**The Three “R”s - RIGHTS, ROLES and RESPONSIBILITIES of health care workers: Covid 19 outbreak in India**

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**Abstract:**

This article addresses the rights, roles and responsibilities of health care workers who are front line warriors in any pandemic outbreak. COVID-19 pandemic has emerged as international public health emergency in March 2020, and exposed the weak/failed health care 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, swiftly responding to emergence of pandemic, safeguarding HCWs, ability to provide care without mental and physical burn out was challenging.

This review emphasizes the need for safety of health care workers and patients, infection control, security to the family, psychosocial and mental well-being, proper allocation of medical supplies, medical ethics and communication.

**Background:**

Coronaviruses belonging to the family of Coronaviridae, long considered inconsequential pathogens often causing mild cold to a severe acute respiratory syndrome in an extreme few. Coronavirus has challenged the world and humanity by the emergence of a highly pathogenic 2019 novel coronavirus (2019-nCoV) causing SARS in millions across the world. [1] After its emergence, in Wuhan in November 2019, the World Health Organization declared COVID 19 a global pandemic on 11th March 2020 [2]. In March 2020 first case of COVID 19 was diagnosed in India [3] Following which Ministry of Health, Government of India proposed standard precautions to prevent the spread of the virus by washing hand repeatedly with water or alcohol-based solution for 20 seconds, social distancing, minimizing the gathering, wearing a mask and avoiding contacts with people with cold, cough and fever [4] As we witness the outbreak taking exponential trajectories, the ultimate scope of this global pandemic is impossible to predict, while what remains certain is that the health care sector is the only hope and our health care workers form the indispensable frontline warriors to help the society deal with the pandemic in the best possible way. While the doctors and the health care workers have been responsible for combating this novel COVID-19 outbreak, these front liners not only had hazards of pathogen exposure but have also been challenged by trying circumstances of long working hours, physical and psychological stress and violence [5]

According to the Global Health Security Index (2019), India ranked 57 in pandemic preparedness and ability to handle the crisis, which emphasizes the presence of various pitfalls and challenges in its demography and healthcare system. [6] India's investment in the health sector, dedicating only 1.3 percent of its GDP, is now making it vulnerable to COVID-19. It contrasts with other developing countries like Brazil, which spends 7.5 percent of its annual GDP on health; Bhutan, which has allocated 3.6 percent; and Bangladesh, which dedicates 2.2 percent [7]. India has a severe shortage of healthcare workers. There is one doctor for every 1,445 Indians as per the country's current population estimate of 135 crore, which is lower than the WHO's prescribed norm of one doctor for 1,000 people. As the emaciated Indian healthcare system attempts to break the tide of the novel coronavirus pandemic, the front liners face a dual challenge of playing the key role of administering healthcare to COVID as well as non-covid patients along with a sea of challenges the pandemic at large and the society in specific has thrust upon them [8]. 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 or treatment delays to the other, this is probably the most appropriate time to revisit and redefine the current scenario of a role, rights, and responsibilities of a health care worker (HCW). This narrative review focus on the roles, rights and responsibilities of Health care workers during the breakdown of pandemic, COVID-19.

**Rights of Doctors/Health Care Workers:**

"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." [9]

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 in all aspects as well as fulfillment in all aspects. However, our doctors, “The frontline Covid warriors”, are threatened with myriad unforeseen challenges in the face of the Covid pandemic.

**a) Violence against healthcare workers:** It is well acknowledged that the healthcare workers 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 normalizing lives and bringing solace to the suffering humanity, come what may. This very unrealistic perception emerges as the major reason of violence meted out to doctors at events of disappointment and the seeming oblivion of the rights of doctors to lead a normal human life. The events of violence range from verbal abuse/ threats, manhandling/ aggressive/ violent gestures, abduction and even homicides and murders, in the most unfortunate incidents.

As the doctors and healthcare workers are battling a vigorous fight against the unprecedented and unchartered terrains of the current global health crisis, unfortunately they also challenged by their increasing vulnerability to violence and public frustrations. There have been several reported incidences of such violence against them during this pandemic time in India. Although the exact numbers of such cases cannot be determined, there are a few glaring examples ranging from being assaulted by patient relatives/ relatives of deceased to stigmatization as the ‘newer untouchables’ and assault by neighbors/ landlords (in the fear of contracting Covid infection) and even denial of burial/ last rites in events of Covid deaths in doctors/ HCWs.

