ARAŞTIRMA RESEARCH

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# Medical Students' Perceptions on the Affect of Infectious Disease Outbreaks and Poor Working Conditions on the Duty to Care: A Cross-Sectional Study

## Tıp Öğrencilerinin Perspektifinden Bulaşıcı Hastalık Salgınları ve Olumsuz Çalışma Koşullarının Hizmet Sunma Yükümlülüğüne Etkisi: Kesitsel Bir Çalışma

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*This study was produced from Filiz Bulut's master's thesis title "An Analysis of the Limits of Duty to Care from a Medical Ethics Perspective" (Bursa: Bursa Uludag University; 2017).*

**ABSTRACT** The existence and limits of the duty to care in certain conditions such as unacceptable working conditions, violence towards healthcare workers, and outbreaks are crucial topics in medical ethics. This study aims to determine the thoughts and reasons of future physicians regarding the limits of the duty to care in infectious diseases and poor working conditions. All 266 sixth-year medical students studying at Bursa Uludağ University School of Medicine were included in this cross-sectional study. Data were gathered by a survey form consisting of 10 questions. The questionnaire had 2 parts: one part with questions on individual characteristics (sex, the reason for choosing the medical school, the opinion on occupational risks, whether the physician was exposed to violence and the opinion about the right to health). The second part focused on participants being asked to state their views on vignettes designed to question whether there is a duty to care. Pearson chi-square test was used for statistical analysis of the data. Half of the participants (55.4%) think that the duty to care does not prevail in the "physical violence" scenario, while 38.7% in "extreme fatigue", 37.0% in "time and quantity pressure", 32.4% in "lack of equipment", 31.1% in "verbal violence", and 19.8% in "outbreaks". Participants who thought they were responsible during outbreaks stated that the duty to care was still valid significantly less in poor working conditions scenarios ($p<0.05$). In all scenarios, patient rights were the most favourable justification to serve (28.4%). Outbreaks along with poor working conditions in healthcare can negatively affect the duty to care. Especially during a pandemic, healthcare workers' burnout should be taken into account; their rights should be protected, efficient measures should be taken to prevent violence, to provide the necessary equipment and a positive working environment by the institutions and authorities.

**Keywords:** Duty to care; communicable diseases; COVID-19; working conditions; medical ethics

**ÖZET** Olumsuz çalışma koşulları, sağlık çalışanlarına yönelik şiddet, salgın hastalıklar gibi bazı durumlarda, bakım yükümlülüğünün varlığı ve sınırları tıp etiğinde önemli bir tartışma konusudur. Bu çalışmanın amacı, geleceğin hekimlerinin bulaşıcı hastalık ve olumsuz çalışma koşullarında hizmet sunma yükümlülüğünün sınırlarına ilişkin düşüncelerini ve gerekçelerini saptamaktır. Kesitsel tipteki bu araştırmaya, Bursa Uludağ Üniversitesi Tıp Fakültesinde öğrenimini sürdüren son sınıf 266 tıp öğrencisinin tamamı dâhil edilmiştir. Veriler, 10 sorudan oluşan bir anket formu ile toplanmıştır. Anket, 2 bölümden oluşmaktadır. Birinci bölüm, demografik sorular içermektedir (cinsiyet, tıp fakültesini seçme nedeni, mesleki riskleri bilme, şiddete maruz kalıp kalmadığı ve sağlık hakkına dair düşüncesi). İkinci bölümde, kurgulanan senaryolara ilişkin katılımcıların hizmet sunma yükümlülüğünün olup olmadığına dair görüşlerini belirtmeleri istenmiştir. Verilerin istatistiksel analizi için Pearson ki-kare testi kullanıldı. Katılımcıların %55,4'ü "fiziksel şiddet" senaryosunda, %38,7'si "aşırı yorgunluk", %37,0'ı "zaman ve sayı baskısı", %32,4'ü "yetersiz malzeme", %31,1'i "sözlü şiddet" ve %19,8'i "bulaşıcı hastalık salgınları" senaryosunda hizmet sunma yükümlülüğünün devam etmediğini düşünmektedir. Bulaşıcı hastalık salgınlarında yükümlü olduklarını düşünen katılımcılar, olumsuz çalışma koşulları senaryolarında hizmet sunma yükümlülüğünün anlamlı derecede daha az olduğunu belirtmişlerdir ($p<0,05$). Tüm senaryolarda en çok hasta hakları (%28,4) gerekçesi işaretlenmiştir. Sağlık hizmetlerindeki olumsuz çalışma koşullarıyla birlikte bulaşıcı salgınlar, hizmet sunma yükümlülüğünü negatif yönde etkileyebilir. Özellikle bir pandemi döneminde sağlık çalışanlarının tükenmişliği göz önünde bulundurulmalı, sağlık çalışanlarının hakları korunmalı, sağlıkta şiddetin önlenmesi için etkin önlemler alınmalı, kurum ve yetkililer tarafından gerekli ekipman sağlanarak, olumlu bir çalışma ortamı sağlanmalıdır.

