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The Right to Protect Healthcare Workers in Covid-19 Pandemic: Legal and Criminal Reflections

Francesco Perchinunno[1]

ABSTRACT

On March 2020, the World Health Organization (WHO) called COVID-19 a pandemic. Millions of cases and deaths have been reported globally. To limit the increase of spreading by COVID-19, prevention strategies were performed to protect people and healthcare workers. The right to health for medical workers is a crucial factor for both control of the outbreak and continuing to provide necessary care to people with COVID-19. Thus, as part of the right to health, governments should create conditions that ensure to medical staff adequate protection even if in an emergency. Nevertheless, these principles, high number of medical doctors died during COVID-19 pandemic. Thus, this paper summarizes measures adopted to social security and highlights some considerations about the respect of human rights for all.

Keywords: COVID-19 pandemic, human rights, healthcare-workers

Introduction

On March 11, 2020 The World Health Organization (WHO) declared that an outbreak of the viral disease COVID-19, had reached the level of a global pandemic. Since as the increasing levels of spread and severity, the WHO invited government to take urgent action to stop of virus disease and spreading.

The brutality of the COVID-19 pandemic rises to the level of a public health prospect that could justify some limitations on human rights, such as imposition of quarantine or isolation limiting freedom of movement. Nonetheless, a warning about respect of human rights such as transparency, respect for human dignity and all human rights principles. All systems of governments implicated in the COVID-19 outbreak must certify that international human rights law are at the heart of the responses issued to deal with the pandemic, resulting in protection of public health and people who are most at risk at adverse impacts. States human rights tasks and human rights principles must be reproduced the reply of different states to COVID-19 pandemic. The effect on human rights is clearly conceivable after preventive measures to protect public health, such as quarantine and travels. Moreover, states ensure access to preventive care, goods and services, accessible care and could guarantee social security and workers rights. In this context, health workers are at the frontline of this epidemic, continuing to deliver services despite the personal risks to them and their families. The risk they face include contracting COVID-19 as well as psychological distress and fatigue. Some international reports describe that over 3000 healthcare workers have infected by COVID-19 and a number not negligible of doctors have died. Although the knowledge about COVID-19 disease and techniques of prevention as social isolation for healthy people are increasing, less well known is the contribution of healthcare workers at high risk of infection and death, as it has been described during many previous infectious disease epidemics, such as EBOLA or SARS.

Governments must minimize the risk of occupational accidents and diseases including by workers have health information and sufficient protective clothing and equipment as well as providing healthcare workers with appropriate training in infection control. The right to health requires states to define a policy for reducing the risk of infection, as well as to provide a policy on occupational protective and health services as working conditions of health workers.

[1] Ionic Department of Mediterranean Legal and Economic Systems Society Environment Cultures, University of Bari "A. Moro", francesco.perchinunno@uniba.it

Thus, suitable human and guaranteed resources, personal protective equipment, information, training and psychological support are mandatory for medical staff. Moreover, a debate about a support for the families of health workers who have died is growing in parallel to request of immunity to licensed healthcare workers providing care resulting from the public health emergency. This paper aims to resume the risk of healthcare workers addressing some observations about human rights law.

COVID-19 pandemic: general features and impact on public health

On February 11, 2020, the World Health Organization (WHO) formally designed the new coronavirus 2019 infection Coronavirus Disease 2019 (COVID-19)[2].

The spread of COVID-19 infected more than 100 000 people in 100 countries and has already reached the epidemiological criteria for it to be declared a pandemic[3], as declared by the World Health Organization on 11 March. Since 31 December 2019 and as of 07 May 2020, 3 713 796 cases of COVID-19 (in accordance with the applied case definitions and testing strategies in the affected countries) have been reported, including 263 288 deaths. Across the whole of Europe, there were 1,591,467 confirmed cases of COVID-19. The situation of the contagions presents diversified features throughout the international territory with peaks in Europe and America. The Countries with the highest number of cases are the United States of America (860,772), Spain (219,764) and Italy (192,994).

Early diagnosis of the clinical symptoms is recommended for promptly starting the adequate restrictive measures as social quarantine and treatments to avoid spreading of the virus and complications in patients. The International Covenant on Civil and Political Rights (ICCPR) requires that restrictive procedures must be "lawful, necessary and proportionate". Control assessment such as quarantine or isolation of symptomatic people must be carried out according to the law. They must be based on scientific findings, proportionate to the plan, neither arbitrary nor discriminatory, limited in time and respectful of human dignity.

