**COVID 19 Related Perceived Discrimination in Medical Settings, March and April 2020**

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**Abstrac**: Global spread of a disease causes fear that can lead to discrimination against the people infected with the disease. On December 2019, COVID-19 emerged in Wuhan, China, and has spread throughout the world. In this descriptive and analytic study Perceived discrimination of the patients admitted to COVID-19 wards was measured in medical settings. Data was collected of 176 patients discharged in March and April 2020. Discrimination scale was used to collect data in medical settings. Overall mean score of the scale was 11.51±3.883 indicating low level of perceived discrimination. The highest level of discrimination belonged to refusal of physicians and nurses to physically examine the patients (0.992 ± 3.49).Low level of perceived discrimination was reported in this study, which necessitated taking useful measures to identify discrimination, determines causes and prevent discriminatory behaviors in medical settings to improve the hospitalization experience and disease outcomes.

**Keywords:** COVID-19, Discrimination, Iran, ethic

**Introduction**

The COVID-19 pandemic has led to dramatic loss of 1308975 people in less than a year. It is still unknown what permanent side effects would have stricken 53766728 survivors [[1](#_ENREF_1)]. According to previous studies, social distance should be at least 1.83cm. Lifespan of the virus varies at different surfaces. For example, the virus survives on plastic surfaces for more than 3 days and survival time SARS-CoV-2 on human skin was determined long 9-hour. The incubation period for COVID-19 is between 1 and 14 days and the symptoms usually manifest within 3 and 7 days after exposure to the disease [[2](#_ENREF_2), [3](#_ENREF_3)]. Average age of the patients ranges from 47 to 59 years of age and 41.9 -45.7% of women are infected with COVID-19 [[4](#_ENREF_4)]. The most common symptoms are fever, cough and tiredness. The course of disease is like influenza. A small number of the patients might experience respiratory distress and failure and die (due to incurable metabolic acidosis, septic shock, and coagulation disorders) [[5](#_ENREF_5)].

New evidence suggests that COVID-19 has higher mortality rate compared to other similar viruses including acute respiratory syndrome or Middle East respiratory syndrome. Therefore, anxiety disorder might be critical in COVID-19 [[6](#_ENREF_6), [7](#_ENREF_7)].

COVID-19 outbreak is widely covered by media throughout the world and epidemiological update is given by various authorities in a daily manner. The pandemic has inadvertently raised public panic. Previous outbreak of infectious diseases were also associated with extreme discrimination and xenophobia, even during SARS outbreak in 2003. Studies have also shown discriminatory behavior in the European society against Asian medical students during COVID-19 pandemic (since the disease was first emerged in Asia) [[8](#_ENREF_8)].

A study showed that 1320 of 97632 medical personnel died of COVID-19 in Mexico [[9](#_ENREF_9)]. The incidence of COVID-19 in the medical staff (3.3%) was higher than the general population (0.33%) and mortality rate of the the medical staff was reported as 0.5% [[10](#_ENREF_10), [11](#_ENREF_11)]. All the above causes increase fear of COVID-19 in them.

Fear of transmitting the disease can lead to discrimination in medical care [[12](#_ENREF_12)]. Fear of social isolation and stigma can increase prevalence of the disease in society because sick people might deny their symptoms and do not pursue treatment. Social stigma and discrimination not only have economic and social consequences, but also causes internalized fear and stigma in the patients [[13](#_ENREF_13)]. Studies have also shown that some patients that were hospitalized due to acute respiratory syndromes were also treated with discrimination and prejudice, and were even suspended and dismissed from the work. These factors led to long-term social isolation resulting from dismissal from work, which increased the risk of suicidal attempts in the patients [[14](#_ENREF_14)].

COVID-19-related discrimination and its causes were not adequately studied in medical settings. Discrimination is rooted in sociocultural factors of every society and should be further assessed in order to find solutions to apply justice in treatment of patients. The study aimed to determine level of discrimination in patients suspected and hospitalized due to COVID-19 in medical settings in Maragheh.