**Anahtar Kelimeler:** Hizmet sunma yükümlülüğü; bulaşıcı hastalıklar; COVID-19; çalışma koşulları; tıp etiği

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Healthcare workers (HCW) can get many fatal and stigmatizing diseases such as Crimean-Congo hemorrhagic fever, hepatitis C, acquired immunodeficiency syndrome, severe acute respiratory syndrome (SARS), and coronavirus disease-2019 (COVID-19) due to their occupational exposure, and these can even result in death. It is reported that 30% of those who died in the Guangdong region of China, where SARS first appeared in 2002, were HCW and their families; likewise, the vast majority of those who died in Vietnam.[1,2] Today, the approximate rate of HCW who died from COVID-19, which affects the whole world, is reported to be over 17,000 by Amnesty International.[3] In addition to be life-threatening, it is known that occupational risks create psychological traumas and have many other adverse effects that affect personal life such as stress, job loss, limitation of sexual habits, side effects of drugs, loss of compensation cases.[2]

The justifications for the duty to care are defined as "traditional virtues of the profession", "social contract between medicine and society", "having chosen the profession", "being the person who knows best what to do", and "patient rights".[2] On the other hand, physicians may claim that they do not have a duty to care under certain conditions to protect themselves, their families, and other patients. HCW may also be faced with poor working conditions such as lack of personal protective equipment, excessive work, and exposure to violence during the provision of healthcare services. For example, due to the complex situation created by the COVID-19 pandemic, some of the HCW resigned, retired, started to withdraw from some services by taking unpaid leave. This situation may make the physician's duty to care controversial.[2,4-8] The opinions of future physicians about duty care are very important. There is a limited number of studies in the literature on the duty to care for medical students, and they are generally related to the duty to care during COVID-19.[9-13] This research aims to determine future physicians' thoughts and justifications about the limits of the duty to care in infectious disease outbreaks and poor working conditions. In such an environment and based on the opinions of medical students, it becomes crucial to discuss the limits of the physician's duty to care in terms of professional ethics, right to health, and patient rights.

## MATERIAL AND METHODS

All sixth-year medical students (266) who were born in the commercialized health and market rhetoric of Bursa Uludağ University Faculty of Medicine (2016-2017 academic year) and agreed to participate voluntarily in the study were included. Data were gathered by a survey form consisting of 10 questions. The survey consisted of 2 sections. The first part entails demographic questions (sex, the reason for choosing the medical school, the opinion on occupational risks, whether the physician was exposed to violence, and the opinion about the right to health). In the second part of the questionnaire in which open-ended questions focused on, participants were asked to state their opinions on vignettes designed to question whether there is the duty to care in contagious disease epidemics, lack or insufficient protection equipment, extreme fatigue due to overworking, time and quantity pressures created by performance-based payment systems, verbal and physical violence. The scenarios are as follows.

**Infectious diseases:** In your region, a new infectious disease epidemic with high mortality is emerging. The chain of infection is not defined, preventive measures and classical treatment methods are insufficient.

**Lack of equipment:** In the polyclinic where you work, some medical supplies such as gloves and masks are insufficient, and some are not available at all.

**Extreme fatigue:** You are a HCW who is on duty every day in a hospital. You are expected to provide polyclinic service after an intense 24-hour shift. You have trouble concentrating and feel tired. You think that caring for patients in this way will harm them.

**Time and quantity pressures:** You know that the time required to provide a qualified service to patients should be 15-20 minutes on average. However, the hospital where you work has a performance-based payment system, and the appointment system gives appointments to each patient at 5-minute intervals. If you spend time with your patient, other patients waiting for you start knocking on the door and complain-

ing. If you spend only 5 minutes with each patient, you know that the patient will not receive adequate care this time and your risk of making mistakes increases.

**Verbal violence:** You are working as a general practitioner in the emergency department of a hospital. Although it is an emergency, you are verbally abused by the relatives of the patients who claimed that he was not taken care of.

