Attacks on healthcare workers during the COVID-19 pandemic in Latin America

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How will you know what adrenaline is if you have never worked a code red?

How will you know what precision is if you have never placed a line that seemed impossible?

How will you know what patience is if you have never stayed (even though you were in a hurry) to hear the story your patient was telling you?

How will you know what sadness is if you have never seen a relative cry while saying good-bye to a loved one?

How will you know what distress is if you have never gone in to see a patient after his doctor has given him the worst diagnosis?

How will you know what acceptance is if you have never seen a relative with tear-filled eyes signing a do-not-resuscitate form?

How will you know what fear is if you have never seen a parent›s face when his child goes into the operating room?

How will you know what pride is if you have never been hugged and thanked by a family member for saving a life?

How will you know what happiness is if you have never seen the faces of the parents of a newborn you brought into the world?

How will you know what it means to miss your family at the holidays if you have never had a shift at Christmas or New Years?

How will you understand my emotions if you have never worn my uniform?

How do you dare judge a healthcare worker without knowing his story?

We will come through this all together

…For all those who still doubt what is happening or do not take it seriously…

The pride of belonging….these are not our words, but we echo them because we completely identify with them, as many of you do.

Taken from Dr. Alejandra Sánchez Cabezas' facebook wall,
President of the Community Health Council of the Sociedad Argentina de Medicina (SAM)

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Abstract

Today, healthcare professionals are a country's most valuable resource for combating COVID-19. Hospital contagion rates are high and linked to the practice of health care. Employers´ protective measures are essential in caring for the caregivers. The panic resulting from a fear of contracting or transmitting the disease, with first responders being at the front line of the battle against the pandemic, has been amplified by various factors. Issues such as psychological pressure, workload, media coverage, legal aspects, lack of protection, lack of rest, new roles, discrimination and assaults are some of the situations faced by these professionals. **(Acta Med Colomb 2020; 45. DOI: https://doi.org/10.36104/amc.2020.1975).**

Palabras clave: *pandemic, COVID-19, discrimination, assaults, healthcare workers*.

The outbreak of the novel SARS-CoV beta-coronavirus has been - as of June 21, 2020 - confirmed in 182 countries and multiple territorial zones, affecting approximately 8,708,008 people worldwide, of whom 5.3% have died (1). The emergency situation caused by this outbreak has become, without a doubt, the greatest difficulty faced by humans in the twenty-first century, and has broken into all aspects of daily life, with immeasurable sociocultural, political and economic consequences, and, of course, having a direct impact on the health of the patients who develop moderate to severe forms of the disease. However, it has also had an indirect impact on other population groups

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affected collaterally by the pandemic, such as healthcare staff, who have been affected by contagion during patient care in hospitals, but have also been victims of acts of discrimination, threats and physical and psychological attacks in and out of the hospitals.

Regarding the lives at risk within the hospitals

Today, healthcare professionals are the most valuable resource each country has for combatting the disease, and it should be a universal principle that they receive the biosafety equipment needed to reduce the risk of contagion during the care of patients infected with coronavirus (2). This is especially important considering that, while the main strategy worldwide has been to instruct the population to remain at home, healthcare personnel prepared to do the opposite; that is, to travel to the healthcare institutions to provide care for patients carrying a virus with a very high ability to spread (3).

The international press reported the case of the infection - and subsequent death - of Dr. Chaolin Huang, one of the first to report the signs found in patients with coronavirus disease (later named "COVID-19"). The infection of Dr. Wenliang Li was also described, who warned of the outbreak emergency and was subsequently reprimanded by the local police; as well as that of Dr. Zhiming Liu, the president of Wuchang Hospital in Wuhang, Hubei Province, the region where the outbreak is presumed to have originated (4, 5). Since then, it has been confirmed that, as a result of exposure to the virus, the rate of nosocomial infections has been high and linked to the act of health care.

In China, at least 3,300 healthcare workers have been affected (3). In Italy, almost 5,000 healthcare workers infected, and in Spain, more than 3,000 workers. In Colombia (6), the last report from the Instituto Nacional de Salud (INS) [National Health Institute] shows that there are at least 1,547 professionals affected with the disease, corresponding to 2.4% of all confirmed cases in the country. Of those affected, 32% are nurse aides, 19% are physicians and 12.9% are professional nurses. Interestingly, 88% of the confirmed cases are symptomatic, which could indicate a large number of underreported asymptomatic or untested individuals. To date, three hospitals have had to be closed due to massive transmission to healthcare and administrative staff in these institutions (7-9).

Furthermore, in Cuba, a healthcare staff infection rate of 7.7% had been recorded up to the end of April, according to the Ministry of Health report, with 92 healthcare workers infected, including 47 physicians. Of the 300 healthcare workers confirmed to have COVID-19 up to June, none were reported to have died. Likewise, in Panama, 440 cases had been counted in healthcare personnel at the beginning of June, and the Health Minister of this country stated in an interview that 17.5% of the Ministry of Health physicians had acquired the disease.

Peru, as of June 26, 2020, occupied the sixth position worldwide for COVID-19 cases, with 268,602 infected, 8,761 deaths and 156,074 recovered.

Peru is only surpassed in Latin America by Brazil, which is in second place worldwide with 1,233,147 infected, 55,054 deaths and 673,729 recovered. Table 1 shows the Latin American figures up to July 18, 2020.

The Colegio Médico del Perú [Medical College of Peru], as of June 26, 2020, reported 1,850 physicians infected, of whom 46 were in intensive care and 12 were very seriously ill. To date, 65 physicians have died in Peru (19).

In Argentina, according to National Ministry of Health data, the total cumulative confirmed cases of COVID-19 in healthcare workers up to July 13, 2020 was 7,979 (with no history of travel) and represented 7.73% of all confirmed cases in the country. Altogether, 39.6% of the cumulative cases had at least one risk factor. The cumulative number of healthcare worker deaths is 26 cases and represents 1.37% of all deaths from COVID-19. The lethality in healthcare workers is 0.33%.

Table 1. *Cases in Latin America as of July 18, 2020. (https://covid19info.live/).*

Country	Total cases	Recovered (%)	Deaths (%)	Currently infected (%)
Argentina	122,524	42.9	1.8	55.3
Bolivia	58,138	31.3	3.6	65.1
Brazil	2,075,246	23.8	1.9	71.4
Chile	328,846	91.1	2.6	6.4
Colombia	190,700	45	3.4	51.6
Costa Rica	10,551	27.5	0.5	72
Cuba	2,445	94.2	3.6	2.2
Dominican Republic	51,519	47.8	1.9	50.4
Ecuador	73,382	43.3	7.2	49.5
El Salvador	11,508	57	2.8	40.2
Guatemala	38,042	61.4	3.8	34.8
Honduras	32,793	11.2	2.7	86.1
Mexico	338,913	45.4	11.5	8.5
Panama	52,261	52.6	2	45.3
Paraguay	3,629	45.3	0.8	53.9
Peru	349,500	68.1	3.7	28.2
Uruguay	1,044	88.2	3.2	8.6
Venezuela	11,483	34.6	1	64.5

At a healthcare institution level, three major factors have influenced the predisposition of healthcare workers to contract the disease.

