, preventive training and health surveillance of workers. In addition, the participation and cooperation of workers and/or their representatives in the management of this risk, particularly through bipartite instances of social dialogue in companies or collective bargaining, will also be crucial.

Emphasis should be placed on certain groups, such as people in the health sector who are on the front line performing tasks with a high degree of exposure and in conditions of high demand, to the extent that in some European countries they represent almost 20% of the total number of confirmed infections.

The risk of infection also affects people in the supply chain of essential products and services for the population, who remain in their workplaces, even when their activities have increased: among others, commerce, transport, agriculture, food, waste collection, cleaning, water, electricity, communications; as well as the police, armed forces and other public services. In addition to exposure to the virus in their workplaces, many of these people face daily commuting by public transport, which is often crowded, particularly in large cities, with the consequent difficulty in respecting the recommended physical distancing measures. The crisis has left entrepreneurs and more than 144 million informal workers in a situation of increased vulnerability and lack of protection, as they are forced to continue working in order to ensure a minimum income.

This is the case of home delivery platform workers, mostly young people and migrants, whose generalized situation of informality deprives them of access to preventive measures against contagion, as well as economic and health benefits. It is worth mentioning that, in the event of suspension of employment relations, many workers are left unprotected in the face of insufficient coverage by the social protection system.

The term health personnel refer to a team made up of different professions and occupations which, together, facilitate and guarantee the physical and mental well-being of the people who come to a health unit. This group includes not only professionals from different areas of medicine and nursing, but also orderlies, technical and administrative assistants, social workers, psychologists, biomedical engineers, chemists, cleaning and maintenance personnel, dieticians, nutritionists and inhalation therapists, among others.

It is important to note that, as they are also part of the general population, they share common characteristics with those mentioned above. However, the exclusive condition of directly caring for people infected with a potentially fatal disease places them in a position of additional physical and mental vulnerability.

Thus, the first level of approach to the problem at hand is related to the psychological vulnerability of the general population in this emergency condition. The specific experience of each country has recognized this vulnerability and established forms of intervention to reduce the negative psychological impact of the pandemic. Some of these are related to the assessment of risk factors (e.g., premorbid mental health characteristics of individuals, such as the presence of psychiatric disorders or other illnesses), mental conditions prior to the health crisis, injuries to self or family members during estrangement, life-threatening circumstances (e.g., increased domestic violence, sexual abuse, homicides and femicides exacerbated by confinement), panic, separation from family, and concerns related to low income, among others.

The rapidity with which SARS-Cov2 transmission evolved into a pandemic (due to its transcontinental geographic spread in a relatively short time) placed a pattern of widespread vulnerability on the world stage. On January 30, 2020, the World Health Organization declared an international public health emergency due to the outbreak of Coronavirus in China. These accelerated changes, which had an impact at different levels, began to generate anxiety and a sense of insecurity in the population from the psychological point of view, which, associated with the lack of knowledge about the new virus, gave rise to rumors, fear and, consequently, a process of stigmatization related to people who had tested positive for the disease or who had been in contact with sick people. Experiences of stigmatization were observed in the civilian population of China with respect to the inhabitants of Wuhan, but also experiences in other parts of the world with respect to inhabitants of Oriental origin, including manifestations of physical aggression. In Japan, for example, they had already had similar critical situations of exposure to previously unknown agents (two atomic bomb attacks, the H1N1 influenza pandemic in 2009 and the Fukushima nuclear accident in 2011), but the COVID-19 pandemic again caused a social disruption, fueled by inaccurate information from the media and the lack of scientific information about the virus and its consequences (Pfefferbaum, 2020).

This serious situation of discrimination and xenophobia caused Tedros Adhanom Ghebreyesus, Director General of the World Health Organization, in his speech of February 14, 2020, to conclude as follows: in the course of the development of the pandemic in Latin America, different forms of aggression against health personnel attending to patients with COVID-19 have also been documented in the media. These aggressions have consisted mainly of threats (against the worker or his family), slander and implausible conspiracy theories (such as

saying that health personnel are killing patients with the disease or that they take advantage of the situation to remove the liquid from the knees and then sell it), property damage (graffiti and destruction of cars and house walls), direct physical aggressions (throwing bleach at nurses, beating different health workers) and denial of basic services (transportation and food) for the mere fact of wearing a uniform of a hospital institution. In its most alarming expression, some populations have organized to threaten or destroy the medical unit if it receives patients suspected of being infected with COVID-19.

The context experienced by doctors and health personnel in Mexico since the appearance of the COVID-19 pandemic is a scenario of insecurity, due to the fact that there is no legal element to guarantee it. The pandemic surpassed the capacity to manage the norms that would allow the physician to perform feeling safe, as well as the management of the necessary material for an adequate implementation without fearing for his health or physical integrity. On the other hand, the common thinking of the population undervalues the feeling of the doctor and places him/her in a place of "acting by vocation", which gives him/her even less opportunity for a performance worthy of a professional. These situations should also be considered, if not in the first place, in a nearby area, by those who can provide health personnel with the security they need, and ensure that society's perspective on doctors is one that is structured by a broader vision of what is experienced in a hospital.

Finally, one of the lessons learned from the pandemic is that discrimination has become increasingly harmful as a result of social development. SARS CoV 2 has shown that it knows no barriers related to economic status, race, social status or political ideology. However, stigma, discrimination and assaults on healthcare workers have significantly aggravated the effects of the pandemic caused by COVID-19 and the long-term effects remain to be known. It will be necessary to establish measures of action that include solidarity, on the one hand, and empathy on the other, but based on human rights, establish new forms of behavior, include the sectors that have been especially vulnerable in this pandemic (street population, indigenous peoples and communities, migrants, health personnel, among others) and make tangible the fact that we are all equal.

Therefore, it should be clear that a redefinition of health personnel is needed, considering that beyond complying with imposed activities, they should provide protection to patients, but above all they should have legal protection, which gives them the right to perform their work without any risk, or without risking more than their own lives, as they are doing in this situation of health contingency due to SARS-CoV2.

However, the responsibility is not only in the authorities or in the institutions that generate this protection to the personnel, but of the society, where we must act with responsibility and respect to the profession but above all to the person who exercises it; acting in accordance with the ethical values that should move society, because although health personnel are an important part for the maintenance and development of a country, and all the

responsibility falls on them, leaving aside the vulnerability, but above all the perception that they are human beings with needs, emotions and feelings that are put to the extreme in a situation like this (Pfefferbaum, 2020).

To the above, we can add the uncertainty that they also live in being at risk, and putting their families at risk, leaving society with the greatest responsibility of respect and coercion to achieve a good treatment to all health personnel. It is important to recognize that society also plays an important role in the control of contagion, without limiting their entry to any health infrastructure, assuming their irresponsibility, so the same treatment to health personnel should be considered.

It is time to thank and recognize the importance, vocation and action of health personnel in the development of a country, which although they have not been well remunerated in safeguarding their safety and integrity and even have not had an economic payment to compensate a little to this already complicated situation for them and their families. What is evident from the SARS CoV2 contingency is the lack of awareness and, above all, respect that society has for a situation such as the one prevailing in our country today, from the ignorance of not respecting social distancing, to holding health personnel responsible for it.

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