**Physical violence:** The emergency room is very busy, and the relatives of the patients are violent towards you who are claimed that their patient is not being cared for. In the meanwhile, the security guard intervenes.

For the answers to the vignettes, justifications were created in the form of "traditional virtues, social contract, being the person who knows best what to do, choosing a profession, patient rights and other answer options".

A non-parametric Pearson chi-square test was used in IBM SPSS Statistics 23 program for statistical analysis. Permission was obtained from the Dean of the Bursa Uludağ University School of Medicine to conduct the study. The study was approved by the Bursa Uludağ University School of Medicine Clinical Research Ethics Committee (#63688658-000/21969, 9.19.2016). The study was conducted in accordance with the Principles of the Declaration of Helsinki. Written informed consent was obtained from the patient.

## RESULTS

All of the sixth-year medical students (266) of Bursa Uludağ University Faculty of Medicine were included in the study, 222 (83.5%) students participated, and 112 (50.5%) were women. The reasons for students to choose the faculty of medicine firstly; it as an ideal job since their childhood (72.1%), secondly; be under the influence of people who are their relatives (32.9%); third having a satisfactory score in the university exam (32.0%) and having high-income expectations (27.0%). Of all participants, 50.0% agreed with the statement, "I cannot say that I fully know the occupational risks". In comparison, 27.5% agreed with "I knew the occupational risks while choosing the profession", and 11.2% think that "If I knew about occupational risks, I would not have chosen it". During their studentship, 45.9% of the participants stated that they were subjected to verbal violence, 2.3% physical violence, and 48.6% stated they were not exposed to violence but witnessed it. The rate of those who were not exposed to violence in any way is 6.7%. Nearly all participants (91.7%) agreed with the statement of "Everyone has the right to health; this right includes accessing all healthcare services needed". Of participants 3.6% stated "Everyone has the right to health; this right includes healthcare services that can be accessed according to the ability to pay", and 2.7% think that "There is no right to health".

According to Table 1, 55.4% of the future physicians think that the duty to care does not prevail if they are exposed to physical violence directed from patients or their relatives. Besides, they stated that the duty to care does not exist in cases of extreme fatigue due to overworking (38.7%), pressures of treating more patients in a certain period (37.0%), lack of equipment (32.4%), verbal violence (31.1%), and infectious disease outbreaks (19.8%). As for the participants who think that duty to care would be valid in those scenarios, "patient rights" were the most

**TABLE 1:** Thought on the duty to care in various scenarios (n=222).

| Scenarios | Agreed that "Duty to care would still prevail." | Disagreed that "Duty to care would still prevail." |
|---|---|---|
| Physical violence | 82 (36.9%) | 123 (55.4%) |
| Extreme fatigue | 121 (54.5%) | 86 (38.7%) |
| Time and quantity pressures | 145 (65.3%) | 60 (37.0%) |
| Lack of equipment | 138 (62.2%) | 72 (32.4%) |
| Verbal violence | 138 (62.2%) | 69 (31.1%) |
| Infectious diseases | 157 (70.7%) | 44 (19.8%) |

favourable justification. On the other hand, the 2 weakest reasons for all 6 scenarios were the reasons for "being the person who knows best what to do" and "choosing the profession" (Table 1). Participants who think that duty to care would still exist in outbreaks stated that patient rights (28.4%), the social contract (27.9%), being the person who knows best what to do (26.1%), traditional virtues (21.1%), and choosing the profession (20.3%) would be the justifications (Table 2).

Apart from analyzing data of all participants, 157 (70.7%) of them who think that the duty to care would still be valid during an infectious disease outbreak were analyzed as a separate group to understand their opinions related to various negative working conditions (Table 3). Their opinions were significantly different compared to all participants ($p<0.05$). Half of them (52.6%) think that duty to care would not prevail in "physical violence", 31.6% in "extreme fatigue", 29.5% in "lack of equipment", 27.4% in "verbal violence", and 20.8% in "time and quantity pressures".

In the "extreme fatigue" scenario, women are significantly more in favour of duty to care than men ($p<0.05$) (Table 4). On the contrary, men think that duty to care would prevail even after being exposed to physical violence, significantly more than women participants ($p<0.001$) (Table 4). The participants who had chosen medicine just because their exam score was enough to enter was not agreed that they should serve their patients in the verbal violence scenario ($p<0.05$) (Table 4). In contrast, the participants who had not chosen medicine as a profession under the influence of the people around them felt less obliged to care in the physical violence scenario ($p<0.001$) (Table 4). In addition, it has been found that the participants who think that "I wouldn't choose medicine if I knew all occupational risks" agreed less on the existence of the duty care in the verbal violence scenario ($p<0.05$) (Table 4). Finally, the participants who think that healthcare should be provided according to the needs of patients agreed less that the duty to care would still exist both in "physical violence" and "extreme fatigue" scenarios ($p<0.05$) (Table 4).