First, that the emergency room staff was not trained on a novel virus, with which there was no experience and which has many aspects which have been discovered throughout the course of the epidemic. This has led to frequent changes in care protocols, predisposing to errors and confusion. Already in 2018, an American study showed that emergency healthcare professionals often lack specialized knowledge for dealing with infectious disease threats (11).

Second, that the disease may manifest with mild symptoms, atypical symptoms, or even behave asymptomatically, and thus healthcare staff may have been exposed to infected patients who appeared healthy or consulted for other reasons, creating a false sense of security. In addition, in Latin America, the outpatient and emergency waiting rooms tend to be constantly crowded and have considerable waiting times, which contributes to the spread of the disease. Worse still, the coronavirus infection coincided with the epidemiological peak of dengue and yellow fever, as well as with other contagious diseases which are prevalent in our setting like HIV and tuberculosis, making it hard to concentrate resources and jeopardizing the possibility of implementing the necessary contingency plans to comply with biosafety protocols (12, 13).

Third, that the high transmissibility of the virus requires the use of biosafety equipment which is costly, uncomfortable and must be disposed of after use. The fact that it is costly means that countries with limited resources will have trouble acquiring it. Its being uncomfortable means that there will be increased physical wear and tear on healthcare staff, and it requires time for correct placement, which may delay care processes or procedures. The fact that it must be removed and disposed of after use indicates that multiple suits will be required for patient care, and, therefore, healthcare institutions will get as much use out of them as possible, even requiring that they be reused, or that elements be recycled which, for safety, should be thrown away. In fact, it has been reported that, in some centers, as the epidemic advanced, the quality of the materials of the biosafety elements was noted to decrease.

Finally, it should be remembered that all of the above does not only apply to the personal protective equipment for physicians, but also for nurses and nurse aides, for respiratory therapists, for x-ray and laboratory technicians, paramedical staff, cleaning staff, food staff, and also includes transportation and sample handling staff, all of whom need protective equipment.

As the pandemic advances, it is expected that there will be a progressive shortage of biosafety equipment, followed by a competitive commercial war to acquire and ensure the availability of medical devices, which will put countries with fewer resources at a disadvantage.

If the protection tools are not available, healthcare staff may decide to limit or avoid patient care to avoid exposure and contamination without the necessary protection. Under this principle, social networks and television news programs have reported healthcare staff resignations (physicians, nurses, respiratory therapists), who have ceased activities upon not receiving biosafety equipment from their healthcare centers (14, 15). Unfortunately, it was also reported that, in some institutions, the healthcare professionals who led the requests for guaranteed safety equipment or who requested to be tested after exposure to patients with the disease were fired from their workplaces (16).

The importance of supplying personal protective equipment appropriate for the healthcare staff has been expressed vehemently through statements by individuals, scientific societies and health sector groups (17). Under the social security structure in Colombia, a debate was raised regarding whose responsibility it was to supply the healthcare team; whether it was the responsibility of the healthcare institutions (e.g. hospitals or hospital centers), or if the responsibility belonged to the occupational risk insurers. The lack of legislation and governmental supervision, who did not take on the supply function either, led to these parties failing to fulfill the required supply, and legal gaps were created in the process. In many cases, healthcare staff had to resort to their own resources or third-party donations to acquire disposable equipment.

In Ecuador, the Medical Federation reported the serious lack of equipment as well as the expiration of others. For example, tomography machines which have been functioning for more than 10 years and have reached the end of their useful lives, and are no longer a diagnostic aid. In addition, it reported cases of stock-outs of essential medicines for surgeries and intensive care, lack of basic supplies, poor quality of N95 masks, and lack of clothing and protection for all the healthcare staff in the country´s hospitals; and that, due to this problem, many healthcare workers had been infected (18).

Regarding psychological attacks

The panic situation caused by fear of contracting or transmitting the disease, as first responders on the frontlines of the pandemic, has been amplified by various factors. On one hand, it has to do with lack of knowledge regarding a new viral disease with erratic behavior, and for which there are no proven treatment strategies to date. Besides that, it has to do with the uncertainty caused by the indefinite closure of businesses and the actual duration of the quarantine measures. Finally, the constant bombardment with scenes of distress through the media and social networks, in some cases disseminating inaccurate information, has had a negative impact on already frustrated and exhausted healthcare staff. This uncertainty is also reflected in the healthcare staff who work in the emergency room, due to the psychological impact caused by:

- The workload required to care for critical COVID-19 patients who frequently develop sudden respiratory failure and thus need frequent reassessments and con-

stant monitoring under heavy protective equipment and meticulous biosafety protocols, which quickly wears out the staff.

- The possibility of contracting the infection and/or transmitting it to loved ones, especially in places with inconsistent availability of the protective equipment necessary to provide care. And, in turn, with the worry of healthcare staff who are responsible for other people (e.g. mothers who are heads of households, only children), regarding who will take responsibility for their loved ones in the event they should succumb to the disease (19).
- The financial burden that would result from periods of inactivity due to having to step down in the event of contracting the disease - or due to preventive quarantines after exposure to the virus - which in some countries, such as Colombia, were not duly clarified in the legal framework, leaving healthcare professionals without legal support and health and occupational risk insurers without the obligation to pay for sick leave. Although it should be clarified that in other, more fortunate countries, like Costa Rica, the Ministry of Health regulated the administration of paid sick leave while professionals complied with isolation.
- The high burden of deceased patients, especially in epicenter zones such as Bergamo, Madrid and New York, where healthcare centers were rapidly oversaturated, causing feelings of anguish due to the magnitude of the situation, or a high emotional impact at having to make very important ethical decisions about human lives under extreme conditions. This includes the burden derived from the responsibility of providing medical care to very complicated patients, with incomplete, insufficient or inadequate resources (2). Finally, it includes the mourning and impact on the morale of healthcare teams caring for colleagues, friends, professors or teachers who are infected or die from the disease (21).

It is important to note that although the healthcare staff, especially in the emergency room, is oriented to face high risk situations with fortitude, they usually do not receive mental health training strategies from their hospitals. Even experienced members of the healthcare staff, with regular experience in the task of imparting bad news, may have been overwhelmed by the prospect of having to report deaths day after day during pandemic peaks, especially if this was accompanied by feelings of helplessness or guilt. In Italy, at least two suicide cases were reported in nurses, and this may occur in other places (22). Measures must be taken to encourage counseling for healthcare staff in this demanding situation, especially if they show signs of burnout, anxiety or depression, in order to minimize the risk of developing psychiatric illness. In China, for example, some specific measures were taken to alleviate the described difficulties. The healthcare institutions resorted to guaranteeing break rooms where the medical team could rest, providing food and daily life items, supplying relaxation tools, providing more security for dealing with uncooperative patients, and ensuring protective and biosafety equipment, which perhaps represents the greatest concern of the working staff and their families at home (23). Likewise, other institutions, including WHO, have published guidelines and recommendations with strategies for protecting the professionals' mental health (24).