At the beginning of COVID-19 disease, restricted measures have been issued by Chinese government for limiting the spread of the virus, such as suspension of public transport, closure of airports, cancellation of celebrations and closure of parks and cinemas[4]. Subsequently, more drastic containment measures were applied in China up to the suspension of all non-essential activities resulting in decrease of COVID-19 spreading progression, as observed in Wuhan. First, the WHO and the Emergency Committee under International Health Regulations have stressed the need to screen travellers from affected areas. After, the WHO has developed a strategy to contain the impact of COVID-19 that included blocking the chain of transmission (working on patients as well as close contacts), to avoid the health system disruption and to limit the impact of the pandemic as much as possible. Isolation of symptomatic subjects is mandatory to reduce transmission as well as social distancing for healthy people are essential. In China, the government imposed a quarantine with little respect for rights as exampled from some measures such as barricade doors of infected families, or arrest people for refusing to wear masks. In Italy, it has been imposed a lock down with respect of human rights as restriction of travel expect for essential work or health-reason /upon self-certification), closure of all cultural centers, cancelling meetings, sports and cultural events[5]. Moreover, all schools and university were closed whereas some countries such as UK, the Netherlands, Romania, Finlandia and Sweden keep their school open. The U.K. government may have been slow to react in the early days of the COVID-19 crisis, but since then it has moved swiftly to implement expansive lock down restrictions.[6]

Moreover, governments provides protective measures also for people living in places of detentions such as prisons or residential institutions for populations with disability or nursing structures for older people where the virus can spread more rapidly.

Defence of human rights during pandemic

The measures that governments have adopted to limit the spread of COVID-19 do not have a limited impact on the fundamental rights and freedoms of people guaranteed by extending their effects within an extra-legal framework, as such also subject to international obligations.

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[2] WHO. Novel Coronavirus (2019-nCoV) Situation Report—22. https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200211- last visited. 02/12/2020.

[3] E. Callaway. Time to use the p-word? Coronavirus enter dangerous new phase (2020), Nature;579: 12

[4] C. Wang, PW Horby , FG Hayden, GF Gao. *A novel coronavirus outbreak of global health concern*. (2020) *Lancet*.

[5] Gazzetta Ufficiale della Repubblica Italiana. G.U. Serie Generale, n. 59 del 08 marzo 2020. https:// www.trovanorme.salute.gov.it/norme/dettaglioAtto? id=73594. Last visited 03/09/2020

[6] Fairgrieve D. The U.K. Races to Catch Up on COVID-19 (2020) The Regulatrory Review.

It is worth recalling, among others, the 1966 International Covenant on Civil and Political Rights (PIDCP), passed on 23 March 1976, ratified by Italy with Law no. 881 and the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) of 1950, approved on 3 September 1953 and ratified by Italy with Law 4 August 1955, n. 848.

The rapid spread of the virus has required the adoption of restrictive measures in various countries not only in Europe, causing, for a third of the world population, a real lockdown if it is true that on 30 January 2020 the Director General of the World Health Organization (WHO) qualified the spread of coronavirus as a "public health emergency of international concern" and on March 11, 2020 WHO then qualified the situation as a "pandemic". It is clear, however, that the WHO declarations, however, cannot constitute a justification for the violation of international obligations, although they constitute evidence of the existence of a "possible" emergency situation, which will be discussed shortly with reference to art. 15 ECHR.