The violence against doctors and other medical personnel has increased over the past few decades, with up to 75% doctors facing this during their practice in India. Doctors attribute the surge in violence against healthcare workers to a mix of ignorance and fear, which is amplified by the pandemic. The lockdown has exacerbated the problem, with patients unable to access healthcare due to transport suspension, fear of law enforcement and frustration following quarantine or containment zone restrictions. The reasons for violence against healthcare workers may vary from fear, anxiety, panic, misinformation (as to how the SARS CoV-2 virus outbreak may spread and affect individuals), mistrust and misplaced quotes in the social-media. Government hospitals in India are inundated in such public health crisis with lack of adequate facilities, equipment and infrastructure are other quoted reasons. The private hospital sectors have largely shut down to non-emergency admissions, and people find it difficult to access medical aid. Aggressive emotional response of relatives may sometimes boil over with frustration exhibited in the form of damage to the healthcare facilities and verbal or physical violence against the healthcare personnel.

COVID-19 health crisis has exacerbated violence against doctors and healthcare workers. They have become unforeseen targets in the fight against the current pandemic. For a sustainable protection of the healthcare workers, the current Ordinance needs to be further extended and incorporated into existing laws in the form of a strict, permanent legislation that is strictly enforced. It would improve the safety of the very individuals who carry out their duties fearlessly for the benefit of sick patients, either during a health crisis such as the current pandemic or during traditional times [11]

**b) Covid infections and deaths:** There is no official data on the number of frontline workers who have died of Covid-19 in India. However, we across come numerous incidents reporting frontline warriors being vulnerable targets of Covid. The IMA, appalled by the lack of data (as declared by competent authorities) on deaths of doctors, reported an evidence based list of the death 382 Indian doctors due to Covid infection and demanded a “martyr” status for these frontline warriors along with appropriate measures for the security of their families [12, 13]. The ICMR portal reports over 23,898 symptomatic HCWs. Further, a recent data reports that more than 87,000 healthcare workers have been infected with healthcare workers have been infected with Covid-19. Maharashtra, Karnataka, Tamil Nadu, Delhi, West Bengal and Gujarat accounts for 74% of the case burden and over 86% of the 573 deaths. Maharashtra alone accounts for approximately 28% of infections among HCWs and 50% of deaths. Maharashtra, Karnataka and Tamil Nadu had tested more than 1 lakh healthcare workers each till August 28 with Tamil Nadu reported 11,169 cases that included doctors, nurses and Asha workers. The three states together accounted for 55% of the total cases among HCWs [14, 15].

Vulnerability of the doctors to Covid infections and deaths depend on [16]:

1. Placement in intensive care unit (ICU) catering to suspected or confirmed COVID-19 cases.
2. Posting in fever clinics screening patients for Covid 19.
3. Posting in OPDs where they are vulnerable to be exposed to asympotomatic patients/ patients hiding travel/ symptoms/ contact histories.
4. Postings in emergency sections like cath labs, emergency surgeries, trauma centres etc
5. Being part of high risk procedures such as nasopharyngeal swab collection, intubation, respiratory suctioning and clinical specimen handling by HCWs
6. Lack or inappropriate use of PPE.
7. Long duty hours
8. Contact with infected colleagues

As the number of HCWs infected and dying continue to rise, our providers continue to diminish. With the surging patient load and increasing incidence of infections among fellow colleagues, HCWs are faced with circumstances challenging their physical/psychological well-being and leading to significant burnout. The effects of this increase in workload in the dangerous atmosphere of this pandemic are the decline in the mental health of our HCW. Despite the fear, they continue to ﬁght on the frontlines to execute their job while in a persistent state of survival mode to protect everyone around them.