Preliminary results presented by the research group on Women's Health of the Universidad de Cartagena (Colombia) on "occupational stress and fear of COVID-19 in general practitioners" reported that, out of 531 physicians surveyed, 84% reported experiencing fear regarding COVID-19. Seventy-five percent of those surveyed reported feeling uncomfortable when thinking about the pandemic, 68% felt nervous when reading or hearing news related to the disease, 55% felt palpitations when thinking of the virus, and 54% could not sleep for the same reasons. Thirty-eight percent of those surveyed reported having thought they had symptoms similar to those caused by the virus. In addition, the study found that female physicians reported three times more anxiety than the males surveyed (25, 26).

To conclude, the psychological pressure that the authorities may have exerted to keep physicians or healthcare staff from expressing their concerns to the community, upon pain of disciplinary sanctions or losing their employment, should be highlighted. In Venezuela, cases of physicians and nurses being punished by government agencies for denouncing the hospital crises have been reported (Annex 1).

Regarding discrimination against healthcare staff

Strikingly, another facet of this psychological attack during the pandemic has been seen in a kind of discrimination, evidenced by the refusal of members of the general population to have contact with healthcare staff outside of the hospital, suspecting that these healthcare workers will spread the virus to them. This discrimination gradually changed to more direct attacks like forbidding healthcare staff to enter supermarkets and stores, keeping them from using elevators or common areas in buildings, and asking healthcare professionals to leave their apartments. In Bogotá, a case was reported of a healthcare professional who received graffiti death threats against his wife and children if he did not give up his apartment (27). In cities like New York, the psychological bombardment aimed at presenting healthcare staff as potential transmitters of the virus forced physicians and nurses themselves to decide to sleep in their vehicles and not return to their homes. This attitude of persecution and discrimination contrasts sharply with the applause and ovations offered by the community for a few minutes as a sign of support for healthcare workers.

Another form of discrimination was seen in the refusal of public transportation to take medical or nursing staff dressed in scrubs to the hospitals. Although the healthcare

staff quickly clarified that once at the hospitals they changed their street clothes for hospital clothes, the community maintained its refusal, which forced authorities in some cities to provide transport vehicles or exclusive transportation routes to ensure the mobility of healthcare workers (28-29). The healthcare institutions, in turn, asked their staff not to travel wearing this type of clothing, to avoid confrontations. However, this often led to healthcare professionals out of uniform being fined by the authorities who believed they were breaking the mandatory quarantine.

In Argentina, the number of queries at the Instituto Nacional Contra la Discriminación, la Xenofobia y el Racismo [National Institute against Discrimination, Xenophobia and Racism] (INADI) increased considerably between March and May 2020. Out of 718 queries, 208 refer specifically to situations related to COVID-19, including cases of discrimination against patients, attacks against and mistreatment of exposed individuals, and stigmatizing declarations against various groups such as the Chinese community and migrants from several countries, among others. On average, four of every 10 queries were related to the pandemic and/or isolation, while one out of every 10 had to do specifically with discrimination due to COVID-19. The discrimination situations occurred predominantly in women (57%) rather than men (41%). The neighborhood and dwellings were the most frequently reported setting (71) in the 208 queries denouncing COVID-19 related discrimination, followed by social networks, where many discriminatory, derogatory and violent comments are posted, often fed by the diffusion of "fake news" which not only misinforms, but also creates fear, anxiety and opinions based on information and events which are not very truthful. The work and public administration environments had 20 and 17 queries, respectively, while 13 of these 208 referred to healthcare providers and centers.

In Colombia, President Iván Duque has condemned the acts of discrimination and attacks on medical staff, and the Public Defender has opened anonymous hotlines for reporting acts, threats or harassment to which they may be subjected (30). The Colombian Penal Code (Article 134 A-C) states that people who commit discriminatory acts may be punished with prison sentences ranging from 12-36 months and fines of 10-15 legal current minimum monthly wages, with the risk of increasing the penalty by one third to one half when the conduct takes place in a public area, public establishment, or site which is open to the public. Even so - criminalized by law - at least 20 cases of aggression in various Colombian cities were found in the national press, of which at least eight were attacks against women (nurses, nurse aides, a social worker, a hospital care technologist) and practically all of them were discrimination situations, especially in dwellings and supermarkets. Three physicians have received death threats, and yet, to date, nobody has been penalized for these acts.

A compilation of the information published in the Latin American press shows that cases of discrimination or violence against healthcare staff have occurred in many countries besides Colombia, with at least 111 cases recorded, distributed as follows: Mexico: 40, Colombia: 20, Argentina: 10, Venezuela; 9, Paraguay: 8, Honduras: 4, Panama: 4, Peru: 2, Costa Rica: 1 and El Salvador: 1 (Annex 1). Forty-five per cent of the cases of discrimination or violence have been against women, while 28% have been against men. Forty percent of the cases of discrimination or violence are against physicians, 40% against nurses and nurse aides (31) and 11% against various members of the healthcare team simultaneously.

Twenty-seven per cent of the cases occur in healthcare centers and another 25% have occurred in the victims' dwellings or buildings; 19% of the cases have occurred in public areas, 12% on public transportation, 5% have happened in commercial establishments such as restaurants, supermarkets and banks, and 4% of the cases have been through social networks, although cyberbullying and defamatory messages sent by these means may be much more frequent but hardly ever reported.

With regard to the main forms of violence, we find that 31% of the news items identified correspond to various forms of discrimination. In 21% of the cases, the violence was physical aggression, and in 7% of the cases it was verbal, with 13% of the cases being mixed aggressions. In 9% of the cases there was police abuse or persecution of healthcare staff. In 11% of the cases there were threats to the healthcare staff.

Most cases of discrimination and attacks against healthcare staff seem to occur in Mexico, where the current pandemic has seen an increase in violence. People who want to burn a hospital, who throw hot coffee or chlorine at physicians and nurses. We should recognize that the violence against healthcare professionals did not begin with the pandemic, it was simply amplified, made more visible, more crude and ruthless. According to Mexican civil law, a certain type of responsibility arises from illegal acts. Article 1910 of the Federal District Civil Code establishes that whoever causes damage in the course of committing an illegal act or an act against public decency is obligated to repair the damage caused. Therefore, if a member of the medical community is harmed, the person who caused the harm would be criminally and civilly liable for repairing it. The harm caused may be to property, that is, having to do with financial loss, or may also be non-property damage, which mainly comprises moral damages. We should work hard to improve healthcare professionals' legal protection, but we must recognize that our main responsibility is to generate the will in the authorities to enforce the law. A document is needed to forcefully encompass the medical community and healthcare staff's feelings regarding the social reality of the context, the crushing anarchy created by impunity, the lack of legal actions, and the arguments that need to be pushed in all the congresses and local chambers, so that laws will be drafted and enforced in an exemplary manner as soon as

possible, before calamity goes from being an anecdote to being part of everyday life; this is imperative.

