VIEWPOINT

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Te Whare Tohu Rata o Aotearoa

Vulnerability and ethical issues faced by general practitioners during the COVID-19 pandemic in Italy: some reflections and lessons learned

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ABSTRACT

Vulnerability during the coronavirus disease 2019 (COVID-19) pandemic is an emotional state that affects all of us globally. The Italian experience shows that our general practitioners (GPs) seem to have a higher rate of death due to COVID-19 infection than other physicians.

This article discusses clinical ethics questions related to the vulnerability of GPs and the community during the pandemic in Italy: the total lack of, or the inadequate protection of personal protective equipment, the increased use of virtual medicine, and the value of a solid synergy between hospitals and territorial systems. We provide a few examples of experiences in other affected countries and populations (Indigenous communities in Brazil, Australia and Germany).

In conclusion, we offer some reflections on the crucial role of communication in dealing with vulnerability issues during this COVID-19 pandemic period.

KEYWORDS: general practitioner; COVID-19 pandemic; vulnerability; clinical ethics; health care; communication; family practise; virtual medicine.

Introduction

The fear of contracting coronavirus disease 2019 (COVID-19) has forced us to admit that we are all vulnerable.[1] Since the beginning of the pandemic, general practitioners (GPs) have had to manage a sort of collective vulnerability, offering care and assistance while fundamentally being in the same situation as the patients who require their care.

In Italy, many thousands of health-care professionals have been diagnosed as COVID-19 positive. As of 7 January 2021, 296 physicians (active and inactive) had died from the virus[2] (physicians' dates of birth were obtained by the Italian Federation of Medical Doctors and Dentists – FNOMCEO). Among them, 86 were active GPs and 164 actively practising medical doctors (MD) belonging to other categories (we included as active: all GPs aged <70 years – the upper age limit for GPs' retirement – and GPs declared as retired but still active; all other MDs except if they were declared as retired). The number of GP deaths was 34.4% of all active doctors' deaths (250) due to COVID-19. If we compare these data to the total number of GPs (~46,200) and MDs belonging to other categories (~185,000),[3] the death rate is ~1.86 per 1000 GPs versus 0.88 per 1000 other physicians. This

discrepancy highlights the need for further research to identify the occupational risks related to COVID-19 infection among different medical groups.

Several reasons may explain this difference, as in part already reported.[4] At the beginning of the COVID-19 pandemic, GPs were not trained or skilled enough in dealing with the new virus by using protection devices and by taking adequate protective measures. In addition, personal protective equipment (PPE) supplies were insufficient, and no one was equipped to deal with the many asymptomatic patients contributing to transmitting the virus.

In addition to the above, others factors were and are still in play:[5] access to GPs' offices is often more direct than to hospitals because there are fewer barriers and filtering systems; PPE is still often not adequate; GPs do not undergo control swabs uniformly and periodically, and are in constant contact with patients not known to be COVID-19 positive because they are asymptomatic, thus exposing themselves to the risk of contagion, particularly through surfaces and aerosol transmission; GPs in Italy often work on their own and do not have the opportunity to coordinate access to their offices and to efficiently filter home visits.

This Viewpoint article identifies and discusses some clinical ethics issues related to the vulnerability of GPs and the community during the pandemic in Italy and reports a few examples from other countries and communities. We conclude that in practice, communication with patients is crucial to deal with individual and collective vulnerability in these times of pandemic, even during the COVID-19 vaccination campaign.

GPs, vulnerability and some clinical ethics issues

Acknowledging GPs' vulnerability requires reflection on the difficulty of balancing the ethical principles of respect for autonomy (in this case, doctors' autonomy), beneficence (referring to the act of caring for individual patients) and non-maleficence (referring to the entire community of patients) without creating a hierarchy.[6] Situations where GPs are forced to choose between the omission of rescue and safeguarding their own health must ideally be avoided.

As reported above, during both the first and the second waves of the pandemic, the vulnerability of GPs in Italy (and in many other countries) was due to the inadequacy or, in some cases, the total lack of PPE.[7] Since the beginning of the COVID-19 pandemic, Italian GP associations rapidly set their own rules regarding daily job organisation. Virtual medicine became the rule with extreme limitations on face-to-face visits.

Virtual medicine is effective in maintaining doctor–patient relationships and the health of both patients and doctors, but it cannot replace face-to-face personal visits, where the essential healing components of touch and compassionate observation of body language are the basic and most important characteristics of family medicine. GPs face the complex burden of balancing the objective (technical) and subjective (relational) aspects of interacting with patients seeking care and assistance.[8]

Last is the issue of the synergy between hospitals and primary health care. In Italy, the different setting of the 21 regional health services has led to different organisation of territorial and hospital services all over the country. In times of pandemic, this issue has underscored the difficulty to have uniform and effective cooperation between hospitals and regional medicine throughout the country. This is crucial to guarantee the right to health care for all citizens, to ensure the same quality and typology of interventions all over the country, and to manage less complex cases and the post-hospitalization follow up of patients.[7]

To this end, territorial structures dedicated solely to COVID-19 patients; for example, COVID-19 hotels and COVID-19 hospitals, have been established in the second pandemic wave in some Italian regions to avoid saturation of hospitals and to manage patients with different levels of symptomatology.

Considering all these issues, everyone is less vulnerable if a balance between the principle of justice, through the defence of the patient's right to access care, and the principle of beneficence, through the progressive and necessary symbiosis between hospitals (specialist care) and primary care exists.

Different issues in different communities

The following vulnerability-related clinical ethics issues are of concern on different levels, and in other contexts apart from the Italian one, even though ways of life and health-care systems in local communities and countries are different.

For example, the effects of the COVID-19 pandemic on indigenous communities in Brazil were underestimated and there were no large-scale medical interventions aimed at containing the spread of the disease among these people. Adequate access to care was already difficult and this led to an increase in the collective vulnerability to COVID-19 within these communities.[9]

In Australia, virtual medicine has been in place for many years in rural areas and its use has exponentially grown during the pandemic, in contrast to the situation in Europe, where virtual medicine is a novelty for primary health care.[10]

In Germany, where the health-care system was already highly efficient, there was a very rapid increase in the number of intensive care unit beds during the first wave (from 12,000 to 40,000). The German network of GPs was immediately available to deal with and manage milder COVID-19 cases, allowing hospitals to focus on the more severely ill patients.[11]

Reflections and lessons learned

Besides optimal cooperation between hospitals and regional health systems, and the use of virtual medicine – both in Italy and in other countries – the GP role remains crucial to prevent as much as possible the transmission of the infection, to control new outbreaks, and to manage post-acute complications.[3,7]

Effective attempts to address COVID-19 vulnerability must be based on enhancing a sense of collective responsibility among the entire population. In this context, GPs play a fundamental role, not only in providing clinical assistance, but also in education and training, and transmitting correct, clear, and truthful information to limit the spread of infections even now when COVID-19 vaccination campaigns are happening everywhere. This can be achieved through emotional coherence, a practical and existential sense of the message communicated, and a choice of ways, timing, and words suitable to the occasion.

In conclusion, the COVID-19 pandemic highlights a growing therapeutic alliance against a common enemy making everyone vulnerable, and a different doctor–patient relationship where there is not any sort of disparity. In addition, during this second pandemic wave, GPs, as core contributors to any health-care systems, have to extend attention and care, not only to their individual patients, their patients' families, and societies, but also to the entire community.[12]

Competing interests

The authors declare no competing interests.

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