## DISCUSSION

### INFECTIOUS DISEASE OUTBREAKS

Although the physician's duty to care continues during the infectious disease outbreaks, what future physicians think is important. In this study, 70.7% of the physician candidates stated that they would con-

**TABLE 2:** Justifications of duty to care by scenarios (n=222).

| Scenarios justifications* | Traditional virtues | Social contract | Being the person who knows best what to do | Patient rights | Choosing the profession |
|---|---|---|---|---|---|
| Infectious diseases | 49 (21.1%) | 62 (27.9%) | 58 (26.1%) | 63 (28.4%) | 45 (20.3%) |
| Lack of equipment | 55 (24.8%) | 42 (18.9%) | 18 (8.1%) | 66 (29.7%) | 18 (8.1%) |
| Time and number pressure | 29 (13.1%) | 47 (21.2%) | 25 (11.3%) | 66 (29.7%) | 38 (17.1%) |
| Extreme fatigue | 33 (14.9%) | 31 (14.0%) | 22 (9.9%) | 55 (24.8%) | 27 (12.2%) |
| Verbal violence | 42 (18.9%) | 28 (12.6%) | 26 (11.7%) | 64 (28.8%) | 28 (12.6%) |
| Physical violence | 16 (7.2%) | 15 (6.8%) | 14 (6.3%) | 37 (16.7%) | 14 (6.3%) |

*Participants marked more than one justification.

**TABLE 3:** Opinions of the participants who think that duty to care exists in infectious disease outbreaks regarding other scenarios (n=157).

| Scenarios | Agreed that "Duty to care would still prevail." | Disagreed that "Duty to care would still prevail." |
|---|---|---|
| Physical violence | 74 (47.4%) | 82 (52.6%) |
| Extreme fatigue | 106 (68.4%) | 49 (31.6%) |
| Lack of equipment | 110 (70.5%) | 46 (29.5%) |
| Verbal violence | 114 (72.6%) | 43 (27.4%) |
| Time and quantity pressures | 122 (79.2%) | 32 (20.8%) |

**TABLE 4:** Variables were affecting the opinions on duty to care in various scenarios (n=222).

| | Agreed that "Duty to care would still prevail." | Disagreed that "Duty to care would still prevail." | p value |
|---|---|---|---|
| **Gender** | | | |
| S: Extreme fatigue | | | |
| Women | 49 (41.9%) | 54 (62.8%) | 0.003 |
| Men | 68 (58.1%) | 32 (37.2%) | |
| S: Physical violence | | | |
| Women | 29 (35.8%) | 72 (60.0%) | 0.001 |
| Men | 52 (64.2%) | 48 (40.0%) | |
| **Reasons for choosing medicine** | | | |
| S: Verbal violence | | | |
| Those who choose according to the exam score | 38 (56.7%) | 29 (43.3%) | 0.046 |
| Those who do not choose according to the exam score | 99 (70.7%) | 41 (29.3%) | |
| S: Physical violence | | | |
| Those who was influenced by people around them | 40 (58.8%) | 29 (42.0%) | 0.000 |
| Those who was not | 42 (30.9%) | 94 (69.1%) | |
| **Knowing the professional risks** | | | |
| S: Verbal violence | | | |
| "I wouldn't choose medicine if I knew all occupational risks." | 10 (43.5%) | 13 (56.5%) | 0.023 |
| Those who do not agree with the statement above | 128 (69.6%) | 56 (30.4%) | |
| **Thoughts on the right to health** | | | |
| S: Physical violence | | | |
| Healthcare should be provided according to needs | 73 (38.6%) | 116 (61.4%) | 0.017 |
| According to ability to pay | 8 (80.0%) | 2 (20.0%) | |
| S: Extreme fatigue | | | |
| Healthcare should be provided according to needs | 109 (57.1%) | 82 (42.9%) | 0.049 |
| According to ability to pay | 9 (90.0%) | 1 (10.0%) | |