In Bolivia, a survey on attacks on healthcare workers found that, of 184 responses, 77.2% responded affirmatively to having suffered some form of aggression, especially women. Most attacks occur against physicians (72%), in healthcare centers and leaving work/on the way to work. The main types of aggression reported by those surveyed were verbal aggression, followed by discrimination, physical violence and death threats. In 8.3% of these aggressions, the police had to intervene, but only in 42% was there a police report. Ninety-four percent of those surveyed knew of other healthcare workers who had been affected.

In Paraguay, there have been statements issued by SPMI and the Sindicato de Médicos de Guairá [Guairá Physician's Union] (SIMEG) warning of the concern regarding the media's reporting (32, 33) the identity of colleagues affected by COVID and regarding the abuse suffered by one physician at the hands of the police force.

In contrast, and fortunately, we found that other countries such as Cuba, Guatemala, the Dominican Republic and Uruguay have not reported major cases of attacks or discrimination against healthcare workers.

Regarding physical attacks

Even before the outbreak, the constant limitations of healthcare systems had created a sense of frustration and discontent in the community, which has adopted defiant and unkind attitudes towards healthcare workers. In turn, healthcare workers also reached this epidemic frustrated by the limitations of the healthcare systems, with high burnout rates, and feelings of helplessness in the face of demanding schedules, delayed payment, employment instability and informality, and lack of legal guarantees and social benefits (28, 34). All of this predisposes to a state of extreme tension which fosters mistreatment and complicates communication channels during patient care. Cases of physical confrontation have been reported, especially by patient companions or relatives, with improper treatment of healthcare staff. A meta-analysis in China showed that workplace violence against healthcare staff reached levels as high as 62% (5).

Patients' relatives or companions frequently direct their feelings of frustration and guilt toward the healthcare team members, and the strict isolation requirements due to the pandemic have increased complaints against and lack of confidence in the hospitals. In other places, frustration is also a product of the need to separate patients from their relatives, who are left with the dilemma of not being able to see their loved ones again until they have recovered, or, unfortunately, until they have died, in which case the funeral arrangements will likewise be limited. In Colombia, there were frequent conflicts with relatives of deceased patients who, on being informed of the measures for the disposition of the bodies, refused to accept the notification protocol and the international recommendation of cremation. This behavior went so far as to lead the general population to doubt the medical reports, influenced by sensationalist media from which arose the false belief that the classification of patients without the disease as COVID-19 cases was providing personal or financial benefits to healthcare workers or healthcare centers, when, on the contrary, the costs of care, imaging and purchase of protective equipment have generated cost overruns and large losses for healthcare institutions.

Indeed, the most recent criminal acts have been attacks by family members against the physical plants of healthcare centers on being notified of the death of a relative. Despite the medical team having expressed its total willingness to face this battle, with no responsibility for the appearance of the outbreak, patients' relatives continue to see them as being responsible for the fatal cases, which has led to death threats or lawsuits alleging medical errors or malpractice, generating derogatory comments which can affect the professionals' reputation and tear down their efforts and spirit. In the worst cases, the resentment of those who blame the healthcare team for the death of their relatives has reached the point of considering the hospital's work as blatant murder of their relatives; clearly an attitude of flourishing terror in limited and misguided minds, lacking clarity but with an undefined and frightening danger of the tangential risk of intra or extramural aggression.

Other aggressive attitudes are related to the inappropriate behavior of the patients themselves who, despite being aware of the need for confinement to avoid infecting other people, refuse to cooperate with the hospital's measures and directly confront the attending staff, putting their physical integrity at risk. In addition, cases have been reported of healthcare professionals or administrative staff who, on their way to the healthcare centers, have been heckled or intercepted by individuals who have physically and verbally assaulted them (34-37). The WHO regretted the death of one of its workers in Myanmar who was attacked while transporting coronavirus samples in a vehicle (38).

Regarding policies for staff in training

Healthcare systems worldwide will probably operate at maximum capacity for many months. However, unlike the mechanical ventilators, which may be manufactured or purchased, healthcare staff cannot be purchased or work at maximum capacity for long periods of time (3). In addition, the possibility that the active healthcare team may be infected, require hospitalization, require sick leave or, in the worst case, die, has led to healthcare services becoming progressively short-staffed.

The response to this situation has been to recruit staff who do not usually work in the emergency rooms (sub-specialists, residents in other fields) and to carry out improvised graduations of final year students in healthcare fields (39) to deal as common soldiers with the care of complicated patients according to care protocols which often change very rapidly, based on the scant available evidence. This desperate mea-

sure may make sense in places with a complete collapse of the healthcare system, but in settings that have not reached a critical point it means enlisting untrained staff in a situation with a high risk of contagion and with frequent complaints of lack of protective equipment. Some institutions have redesigned their academic training programs, orienting the students to "non-COVID" services or the performance of activities which do not involve direct patient care contact, such as call center management or telephone follow up of patients who are referred to home observation due to their mild symptoms. In other institutions, the teaching alliances have withdrawn their students indefinitely, and now have them cover portions of the curriculum through virtual meetings or carry out research activities, with the impact of this modality on the quality of professional education still unknown.

In Colombia, there are at least nine confirmed cases of healthcare staff students who have been affected by the disease (6). It is essential that the continuity of clinical practice or rotations go hand in hand with careful coordination and with the absolute guarantee of biosafety measures which, as professionals in training, they deserve.

Final reflection and request

Based on the foregoing, there is a need in all our continent to continue strengthening awareness raising tasks in order to prevent and eradicate the cases of discrimination, stigmatization and/or violence which occurred during the study period, many of which had the distinction of referring to situations specific to the exceptional context which the pandemic has presented. In effect, we are presented with a new setting, with multiple challenges, in which pre-existing situations worsen and new ones appear, tied to the historical moment the world is experiencing, which forces us to think of new approaches and strategies to reach the greatest number of people possible.