**c) Insurance facilities to medical professionals:** Anticipating the deaths of healthcare workers, the Central government announced an insurance scheme of Rs 1.7 lakh crore under the Covid-19 relief package claiming to cover approximately 22 lakh HCWs. However, the scheme does not cover treatment costs and is limited to insurance in event of death (that is loss of life due to Covid-19/ accidental death on account of Covid-19 related duty). However, as we explore this unprecedented challenge, it is proving hard to even access the bereaved families of healthcare workers 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. How do we address situations where Covid positivity could not be established due to false negative reports, or Covid is contracted while on duty in apparent non Covid hospital settings or if the doctor/ health care professional 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?” [17]

**Ethical & moral challenges threatening our frontline warriors:**

In a country with a huge population, a sub minimal doctor patient ratio and highly disparate access to healthcare facilities, 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) and unfortunately many 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 [18, 19]:

i) Allocation of scarce medical resources (ventilators, ECMO etc) among Covid-19 patients

ii) Resource allocation between COVID and non-COVID 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 stigmatization of COVID 19 (in face of the awareness notices put up by the municipal authorities in cases of home isolation)

vi) Protecting their kith and kin from nosocomial acquired COVID 19/ protecting critically ill non Covid patients from nosocomial Covid infections

vii) Delivering effective and holistic care at isolation settings

(Note: For most therapy and healing regimes, the patient family forms an integral support system, however the highly infective nature of Covid excludes family presence in the vicinity of the patient. What measures should be taken to address the psychological and emotional burden of this excluded/ diminished psychological support? Who has the onus to address it? And are we at a stage to address such seemingly subtle challenges when we are struggling with basic amenities like shortage of beds, oxygen cylinders and ventilators?

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

ix) Adaptation to telemedicine technology and making the same accessible to our masses

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

xi) Assertion of their rights of protection (against occupational hazards, violence, and psychological burnout) without compromising to their duties amounting to patient harm

xii) Ensuring mental wellness and psychological coping skills to preserve tranquility in face of violence to medical professionals by the society

Added to all the factors mentioned above, as rightly quoted, ***“While you fear going out of home and we fear going back to our homes/ loved ones”***, throughout the pandemic, the frontliners have had to self-isolate from their own families in the fear of transmitting infection to their family and dear ones. Such manifold and multi-channel unresolved challenges along with extremely long duty hours, single handed management of huge patient loads, witnessing patient/ patient bystanders’ fears, loss of patients/ colleagues/ paramedical supporting staff to Covid fatalities and non-acknowledgment from the masses as well as the stakeholders (at occasions) amounts to severe emotional burnout and trauma which can result in post-traumatic stress disorder, anxiety and depression. It is hence essential to evaluate the well-being of our HCW and implement effective measures ensure the safety, security and overall well-being of our precious healthcare workers. The World Health Organization has rightly taken the lead to redefine and explicitly update the rights of healthcare workers and the responsibilities of employers/ managements employing healthcare workers, especially relevant to the present pandemic time. The document highlights the importance of:

• Ensuring necessary preventive and protective measures are taken to minimize occupational hazards and health risks (adequate supply of PPEs, SOS protocols of health emergencies for frontliners etc)

• Providing adequate information and training on occupational safety and health (especially to trainees/ interns/ HCWs for non-infectious fields of practice, this includes a detailed training on personal protective equipments, triage, management and referral protocols)

• Facilitating Refresher courses for doctors and paramedical staffs aimed at technical updates on COVID-19 and provide adequate resources (materials and human) to assess, triage, test and treat patients

• Providing appropriate security measures for personal safety (disarming incidents of violence against HCWs through strictest and fast track legal punishments for offenders and well as compulsory implementation of robust security forces in all healthcare facilities)

• Ensuring a non-threatening and blame-free environment which will encourage transparent reporting of incidents, such as exposures to blood or bodily fluids from the respiratory system or to cases of violence, and to adopt measures for immediate follow-up, including support to victims;

• Ensuring provisions for periodic assessment of symptoms and obtaining leaves to recover from health needs

• Maintaining adequate work force to ensure reasonable working hours and doctor to patient ratio

• Ensuring provisions to extend leave/ non threatened absence from work situation where there is continuing or serious danger to life or health until the management has taken necessary remedial actions to the satisfaction of the concerned HCW.