**Materials and Methods**

This was a descriptive and analytic study. The code of ethics was obtained from the ethics committee of Maragheh University of Medical Sciences (IR.MARAGHEHPHC.REC.1399.012). Required data was collected. Medical records of 176 patients discharged from the hospital were collected. A convenience sampling was used. Since the researcher could be infected with COVID-19 if he contacted the patients during their hospitalization, the researcher decided to collect their medical records after their discharge from the hospital to get accurate information from the patients themselves. Objectives of the study were explained to the patients and consent forms were collected from the patients. The instruments used to collect the data were demographic questionnaire (made by the researcher) and discrimination scale in medical settings. The latter contained seven items scored based on a five-point Likert scale (never, sometimes, most of the cases, often, and always). Overall score of the instrument ranged from 7 to 35. Score 7-15 represented poorly perceived level of discrimination, scores 16-25 showed moderate level, and scores 26-35 indicated high level. Validity and reliability of the scale were high in previous studies [[12](#_ENREF_12), [15](#_ENREF_15)]. Ten faculty members of Maragheh School of Medical Sciences were asked to comment on the scale, which led to removal of intelligence item and replacement of physical examination in the scale. Cronbach’s alpha was used to assess reliability of the scale in twenty patients (0.83). SPSS v.21 was used for data analysis.

**Findings**

Half of the patients were females. Majority of them were above 60 years of age (62.5%). Most patients had no history of comorbidities conditions (63.6%) and most patients complained of myalgia (81.3%). RT-PCR was tested positive in only 38.6% of patients. The more length of hospitalization was between 4 and 7 days (Table 1).

Table 1-Distribution of descriptive characteristics of samples (n=176).

|  |  |
| --- | --- |
| Descriptive characteristics | Percentage |
| Female | 50 |
| Age  18-40  41-60  >60 | 8  29.5  62.5 |
| Co-morbid conditions  None  Coronary artery disease  Hypertension  Diabetes  CKD  Cancer  Pulmonary disease  other | 63.6  9.1  1.1  10.2  2.3  2.3  5.7  5.7 |
| Days of hospitalization  1-3 days  4-7 days  Over 8 days | 43  52  5 |
| common symptom  Fever  Cough  Shortness of breath  nausea and vomiting  Diarrhea  Myalgia  other | 14.8  70.5  70.5  21  28.5  81.3  14.8 |
| RT-PCR test  Positive  Negative | 38.6  61.4 |

Table 2 shows level of perceived discrimination in patients hospitalized in COVID-19 wards. Their scores were less than average in items 1 to 6 (the range of scores was between 1 and 5) but their score was 3.49 in item 7 (physical examination), which was higher than average. This showed that nurses and physicians were reluctant to physically examine the majority of patients. The mean overall score of the scale was 11.51±3.883 indicating low level of perceived discrimination.

Table 2- Discrimination in Medical Settings Scale

|  |  |
| --- | --- |
| Item | Mean (SD) |
| You are treated with less courtesy than other people. | 1.45 (.820) |
| You are treated with less respect than other people. | 1.42 (.852) |
| You receive poorer service than others. | 1.50 (.907) |
| You feel like a doctor or nurse is not listening to what you were saying. | 1.19 (.583) |
| A doctor or nurse acts as if he or she is afraid of you. | 1.24 (.725) |
| A doctor or nurse acts as if he or she is better than you. | 1.22 (.575) |
| A doctor or nurse avoided your physical examination. | 3.49 (.920) |
| All 7 items | 11.51 (3.883) |

Table 3 showed no statistically significant difference between men and women (p = 0.222) in different age groups (p = 224) and between patients with positive and negative PCR results (p = 0.541).

Table 3-

|  |  |  |
| --- | --- | --- |
| P-Value | DMSS | Variables |
| .222 | 11.15 (3.124)  11.86 (4.506) | Gender  Female  Male |
| .224 | 10.54 (1.613)  11.98 (3.808)  11.15 (4.137) | Age  18-40  41-60  >60 |
| .541 | 11.28 (3.920)  11.65 (3.870) | RT-PCR test  Positive  Negative |

**Discussion**

Any transmittable disease force the healthcare personnel to adhere to principles of personal protection. Frequent modifications in scientific findings related to transmission of COVID-19 also raised doubts in minds of medical staff. However, personal experiences of COVID-19 survivors or hospitalized patients are unbelievable. Stress, emotional torment, internalized stigma, fear of infecting loved ones, shame of infecting others, self-hatred, cursing fate, thinking “why God has punished me and my family” exacerbate patients’ feelings of “being imprisoned” and being away from family [[16](#_ENREF_16)]. These are frustrating feelings and confirm that medical personnel have the right to feel frightened.