For these reasons, we, clinical specialists from all Latin American countries, call for guarantees in this relentless fight which is about to begin in its fiercest form, through the following requests and recommendations, extended also to human rights organizations, government organizations, the International Labour Organization and other multinational authorities:

1. That the supply of inputs be guaranteed in all healthcare centers or patient care sites.
2. That physicians have their children's education and family's livelihood guaranteed through an insurance policy, in case of death. Payment of their full salary to their family, social security until their children are of age, free education up to the university level and lifelong social security for their spouse.
3. That when physicians and healthcare staff experience personal or property damage, reparation be guaranteed, as well as appropriate compensation if the physicians are unable to continue practicing their profession, with their families' insurance being activated.
4. That compensation be commensurate with the risk and job performed, so that physicians can work for a single institution, rather than having to double and triple their shifts.
5. That the physician's reputation be respected, and that when it is unfairly damaged, no matter by whom, reparation of the damage to his/her professional image and prestige be required.
6. That filming a physician at work, publishing his/her image on networks without his/her authorization be considered illegal, have consequences for the aggressor and be punished by forcing the aggressor to repair the damage financially and morally.
7. That work shifts during training be those stipulated by law, without the excuse that since they are staff in training, their shift may be extended without justification; and, if it is, that they be compensated according to the time worked.
8. That all types of transportation be prioritized for facilitating the travel of physicians and healthcare personnel.
9. That their status as women be respected, along with their particular periods such as pregnancy, breastfeeding and their children's illnesses.
10. That there be an office especially in charge of matters related to physicians and healthcare staff, which will streamline and activate the mechanisms for enforcing the law, punishing crimes and guaranteeing physicians the previously mentioned line items; that each country's law be enforced in all its breadth and rigor, and that with this effort, flaws which injure the physicians' professional practice in these difficult circumstances may be eradicated.

The Foro Internacional de Medicina Interna (FIMI) [International Forum of Internal Medicine] has drafted a decalogue of the conditions under which all physicians should be able to practice their profession (Annex 2).

Likewise, the message from the FIMI authorities for all Latin American colleagues is transcribed (Annex 3).

References

1. **WHO** - Organización Mundial de la Salud. Coronavirus disease 2019 (COVID-19) Situation Report - 97. Junio. 2020. Disponible en: https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200621-covid-19-sitrep-153.pdf?sfvrsn=c896464d_2
2. **Chen W, Huang Y.** To Protect Healthcare Workers Better, To Save More Lives. *Anesth Analg*. 2020. Disponible en: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7172566/
3. **The Lancet.** COVID-19: protecting health-care workers. Lancet. 2020;395**(10228):**922. Disponible en: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7138074/
4. **Zhu J.** Is it ethical to be a 'whistleblower' during COVID-19 pandemic? Ethical challenges confronted by health care workers in China. *J Adv Nurs*. 2020. Disponible en: https://onlinelibrary.wiley.com/doi/full/10.1111/jan.14376
5. **Xiang Y, Jin Y, Wang Y, Zhang Q, Zhang L, Cheung T.** Tribute to health workers in China: A group of respectable population during the outbreak of the COVID-19. *Int J Biol Sci*. 2020;**16(10):**1739-1740. Disponible en: https://www.ncbi.nlm.nih.gov/pmc/articles/pmid/32226292/
6. **Instituto Nacional de Salud** [Colombia]. Datos abiertos de COVID-19 en personal de salud, boletín n.8. Junio 2020. Disponible en: https://infogram.com/1pyg0lgpndvwweh3yx1exq1dq1uy6l7xmpg; https://twitter.com/INSColombia/