• Ensuring measures to honor the right to compensation, rehabilitation, and curative services if infected with COVID-19

• Providing access to mental health and counseling resources to address burnout and psychological trauma

• Enabling co-operation between management/ stakeholders and the precious healthcare workers to facilitate adequate representations and redressal of institutional/ local as well as national concerns among HCWs.

To win this war against COVID 19, we must come together on a united front to support those on the frontlines. While our healthcare workers continue to ﬁght, we must help them ﬁght off any potential short or long-term effects during and after the COVID19 pandemic.

**Roles and Responsibilities of Doctors/ allied health care workers [20]:**

In simple words, responsibilities are the items or action which we have to perform whereas role is the part of our actions to fulfill those responsibilities. The attempt to define the roles and responsibilities of doctors towards their patients in particular and society at large remains incomplete without the mention of the Hippocratic oath, a ceremonial oath taken by every graduating medical student, marking their transition from undergraduate students to responsible doctors (healers of the society) and prefixing the golden initials Dr before their names for the entire lifetime. While it is a day of a landmark achievement for any doctor, probably the responsibilities and promise the ceremonial oath brings with it is realized and fully assimilated only on a later period when they begin their journey of the rigorous practice of the art and science of medicine. One of the oldest binding documents in history, the Hippocratic Oath, still held sacred by physicians and comprehensively outlines the roles and responsibilities of doctors as they take their first step towards ***“The Nobel Profession of serving humanity”***. The pandemic of Covid 19 has witnessed doctors and HCWs serve the society tirelessly jeopardizing their individual and family safety. Covid 19 is a battle which was impossible to even attempt in absence or reluctance of our frontline warriors.

However, ***DEFICITS & SHORTCOMINGS*** are an evitable reality in any system and the Covid 19 pandemic has brought forth hidden and less acknowledged fallacies of our healthcare system. In this hour of crisis, these deficits seem to be a major cause of frustrations among the general masses and redressal of the deficits is an imperative direction towards strengthening not only our battle against Covid 19 but also our ensuring a robust healthcare system. The major shortcomings reported in the Covid era include:

**A) Medical negligence, apathy and ostracisation** [21, 22]**:**

While social distancing is this need of the hour, it is indeed unfortunate to witness the emotional oblivion and apathy which is gripped our society in this testing time. Reports of people being ostracised and hospitals refusing care and admission to non Covid critically ill patients is rampant. Diagnostic utilities diverted solely for Covid care leaves patients suffering from other equally fatal/ chronic conditions feel orphaned and deprived of healthcare facilities. Are the lives of non Covid 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 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.

**B) Assault of Covid 19 patients** [23] **:**

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 from many areas across the country (Gaya, Mumbai, Noida and a recent incident of such abuse by ambulance staffers was reported from Kerela).

These shocking incidents are a reflection of the weak security systems in our hospitals and a cause of deep concern. Covid 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 incidents bring to the fore the reality that safety is a comfort that patients in India are denied. Feelings of insecurity are enhanced as they are surrounded by staff in suits and it is difficult to tell who is who. Even first-responders such as the police are unreachable, because they are overburdened and have shifted priorities during the lockdown. Measures to restrict contact and the shift to online discourse have also hindered the ability of civil society groups to provide urgent relief. 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.

The Prevention of Workplace Sexual Harassment (Prevention, Prohibition and Redressal) Act, 2013 (PoSH Act) [24], which makes it mandatory for all workplaces, which includes hospitals, to have in place policies and Internal Committees (ICs) to address workplace sexual harassment. The harsh reality, however, is that most hospitals continue to function without any such mechanism in place as both vulnerable patients and medical staff lack awareness. The Medical Council of India (MCI) too, with the approval of the central government, has prescribed the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. This includes the Code of Medical Ethics imposes liability on medical practitioners to “aid in safeguarding the profession against admission to those who are deficient in moral character”, governs that a medical practitioner shall not “aid or abet torture” nor “be party to infliction of mental or physical trauma” and that an abuse of professional position by committing adultery, improper conduct with a patient, or maintaining an improper association with a patient would render a physician liable for disciplinary action. Medical practitioners are also forbidden from concealing torture if inflicted by some other person or agency in clear violation of human rights. The code stipulates rigorous punishments if a medical practitioner is found guilty of committing professional misconduct, which encompasses disciplinary action if they are convicted by a court of law for offences involving moral turpitude or any criminal acts (direct removal of the delinquent’s name from the register of registered medical practitioners).