Fear of transmitting the disease can lead to discrimination in health care disparities [[12](#_ENREF_12)]. This case is not limited to COVID-19. Previous studies on other transmittable diseases have also shown discrimination in health care services including:

Wang *et al.* showed instances of discrimination against AIDS patients including offensive behavior, refusal to offer healthcare services, delay in treatment, different treatment methods, not respecting patient privacy, and overprotection of medical staff [[17](#_ENREF_17)]. Discrimination against AIDS patients was reported in nurses working in hospitals affiliated to Tehran University of Medical Sciences and Shahid Beheshti University of Medical Sciences in Iran. Half of the nurses felt right to treat these patients by discrimination and 36% of nurses strongly felt frightened of being infected with disease [[18](#_ENREF_18)]. Al-Mutari *et al.* studied transmittable respiratory diseases in health workers who survived MERS and recalled painful experiences of discrimination and social stigma [[19](#_ENREF_19)]. This showed discrimination in other diseases too.

Discrimination might target a specific group of society and not those infected with the disease. For example, 61.2% of Asian students living in Poland were discriminated from the society [[8](#_ENREF_8)]. Perceived discrimination can also depend on the underlying circumstances and conditions. He *et al.* reported the level of COVID-19-related social discrimination in Chinese people living in the country under study as 90% and in foreign countries as 25.11%. In the former study, 50.58% of the participants tended to avoid residents of Hubei province, 16.94% of them even agreed to expel residents of Hubei province from the country. Social discrimination and isolation has destructive social consequences that necessitate an immediate action to design policies and teach media to deal with this public health emergency [[20](#_ENREF_20)].

Level of discrimination against COVID-19 patients was lower than average in the present study. Other studies also showed discrimination against COVID-19 patients although discrimination in treatment and health care system should be assessed and eliminated. Acharia showed some instances of discrimination against patients with fever symptoms in healthcare centers and showed that healthcare personnel were frightened of caring for patients suspected of COVID-19 due to shortage of personal protection equipment (PPE). As a result, some patients (not infected with COVID-19) died due to negligence of medical staff in COVID-19-isolated wards [[21](#_ENREF_21)]. This indicated seriousness of discrimination against COVID-19 patients. Liu *et al.* also showed that discrimination against COVID-19 increased over time as the incidence of the disease increased. Discrimination was also higher against black people and the Asian and those wearing face masks, which showed discrimination in society against black and Asian people even in absence of COVID-19 [[22](#_ENREF_22)].

COVID-19-related stigma might lead to decreased access to healthcare services, not adhering to treatment, delay in treatment, and not being tested for COVID-19 [[23](#_ENREF_23)]. Chopra and Aurora highlighted the role of the scientific members of society who should try to eliminate COVID-19-related social stigma. They confirmed that the most important and crucial role of this segment of society is controlling spread of the disease and their second role is assessing social stigma of COVID-19 patients in society, family, friends, and workplace [[24](#_ENREF_24)], which necessitate serious actions in the field of health to inform the public about the disease and prevent the spread of the disease.

**Conclusion**

This study showed low level of perceived discrimination in patients admitted to COVID-19 wards. The highest level of perceived discrimination belonged to physical examination. Perceived discrimination in medical settings can reflect perceived social discrimination against the patients by health professionals. Although shortage of PPE can increase discrimination against these patients, it is necessary to identify, assess and eliminate discrimination in medical settings to improve hospital experience and disease outcomes to encourage the patients to pursue treatment and not be afraid of positive test results. Authorities and practitioners should take advantage of expert human resources to inform the public the medical staff of COVID-19 latest information, useful personal protection methods, transmission period, accessible PPE in order to prevent discrimination against COVID-19 patients and decrease negative effects of COVID-19 discrimination and stigma in the health system.

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