status/1273783917061996545/photo/1

7. **Redacción Bogotá.** (14/04/2020). Anuncian cierre temporal de la UCI del Centro Policlínico del Olaya por brote de COVID-19. El Espectador. Disponible en: https://www.elespectador.com/noticias/bogota/anuncian-cierre-temporal-de-la-uci-del-centro-policlinico-del-olaya-por-brote-de-covid-19-articulo-914570
8. **Múnera A.** (17/04/2020). Cierran servicios en clínica de Pereira por aumento de casos covid-19. El Tiempo. Disponible en: https://www.eltiempo.com/colombia/en-pereira-cierran-una-clinica-por-propagacion-del-covid-19-485882
9. **Urieles R.** (23/04/2020). Cierran urgencias en clínica de Santa Marta por incumplir protocolos. El Tiempo. Disponible en: https://www.eltiempo.com/colombia/otras-ciudades/coronavirus-en-colombia-cierran-cinica-en-santa-marta-por-incumplir-protocolos-del-coronavirus-487792
10. **Nodal Noticias de America Latina y el Caribe**. (26.06.2020). Perú se mantiene como el séptimo país con más contagios y ya fallecieron 65 médicos. Disponible en: https://www.nodal.am/2020/06/peru-se-mantiene-como-el-septimo-pais-con-mas-contagios-y-ya-fallecieron-65-medicos/
11. **Popescu S.** Roadblocks to Infection Prevention Efforts in Healthcare SARS-CoV-2/COVID-19 Response. *Disaster Med Public Health Prep*. 2020:1-7. Disponible en: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7156573/
12. **Bong CL, Brasher C, Chikumba E, McDougall R, Mellin-Olsen J, Enright A.** The COVID-19 Pandemic: Effects on Low and Middle-Income Countries. *Anesth Analg*. 2020. Disponible en: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7173081/
13. **Litewka S, Heitman E**. Latin American healthcare systems in times of pandemic. Dev World Bioeth. 2020. Disponible en: https://onlinelibrary.wiley.com/doi/full/10.1111/dewb.12262
14. **Goez A.** (08/04/2020). 21 médicos de la Clínica San José de Torices renuncian por falta de insumos. El Universal. Disponible en: https://www.eluniversal.com.co/cartagena/21-medicos-de-la-clinica-san-jose-de-torices-renuncian-por-falta-de-insumos-FF2654236
15. **López A.** (22/04/2020). Terapistas de clínica en Cartagena renuncian por falta de garantías para atender COVID-19 Disponible en: https://www.elheraldo.co/bolivar/terapistas-de-clinica-en-cartagena-renuncian-por-falta-de-garantias-para-atender-covid-19
16. **Redacción Nacional.** (22/04/2020). Historia de una médica despedida por solicitar prueba del covid-19. Semana. Disponible en: https://www.semana.com/semana-tv/semana-noticias/articulo/coronavirus-en-colombia-despiden-a-medica-por-solicitar-prueba-de-covid--19/665144
17. **Hero I.** Prevent loss of life by providing all NHS staff with WHO standard personal protective equipment. BMJ 2020;368:m1275. Disponible en: https://www.bmj.com/content/368/bmj.m1275
18. Redacción Nacional Ecuatoriana. Disponible en: https://www.edicionmedica.ec/secciones/profesionales/federacion-medica-ecuatoriana-advierte-sobre-varios-problemas-en-el-sistema-de-salud--96045
19. **Mo Y, Deng L, Zhang L, Lang Q, Liao C, Wang N, et al.** Work stress among Chinese nurses to support Wuhan for fighting against the COVID-19 epidemic. *J Nurs Manag*. 2020 Disponible en: https://onlinelibrary.wiley.com/doi/abs/10.1111/jonm.13014
20. **Greenberg N, Docherty M, Gnanapragasam S, Wessely S.** Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *BMJ*. 2020;**368:**m1211. Disponible en: https://www.bmj.com/content/368/bmj.m1211.long
21. **Ripp J, Peccoralo L, Charney D.** Attending to the Emotional Well-Being of the Health Care Workforce in a New York City Health System During the COVID-19 Pandemic. *Acad Med*. 2020 Disponible en: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7176260/
22. Montemurro N. The emotional impact of COVID-19: From medical staff to common people. Brain Behav Immun. 2020. pii: S0889-1591(20)30411-6. Disponible en: https://www.ncbi.nlm.nih.gov/pmc/articles/pmid/32240766/
23. **Chen Q, Liang M, Li Y1, Guo J, Fei D, Wang L, et al.** Mental health care for medical staff in China during the COVID-19 outbreak. *Lancet Psychiatry*. 2020**;7(4):**e15-e16. Disponible en: https://www.ncbi.nlm.nih.gov/pmc/articles/pmid/32085839/
24. **World Health Organization.** (2020). Mental health and psychosocial considerations during the COVID-19 outbreak. 2020. World Health Organization. Disponible en: https://apps.who.int/iris/handle/10665/331490
25. **López A.** (20/04/2020). 84% de médicos generales de la Costa le temen a la COVID-19. El Heraldo. Disponible en: https://www.elheraldo.co/colombia/en-video-84-de-medicos-generales-de-la-costa-le-temen-la-covid-19-719159
26. **Jaime J.** (22/04/2020). El personal de salud no es inmune al miedo. El Espectador. Disponible en: https://www.elespectador.com/coronavirus/el-personal-de-salud-no-es-inmune-al-miedo-articulo-916025
27. **El País.** (23/04/2020). Autoridades investigan amenaza de muerte que recibió un médico en Bogotá. El País. Disponible en: https://www.elpais.com.co/colombia/autoridades-investigan-amenaza-de-muerte-que-recibio-un-medico-en-bogota.html
28. **EFE.** (01/04/2020). La COVID-19 desata la discriminación en Colombia contra quienes salvan vidas. EFE Disponible en: https://www.efe.com/efe/america/sociedad/la-covid-19-desata-discriminacion-en-colombia-contra-quienes-salvan-vidas/20000013-4211172
29. **Nación.** (10/04/2020). En defensa de los héroes: los médicos sufren discriminación. Semana. Disponible en: https://www.semana.com/nacion/articulo/discriminacion-a-medicos-y-trabajadores-de-la-salud-por-coronavirus/662655
30. **Castrillón D.** (24/04/2020). Colombia: Defensoría del Pueblo recibirá denuncias de amenazas al personal de la salud. CNN en español. Disponible en: https://cnnespanol.cnn.com/2020/04/24/alerta-colombia-defensoria-del-pueblo-abre-un-canal-para-recibir-denuncias-de-amenazas-al-personal-de-la-salud/
31. Redacción. (08.05.2020). Los Olivos: Hombre escupe en la cara a enfermera en una clínica. Diario El Correo. Disponible en: https://diariocorreo.pe/edicion/lima/los-olivos-hombre-escupe-a-enfermera-en-una-clinica-coronavirus-peru-covid-19-video-noticia/
32. Denuncian posible "caza de brujas" en Villarrica por caso de coronavirus. 12 de abril de 2020. Disponible en: https://www.hoy.com.py/nacionales/denuncian-posible-caza-de-brujas-en-villarrica-por-caso-de-coronavirus
33. Escrachan a médicos y los acusan de contagiar COVID-19 en Concepción. 10 de junio de 2020. Disponible en: https://www.lanacion.com.py/pais/2020/06/10/escrachan-a-medicos-y-los-acusan-de-contagiar-covid-19-en-concepcion/#.XvOuAwrOdsU.whatsapp
34. **González D.** (04/04/2020). Entre aplausos y discriminación, la lucha de los médicos contra el Covid-19 en Argentina y Colombia. France 24. Disponible en: **https://www.france24.com/es/20200404-discriminacion-medicos-argentina-colombia-coronavirus**
35. **Redacción nacional.** (14/04/2020). Alcaldía de Montería rechazó agresión contra enfermera del hospital San Jerónimo. El Espectador. Disponible en: https://www.elespectador.com/coronavirus/alcaldia-de-monteria-rechazo-agresion-contra-enfermera-del-hospital-san-jeronimo-articulo-914548
36. **Redacción nacional.** (18/04/2020). Enfermera en Barranquilla fue atacada tras ser acusada de tener covid-19. Semana. Disponible en: https://www.semana.com/nacion/articulo/coronavirus-en-colombia-agreden-a-enfermera-en-barranquilla-por-la-covid-19/664524
37. **Agredo P.** (16/04/2020). Personal médico en Medellín denuncia que han recibido agresiones físicas. RCN Radio. Disponible en: https://www.rcnradio.com/colombia/antioquia/personal-medico-en-medellin-denuncia-que-han-recibido-agresiones-fisicas
38. **Sharma S.** (21/04/2020). WHO condoles death of staff in Myanmar, condemns targeting of health workers involved in COVID19 response. WHO SEAR/PR. Disponible en: https://www.who.int/southeastasia/news/detail/21-04-2020-who-condoles-death-of-staff-in-myanmar-condemns-targeting-of-health-workers-involved-in-covid19-response
39. **Linde P, Silió E.** (19/03/2020) El colapso del sistema obliga a Sanidad a contratar a miles de jubilados y estudiantes. El País. Disponible en: https://elpais.com/sociedad/2020-03-19/espana-suma-169-muertos-y-3431-nuevos-casos-de-coronavirus.html

Annex 1. *List of attacks found in the news during the COVID-19 pandemic in Latin America.*