However, the dismal record of enforcement of guidelines is the underlying reason on rampant incidents of harassment and abuse to patients. It is imperative that hospitals/ clinical establishments are made accountable to protection of patients’ rights and implement/ enhance/ enforce their security systems (monitor movements, ensure access control entry & 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.

**C) Lack of sufficient hospital beds & blackmarketing of beds** [25 -30]**:**

Lack of hospital beds, ventilators and oxygen cylinders in by far the most reported reason for distress among the masses afflicted with Covid. 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 identifies that this challenge cannot be addressed by the doctors or allied health care workers and doctors (in this scenario) are unfortunate targets of misdirected frustrations. The public and the private stakeholders should come together in this crisis period to ensure sufficient availability of beds and essential/ critical life support facilities. Heinous acts of black marketing should be prosecuted with the strictest punishment for failing humanity in this crucial hour calling for unified and unconditional compassion and cooperation.

**D) 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 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 and doubts of patients and bystanders is adding an enormous toll on the mental health of the patients and might account for incidents of escape from hospitals [31] or panic attacks or abuse by the family and loved ones.

**E) Suboptimal ambulance services** [32, 33, 34,35]**:**

There has been a widespread complain 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 patients. Limited ambulances, lack of adequate number of trained drivers, over worked existing drivers, shortage of equipped ambulances and the rising burden of Covid 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 responsibilities to explore and understand the situation of our doctors and HCWs, their challenges and concerns, their powers to address our frustrations as a society and the point at which we burden our HCWs with over accountability for situations which might not be under their control.

**The crossroad/ check mate situation for doctors/ HCWs:**

**1) Acts and omissions**

Many Covid care units are hugely managed by the interns/ post graduate students and the junior practitioners without the physical presence of a senior and experienced clinician in the vicinity. 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].

**2) Identity and expectations**

As emphasized before, many Covid care units are hugely managed by the interns/ post graduate students and the junior practitioners. The junior/ budding doctors/ HCWs 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, dehumanized, 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 behavior against their expectations of themselves and 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 falling short of 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].

**3) 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 our healthcare system. The doctors and HCWs have no role in creating these deficits and hence can in no circumstance 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 as the frontline warrior, the life savior and the all responsible representative of the complete system. Such a scenario instills serious challenges for the doctors who find themselves completely helpless, sandwiched between the system and the patient frustrations and soft/ vulnerable targets of system deficits.

**4) 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. However, it is worth emphasizing in an extremely demanding profession of medicine and a global pandemic amounting to an unprecedented crisis, delivering the highest standards of treatment and compassion is near to impossible unless the system and the society paves way to address and heal the physical and mental burnout of its frontline warriors, the HCWs. As the old maxim rightly says ***“YOU CANNOT POUR FROM AN EMPTY CUP”***, individuals in need of desensitization to mental burnout can hardly display compassion or offer psychological support, irrespective of the social and moral responsibilities levied on them.

**5) Apathy towards system**

Medical students/ interns/ post graduates and junior doctors are faced with myriad unheard challenges (long duty hours, competing for PG entrance exams, lack of post-graduation seats, sky rocketing fees for acquiring post graduate 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 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.

**How to address these deficits/ needs:**

Inspite of innumerable challenges, 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 wellbeing. In testing times, HCWs need to turn back to their historical Hippocratic oath for inspiration, probably the most underemphasized 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 emphasizes ***"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."***

The World Health Organization took its lead to redefine and explicitly update the responsibilities of healthcare workers especially relevant to the present pandemic time. The document reads as follows.

**Health workers should** [38]**:**

• 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 company should supply masks or make their employee to strictly adhere to wearing masks, prevent gathering and encourage to use e technology for meetings. Rearrange work area to make employee to maintain maintaining social distancing, extensive sanitization of work places.

• use provided protocols to assess, triage and treat patients;

Ministry of Health, Govt of India and state ministry have regularly updated the protocols, triaging and treatment process. Indian Medical Association, Ayush and other medical fraternity have equally contributed in these phases.