tinue to provide services in infectious epidemics, based on the reasons of patient rights (28.4%) and the social contract (27.9%). According to the research of Compton et al., it was found that during the COVID-19 pandemic, approximately one-third of students preferred not to return to the clinical setting.[9] According to another research of Qureshi et al., it was found that during a SARS-like epidemic, healthcare professionals will have the lowest willingness to work, only 47% will come to work, and 86% of the participants are more likely to go to work only when there is a mass casualty.[14] Therefore, it is possible to claim that those data reflect a worrying problem, especially when the world is experiencing the COVID-19 pandemic. A moral justification is made for the duty to care during outbreaks based on the grounds of the social contract, being the person who knows best what to do, traditional virtues of the profession, patient rights, and having chosen the career.[2,6] Malm et al., emphasizing the reason for choosing the profession, argues that a physician who chooses the profession knows all the risks involved and accepts these risks by choosing the profession. When it is asserted that a physician would not choose the medical profession if she had known all the risks involved in the profession, it could be claimed that the physician could be informed about the risks during medical education and consented to take these risks by continuing the profession.[6] However, the justification for choosing the profession is not sufficiently sound as a basis of the duty to care. Indeed, when the opinions of the physician candidates are examined, it is seen that the reason for choosing the profession (20.3%) has the lowest rate. In addition, the assumption that all future physicians know all risks involved in medicine when choosing the profession and agree accordingly

is not valid for all physicians. Also, being informed about occupational risks and continuing education throughout medical education will not mean accepting all of the risks.[15] On the other hand, a physician is expected to get a certain degree of risk and provide services in routine conditions and extraordinary situations such as a pandemic. In particular, the social contract justification of the duty to care makes this acceptance compulsory. However, it is clear that when the prevention methods are not known sufficiently, the obligation to provide services should have certain limits in pandemics such as COVID-19 with high mortality. If the patient's case is not urgent, there is a lack of protective equipment, and when the physician could also cause contamination, an unlimited responsibility cannot be defined to the physician. For example, in a study that describes physicians' liability in communicable diseases according to the levels/stages of the risks, Schluger argues that no ethical basis for the physician's duty to care is strong enough to create a true sense of duty or expectation.[2,16] Although this argument seems quite strong, the concepts of right to health, patient rights, and public health will continue to support more physician's duty to care.

However, in terms of medical ethics, even in the most dramatic scenarios such as COVID-19, the duty to care can be justified by other reasons. Especially, it is because the medical profession, which has been ongoing throughout history, is based on helping as a virtue. Because of the physician's professional knowledge and skills, she is the only member of the society that can take effective action compared to other members of the society.[17] Therefore, apart from choosing the profession, the traditional virtues of the profession, the social contract, and being the person who knows the best in that kind of circumstances seem to be quite solid for justifying the duty to care.

## POOR WORKING CONDITIONS

Extreme fatigue, working within the performance-based payment system, lack of adequate protective medical equipment and exposure to violence are the main situations that make the service provision harder. Of all physician candidates, 64.7% stated that they must serve under the "time and quantity pressure" scenario designed to understand the possible effects of a performance-based payment system, primarily because of patient rights and social contract. Today, it can be said that health systems are generally under the influence of market conditions. Starting with implementing the "Health Transformation Project" proposed by the World Bank, physicians in Turkey had to work in a "performance-based payment system" that creates time and quantity pressure on physicians. One participant criticized that he was not obliged by saying, "It is easy to reach a doctor, but it is difficult to reach treatment". There are significant studies that emphasize that physicians should not be employed under such pressures, that the performance-based systems constitute an obstacle in the provision of qualified healthcare and, therefore, is against patients' rights. In addition, it is emphasized that the physician's charge based on the number of services provided and being forced to care for more patients in a short time will negatively affect the patient-physician relationship, and it is one of the most important causes of violence in health. In terms of medical ethics, a physician has not a duty to care for as many patients as possible in a short time in usual times. The priority of a physician is to provide qualified and appropriate healthcare based on her patients' needs. To do that is expected that she needs to devote as much time to her patient as necessary.