Country	City / Department or State	Affected staff	Sex	Site	Aggression	Date (2020)
Argentina	Ciudad de Bs.As./Belgrano	Physicians	M	Dwelling	Threats	NR
	Ciudad de Bs.As./Villa Crespo	Physicians	M	Dwelling	Threats, Verbal aggression	NR
	Ciudad de Bs.As. / Recoleta	Nurses	F	Dwelling	Verbal aggression	NR
	Provincia San Luis	Physicians	M	Healthcare center	Physical aggression	NR
	Rosario – Provincia de Santa Fe	Physicians	M	Ambulance	Mixed aggression	NR
	Provincia de La Rioja	Physicians	F	Dwelling	Property destruction	NR
	Provincia de Bs.As – Mar del Plata	Physicians	F	Dwelling	Physical aggression	NR
	Rosario – Provincia De Santa Fe	Nurses	F	Healthcare center	Mixed aggression	NR
	Provincia de Bs.As - La Plata	Physicians	M	Doctor's office	Threats	NR
	Provincia de Santa Fé -Venado Tuerto	Physicians	M	Healthcare center	Verbal aggression	NR
Bolivia	Cochabamba	Healthcare team	NA/NS	Healthcare center	Threats	June
	Cochabamba	Physicians	F	Dwelling	Discrimination	June
	Cochabamba	Physicians	M	Healthcare center	Mixed aggression	June
	La Paz	Healthcare team	NA/NS	Healthcare center	Threats	May
	El Alto	Physicians	NA/NS	Public area	Physical aggression	May
	La Paz	Physicians	NA/NS	Isolation hotel	Discrimination	June
	Oruro	Physicians	NA/NS	Healthcare center	Mixed aggression	June
	Yapacaní / Santa Cruz	Physicians	NA/NS	Public area	Threats	June
	Cochabamba	Physicians	NA/NS	Public area	Threats	June
	Cochabamba	Physicians	F	Dwelling	Discrimination	April
	Beni	Healthcare team	NA/NS	Healthcare center	Threats	April
	El Alto	Paramedics	NA/NS	Public area	Physical aggression	May
Colombia	Barranquilla / Atlántico	Nurses	F	Public area	Mixed aggression	April
	Bogotá (D.Capital)	Physicians	M	Dwelling	Threats	April
	Bogotá (D.Capital)	Nurses	F	Public area	Mixed aggression	May
	Bogotá (D.Capital)	Healthcare team	F	Dwelling	Discrimination	May
	Cali / Valle	Healthcare team	NA/NS	NA/NS	Mixed aggression	April
	Cali / Valle	Physicians	F	Shops	Discrimination	April
	Cali / Valle	Physicians	M	Dwelling	Discrimination	April
	Cartagena / Bolívar	Healthcare team	NA/NS	Public transportation	Discrimination	April
	Cartagena / Bolívar	Physicians	NA/NS	Healthcare center	Mixed aggression	June
	Cartagena / Bolívar	Physicians	M	Healthcare center	Mixed aggression	June
	Medellín / Antioquia	Nurses	NA/NS	Dwelling	Discrimination	April
	Medellín / Antioquia	Prehospital care technologist	F	Public area	Physical aggression	April
	Montería / Córdoba	Nurses	F	Public area	Mixed aggression	April
	Montería / Córdoba	Nurses	F	Dwelling	Discrimination	April
	Montería / Córdoba	Physicians	M	Dwelling	Discrimination	April
	Montería / Córdoba	Healthcare team	NA/NS	Healthcare center	Property destruction	June
	Soledad / Atlántico	Healthcare team	NA/NS	Healthcare center	Physical aggression	May
	Soledad / Atlántico	Physicians	M	Dwelling	Threats	June
	Tolima	Nurses	F	Shops	Discrimination	April
	Valledupar / Cesar	Social worker	F	Dwelling	Discrimination	April
Costa Rica	Alajuela	Nurses	NA/NS	Public transportation	Discrimination	March
Cuba	-	-	-	-	No reported aggressions	-

NA/NS: Not applicable or Not specified, or refers to a group of both sexes. NR: Not recorded

Keep going...

... Continuation. **Annex 1.** *List of attacks found in the news during the COVID-19 pandemic in Latin America*.

Country	City / Department or State	Affected staff	Sex	Site	Aggression	Date (2020)
Dominican Republic	-	-	-	-	No reported aggressions	-
El Salvador	San Salvador	Nurses	NA/NS	Dwelling	Discrimination	April
Guatemala	-	-	-	-	No reported aggressions	-
Honduras	NE	Nurses	F	Dwelling	Discrimination	April
	Cortés	Nurses	F	Dwelling	Discrimination	May
	San Pedro Sula	Nurses	F	Dwelling	Discrimination	May
	San Pedro Sula	Nurses	F	Dwelling	Discrimination	June
Mexico	Bahía de Banderas, Nayarit	Nurses	F	Dwelling	Discrimination	April
	Balbuena, CDMX	Physicians	M	Public transportation	Discrimination	April
	Cadereyta, Querétaro	Nurses	F	Public area	Physical aggression	April
	Chiapas	Healthcare team	NA/NS	Healthcare center	Property destruction	May
	CDMX	Nurses	F	Public transportation	Verbal aggression	April
	CDMX / Azcapotzalco	Nurses	M	Healthcare center	Physical aggression	April
	CDMX / Azcapotzalco	Physicians	F	Healthcare center	Threats	April
	Ciudad de México	Nurses	F	Public area	Discrimination	April
	Ciudad de México	Nurses	F	Public area	Discrimination	April
	Ciudad de México	Nurses	F	Public area	Physical aggression	April
	Ciudad de México	Nurses	F	Shops	Discrimination	April
	Ciudad de México	Physicians	NA/NS	Healthcare center	Threats	April
	Ciudad de México	Nurses	F	Not recorded	Physical aggression	April
	Ciudad Obregón, Sonora	Nurses	F	Public area	Physical aggression	April
	Córdoba, Veracruz	Nurses	F	Public transportation	Discrimination	April
	Culiacán	Nurses	F	Public area	Physical aggression	April
	Ecatepec, Edo Mex	Nurses	F	Public area	Aggression by the authorities	May
	Estado de México	Nurses	F	Public transportation	Physical aggression	April
	Estado de México	Nurses	M	Public transportation	Discrimination	April
	Guadalajara, Jalisco	Physicians	F	Public area	Physical aggression	April
	Guadalajara, Jalisco	Paramedics	M	Public area	Physical aggression	April
	Jalisco	Nurses	F	Healthcare center	Mixed aggression	April
	Jalisco	Nurses	F	Public area	Mixed aggression	April
	Las Margaritas, Chiapas	Physicians	M	Healthcare center	Physical aggression	June
	Mérida, Yucatán	Nurses	M	Public transportation	Physical aggression	April
	Mérida, Yucatán	Nurses	F	Public area	Physical aggression	April
	Mérida, Yucatán	Nurses	F	Dwelling	Property destruction	May
	Monclova, Coahuila	Physicians	M	Personal vehicle	Aggression by the authorities	April
	Morelos	Healthcare team	NA/NS	Healthcare center	Threats	April
	Oaxaca	Nurses	M	Shops	Discrimination	April
	Oaxaca	Healthcare team	NA/NS	Healthcare center	Physical aggression	April
	Oblatos, Jalisco	Nurses	F	Public transportation	Mixed aggression	March
	Querétaro	Nurses	F	Public transportation	Mixed aggression	April
	Reynosa, Tamaulipas	Nurses	M	Public area	Physical aggression	April
	San Luis Potosí	Not specified	F	Shops	Physical aggression	April
	San Melchor	Paramedics	NA/NS	Ambulance	Physical aggression	May
	Sonora	Nurses	M	Dwelling	Discrimination	April
	Tamaulipas	Nurses	NA/NS	Public area	Kidnapping	May
	Tampico	Emergency care technologist	M	Public transportation	Discrimination	April
	Veracruz	Nurses	NA/NS	Shops	Discrimination	April

NA/NS: Not applicable or Not specified, or refers to a group of both sexes. NR: Not recorded

Keep going...