• treat patients with respect, compassion, and dignity;

Covid positive and suspects should be treated with respect, compassion and dignity. Initially the general public was overtly anxious about covid positive reports, awareness drives seem to have partly addressed their fears and mental discomforts now.

• 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 seeking home isolation still continues to cause anxiety and distress among patients and relatives due to the social stigma associated with Covid 19.

• follow established public health reporting procedures (for suspected and confirmed cases);

ICMR has made it mandatory to entry COVID positive reports on the website and maintained confidentiality of patients by giving coded number to the positive cases. State govt has made it mandatory enter details of patients with symptoms of cough, cold, throat infections and fever by each and every doctors

• provide/ reinforce infection prevention and control information to the general public;

In local languages, in newspaper, televisions, social medias and in phones before caller tune 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. A few months through the Covid pandemic, many hospitals have set up telemedicine facilities which ensure public and patients to obtain online consultations to clarify their doubts and fears.

• put on, use, take off and dispose of personal protective equipment properly;

Doctors were trained to use PPEs and in local languages videos were made regarding use and disposal of PPE (donning and doffing). Hands on workshops were conducted to train HCWs regarding the same. However, the quality of PPEs and adequate supply of PPEs remain a concern in atleast few of the health care facilities.

• self-monitoring 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 hospitalization, 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 set of monitoring devices, necessary goods were supplied along with moral support to the family of HCWs.

• advise management if they are experiencing signs of undue stress or mental health challenges that require support interventions; and

Due to increasing mental health issues, IMA Karnataka and IMA Udupi planned for mental health cell under the guidance of psychiatrists to support COVID 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. Patients and their families diagnosed with COVID-19 undergo a great deal of suffering caused by the physical manifestation of the disease, the uncertainty, fear of illness and death, stigma, and the socio-economic hardships and therapy is incomplete in absence of psychosocial support of the patients and the bystanders.

***The magic pill is always hidden in communication:***

* 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
* 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 (in pandemic scenario), provide a clarity on guidelines and explain what this means to the patient (talk about what can be done and what cannot be and reassure that same rules apply to everyone)

***Bereavement support:***

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 in an important component of palliative care service provision.

***Again the magic lies in observation, identification and effective communication and response:***

* Recognizing Distress (crying, anxious, fearful, having mood swings, withdrawn, having death wishes)
* Recognizing Grief (Shock, denial, guilt, blaming, anger, bargaining with self or family or God or with health systems, searching/yearning for the loved ones, sadness, separation anxiety, recalling or reliving the dying experience)
* Ruling out Complications (Rule of depression, assess risk of suicide)
* Facilitating Grief interventions through hospital/ local support centres (Normalizing the grieving process, talking about loss and death, facilitating bedside good-byes through video conferencing, facilitating virtual funerals, allowing families to recall and relive the experience, acknowledging and validating the experience, using support systems – family, community, spiritual faith of worship)

***Golden pearls of communicating with patients and bystanders in apparent psychological distress:***

* Giving reliable information in bits which can be understood by laymen
* Keeping messages simple and accurate; avoid medical jargons, repeat and reemphasize if necessary. Be honest, avoid false reassurances.
* Maintaining calm behavior and empathy
* Enhancing coping skills (facilitation of expression of emotions, validation of feelings, providing reassurance, helping normalization of daily routine, ensuring adequate sleep, nutrition and hydration, promoting realistic hope and goal-setting, normalising anger and grief, exploring feelings of guilt, remorse, or shame, resorting to psychotherapeutic techniques (Cognitive restructuring, Thought stopping- adressing negative thoughts, Distraction, Relaxation techniques, yoga, mindfulness, Problem solving therapy, focused group therapies)

• report to their immediate supervisor any situation which they have reasonable justification to believe presents an imminent and serious danger to life or health.

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

As we tread the unchartered terrains of an unprecedented Covid 19 pandemic, continue to fight the virus with the tireless efforts of our 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 non-judgmental 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 jeopardizing 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 frontline warriors and overcome the Covid crisis.

As rightly said,

***“We shall overcome”,***

***“Together We can and We Shall”***

***&***

***Humanity will definitely emerge victorious***

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