One-fifth of the participants think that they do not have a duty to care in case of a lack of protective equipment. Those who believed they were obliged to have based it on patient rights and traditional virtues mostly. Lack of personal protective equipment such as gloves, masks, and visors is a common problem that could be encountered in epidemics like the COVID-19 pandemic. Because in such circumstances, resources are generally limited not only in terms of intensive care beds or ventilators but also in terms of routine protection materials. There is a different point of view in the literature stating that the limits of the obligation of physicians during a pandemic depend on the lack of protective materials. For example, in Bangladesh, where resources are insufficient, many physicians refuse treatment for COVID-19 patients.[18] In Russia, another country with inadequate resources, physicians are fighting with the pandemic at the forefront.[19] A study published in The

Lancet emphasizes that the first step to combat the pandemic should be taken with personal protective equipment. It identifies healthcare professionals as the most valuable resource in every country.[20] It is generally accepted that physicians should not expose themselves to fatal risks if there is insufficient protective equipment in pandemic situations.[18,21,22] Sheather and Chisholm justify this position by claiming that protective equipment needs to be procured by employers and governments, dissolution of the social contract, and increased risk of transmission.[22] In particular, as for the social contract, HCW should have adequate protective equipment so that they are not exposed to disproportionate risk while performing their care duties.[23] A distinction can be made as to whether the patient is in an emergency or not. In cases where the patient's issue is urgent, a physician is expected to provide emergency assistance while providing protection as much as possible. In this condition, the traditional virtues of medicine provide a solid base for justifying the duty to care.

Verbal or physical violence has become one of the most important and common problems in healthcare.[24] World Medical Association reacted by condemning the violence in healthcare that continued in the pandemic.[25] Many causes of violence have been researched, various opinions have been put forward, but none of them has been sufficient to prevent violence. In terms of medical ethics, it can be stated that in case of verbal violence, the duty to care continues if the patient is urgent. If the patient is not acute, they can be referred to another physician, thus providing the patient's right to access the service and preventing physical violence. In this study, approximately half of the physician candidates stated that they had witnessed some form of violence during their education. In the "verbal violence" scenario, two-thirds of the participants think that the duty to care continues, while about half of them believe that they are not responsible to a patient in case of physical violence. In a study that investigated medical students' thoughts, it was found that sixth-grade students' view towards the profession was negatively affected because of the violence directed to HCW. The students state that they cannot make professional decisions with courage, get cold from patients, and not care for risky patients.[26] The effect of violence on students' thoughts on duty to care is very worrying for the future of the medical profession. In the case of verbal violence, those who do not choose medicine according to their exam score think they have a higher rate of service duty. This finding can be interpreted as that future physician who is believed to have chosen medicine more consciously may have thought more about the continuation of the duty in case of verbal violence. In addition, those who do not agree with the statement "I did not know about the occupational risks" think that the responsibility continues at a higher rate. This finding can be interpreted as participants who will fulfill their profession fondly and willingly accept the risks even if they do not know the risks and will consciously provide health services.

The most important limitation of this study, which investigates what future physicians think about their obligations to provide services in infectious disease epidemics and poor working conditions is that it did not ask a specific question of "If negative working conditions are added to epidemic situations, will your obligation continue?". Instead, a unique situation was presented to the participants by each scenario. Especially in today's conditions where the COVID-19 pandemic is experienced, it will be valuable to further studies evaluating this point. However, some inferences can still be made. Quite remarkable results have been obtained in terms of seeing how poor working conditions affect the thoughts on the duty to care.

## CONCLUSION

This study investigated what future physicians think about their obligations to provide services in infectious disease epidemics and poor working conditions. More than two-thirds of the future physicians participating in the study believe they must have a duty to care for infectious disease outbreaks. However, those participants' thoughts change negatively in case of poor working conditions. So, it is possible to say that when a physician who struggles with an epidemic is faced with the lack of protective equipment, extreme fatigue, time and quantity pressure, or is subjected to violence, her opinion on duty to care may change negatively. Indeed, in severe cases such as epidemics, physicians' duty to serve becomes highly controver-

sial in such cases. Therefore, it is clear that this problematic situation could significantly affect the fight against an epidemic.

The COVID-19 pandemic, which has affected the whole world, has demonstrated the value of HCW who play a major role in combating the epidemic. To implement good medical practices, instead of applauding all healthcare professionals working in the field, their burnout should be taken into account, and their rights should be protected; the struggle with epidemic should not be left only to HCW. In short, realistic, helpful, and practical measures should be taken. To do that, authorized institutions and organizations must fight with poor working conditions simultaneously. It should be ensured that a law on violence in healthcare is enacted, necessary measures are taken to save physicians from excessive workload, and standard protective equipment such as missing or insufficient gloves, masks, and visors should not be encountered. Demotivating HCW on the duty of care will render the measures taken insufficient to a great extent.

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### *Conflict of Interest*

*No conflicts of interest between the authors and / or family members of the scientific and medical committee members or members of the potential conflicts of interest, counseling, expertise, working conditions, share holding and similar situations in any firm.*

### *Authorship Contributions*

*This study is entirely author's own work and no other author contribution.*

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