... Continuation. **Annex 1.** *List of attacks found in the news during the COVID-19 pandemic in Latin America*.

Country	City / Department or State	Affected staff	Sex	Site	Aggression	Date (2020)
Panama	National announcement	Healthcare team	NA/NS	Healthcare center	Threats	June
	Veraguas	Physicians	NA/NS	Dwelling	Discrimination	April
	Not specified	Physicians	F	Dwelling	Discrimination	April
	Not specified	Nurses	F	Public transportation	Discrimination	April
Paraguay	Asunción	Physicians	F	Social networks	Discrimination	March
	Asunción	Physicians	F	Social networks	Discrimination	March
	CDE	Therapist	F	Social networks	Verbal aggression	March
	CDE	Physicians	M	Social networks	Verbal aggression	March
	Guaira	Physicians	F	Dwelling	Verbal aggression	April
	Guaira	Nurses	F	Dwelling	Discrimination	April
	Concepción	Physicians	M	Healthcare center	Verbal aggression	June
	Altos	Nurses	F	Dwelling	Verbal aggression	April
Peru	Lima / San Juan de Lurigancho	Healthcare team	NA/NS	Healthcare center	Physical aggression	April
	Piura / Talara	Physicians	NA/NS	Healthcare center	Physical aggression	May
	Lima / Los Olivos	Nurses	F	Healthcare center	Physical aggression	May
Uruguay	-	-	-	-	No reported aggressions	-
Venezuela	Carora /Lara	Physicians	M	Doctor's office	Aggression by the authorities	April
	Margarita/Nueva Esparta	Physicians	F	NA/NS	Aggression by the authorities	April
	Villa de Cura/Aragua	Physicians	M	Public area	Aggression by the authorities	NA/NS
	San Cristóbal/Táchira	Nurses	M	Healthcare center	Aggression by the authorities	NA/NS
	Maturín/Monagas	Physicians	M	Healthcare center	Aggression by the authorities	NA/NS
	Maturín/Monagas	Physicians	M	Healthcare center	Aggression by the authorities	NA/NS
	Maturín/Monagas	Physicians	F	Healthcare center	Aggression by the authorities	NA/NS
	Barquisimeto/Lara	Physicians	M	Healthcare center	Aggression by the authorities	June
	Zaraza/Guárico	Physicians	M	Healthcare center	Aggression by the authorities	June

NA/NS: Not applicable or Not specified, or refers to a group of both sexes. NR: Not recorded

Annex 2. *Decalogue of the conditions under which all physicians should be able to practice their profession.*

1. Practice their profession freely and with no pressures of any kind. Physicians have the right to have their clinical judgement (diagnostic and therapeutic) and prescriptive freedom respected, as well as their likely decision to refuse care for some patient, as long as these aspects have an ethical, scientific and regulatory basis.

2. Work in appropriate and safe facilities which guarantee their professional practice. Physicians have the right to workplaces and facilities which meet the standards of safety and hygiene, including those mandated by law, according to the characteristics of the service to be provided.

3. Have at his/her disposal the resources required for his/her professional practice. It is a physician's right to receive from the facility where he/she practices: suitable staff, as well as the necessary equipment, instruments and supplies, according to the service provided.

4. Abstain from guaranteeing healthcare results. Physicians have the right to not render conclusive opinions on the expected healthcare results.

5. Receive respectful treatment from the patients and their relatives, as well as from the staff related to their professional work. Physicians have the right to receive respectful treatment from the patient and his/her relatives, as well as complete, truthful and timely information regarding the health condition. The same respect should be received from their superiors, staff related to their professional work and third-party payers.

6. Have access to continuing medical education and be considered equally for professional development. Physicians have the right to facilitated access to continuing medical education and to be considered equally for professional development, in order to stay current.

7. Have access to research and teaching activities in their professional field. Physicians have the right to participate in research and teaching activities as part of their professional development.

8. To associate with others to promote their professional interests. Physicians have the right to associate in organizations, associations and colleges for their professional development, in order to promote the advancement of their members and monitor professional practice, according to the law.

9. Safeguard their professional prestige. Physicians have the right to the defense of their professional prestige and to have information regarding the course of a probable controversy treated privately; and. when applicable, to claim redress of the damage caused. The safeguarding of their professional prestige requires respect by the media of the rule of law and the right to a hearing, such that illegal acts not be presumed to have been committed until any controversy over the medical attention provided has been legally resolved.

10. Receive compensation for the services provided. Physicians have the right to be compensated for the professional services they provide, according to their work or contract conditions or to their agreement with the patient.

Annex 3. *Message from the FIMI authorities to Latin American colleagues.*

FIMI Colleagues:

We are all working, each in his/her own area and always based on internal medicine, whether in community care, outpatient care, the emergency room, an ambulance, general hospitalization, progressive care, home care or now doing triage in various places throughout our countries.

Others are managing hospitals, hospital wards, developing triage tactics, writing documents, and, as we are the reference points for many patients or acquaintances, and even healthcare team members, sometimes stuck to our cell phones answering questions and advising.

We want to tell you that we are going to combat this pandemic with our entire arsenal: knowledge, debate (between clinicians and with the rest of the healthcare team, whether at a societal or institutional level), effort, thinking, and fundamentally, with one of the most powerful tools: **solidarity.**

The quarantine and healthcare and institutional management work to which we have been subjected recently presents a challenge which we clinicians will know how to face because almost all of us, almost always, appeal to resilience, and it has served us well. We are a continent of clinicians united through FIMI, its societies, and some who are listening to us, together with other colleagues, in some ministries of health.

Difficult times came, are still here and will come, and we know the difficulty will be different according to the geographical and work context, but we will fight with our will (although, naturally, it wavers at times) and with the abilities which define us, and which we know how to bring out in times of crisis.

We will not accept:

- ✓ Being forced to work without the appropriate Personal Protective Equipment for each case.
- ✓ The hasty judgement which is happening in many regions, resulting from fear and the need to blame someone.
- ✓ The (always COWARDLY) aggression exercised by some sectors of the population, in any of its masks: physical, psychological, social, or discriminatory.
- ✓ Relegation to second place, compared to other specialties, whether by the public, the media, leaders, the population or other colleagues. The clinicians/internists are the ones who confront the virus.
- ✓ Intolerance towards other colleagues (from the same or a different country).

I go out walking
along the cosmic waistline of the south.
I walk through the most vegetated region
of the wind and the light.
As I walk,
I feel the skin of all America on my skin
and in my blood a river runs
which releases its stream in my voice.