The widespread spread of COVID-19, therefore, has induced almost all States to adopt measures restricting individual rights, while fully aware that it was necessary to follow formal and substantial parameters in according to the principle of legality, a concrete limit to the arbitrariness of the 'public authority; these limitations must be proportionate to the interest to be protected and the State is called to strike a fair balance between the restrictive measure and the collective good policy of protection. Ordinary limitations include the right to personal freedom, codified in article 5 of ECHR, in the part in which it provides that no one can be imprisoned, without prejudice, among various exceptions, to the "Regular detention of a person likely to spread a contagious disease"[7]. The ECHR had the opportunity to provide an authentic interpretation of the rule, recalling the need for a balance judgment to always be made between the applicant's right to personal freedom and that the collective right to health was guaranteed by assessing factors such as the length of the period of detention, the dangerousness of the disease and the availability of other measures less harmful to individual freedom useful to face the situation[8]. If we follow the number of deaths caused by COVID-19 and the difficulties of many States in curbing the epidemic, the hospitalization or quarantine measures adopted by different States could appear to comply with the requirements set out in article 5 of the ECHR. The possibility of derogation from the treaties for states has been identified in cases of threats to the interests of each state; in such cases, it is possible to resort to an act of notification (derogation clause provided for by the treaties, e.g. article 15 ECHR) which can suspend the full enjoyment of some rights, to introduce extraordinary measures[9]. Moreover, the monitoring of human rights is ongoing on behalf of both the United Nations and the Council of Europe, so much so that the Member States have been invited to adopt measures to fighting the virus , in line with respect for fundamental rights. The aim is to avoid that the actions taken do not lead to discrimination, taking care of the specific needs of particularly vulnerable groups, such as the elderly or homeless and aiming to contain the spread of contamination, in full respect of human rights and the state of right. This is dependent on the compliance with the human rights treaties which imposes on States the duty to protect individuals from serious and imminent threats, especially when the right to life is seriously endangered, under penalty of violation of their international obligations. The ECHR and Fundamental Freedoms of 1950 were mentioned, in the awareness that each country , during the emergency, has committed a violation of Convention. In particular, relatively to the so-called limitation clauses, contained in articles 8 to 11 of the aforementioned Convention, which protect, respectively, the right to respect for private and family life, freedom of thought, conscience and religion, freedom of expression and of practice of assembly, as well as in art. 2 Prot. 4, freedom of movement. Then, there is another provision, art. 15 ECHR ("Derogation in the event of a state of urgency"), which applies in emergencies and provides for the faculty, for each acceding State, to adopt measures derogating from the obligations under the Convention, in the event of "public danger that threatens the life of the nation "and to the extent that the situation requires it and always on condition that these measures do not lead to a conflict with other obligations deriving from international law.

[7] Article 5. Right to liberty and security"*(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants…*".

[8] The European Court of Human Rights (Second section, Enhorn case v. Sweden, application no. 56529/00) 25 January 2005.

[9] It remains to be seen whether there was a real need to use the derogation to introduce such measures, given that numerous (and heavy) restrictions can still be adopted through ordinary limitations. At the basis of this choice there could be the expectation of a greater indulgence by the European Court in assessing the adequacy of measures introduced in the presence of full-blown states of emergency. Another plausible explanation is that, having adopted measures whose legitimacy has not yet been tested by the Court, the States are not sure of their compatibility with the ECHR, and therefore prefer to derogate to protect themselves from any future complaints.

The Article. 15, therefore, adapts the principles of legality, necessity and proportionality which base the logic of balancing human rights and collective interests to situations which, by their nature, do not allow an assessment of each individual concrete case. So, from the examination of art. 15 and European jurisprudence it will be necessary to verify, case by case, the existence of the conditions for the legitimate invocation of the limits set by the Convention to exercise the right of derogation.

Then, there is the obligation, established in the last paragraph, that each State informs the Secretary General of the Council of Europe in the most complete way on the measures taken and on the reasons which determined them, as well as on the date on which these measures stop. The notification, in fact, has a dual purpose, the legal one related to the applicability of art. 15 and the political one, which pertains to the manifestation of concern by each individual State to ensure that the limitations of fundamental rights remain within the limits of what is strictly necessary.

Recent practice has shown that these are notifications most frequently issued by the most democratic states[10]. However, if on one hand there are European countries that have chosen to derogate from respect for fundamental rights, on the other hand there are countries that have adopted a model of discipline (Coronavirus Act of 25 March 2020), in which for the application of the measures there must have been a previous check by a doctor of the public health service who has found positivity to the virus, or in the event that there is a reasonable suspicion of infection[11]. So, the competence in the request for the adoption of the measures is of the doctor, according to criteria of necessity and proportion, burdening on the doctor the duties of information in parallel to the hypotheses of the replacement and revocation of the measure and the periodic revision, in an ordinary framework that provides a maximum quarantine limit of 14 days. Then there is the discipline of the forced execution of the quarantine with the right to make a judicial appeal, entrusted to a judge who can confirm or cancel the measure, or even modify it.

The outcome of healthcare workers in COVID-19 pandemic

Relatively to healthcare workers, the "International Covenant on Economic, Social and Cultural Rights (ICESCR)" declares that governments school create conditions that "would assure to all medical service and medical attention in the event of sickness".

Surveillance system data provides reliable information for epidemiologists to identify weak chains of transmission and facilitates evidence-based decisions by policymakers both inside and outside the healthcare service. A key lesson from the Ebola epidemic was that infection-rates among health care workers due to poor and insufficient personal protective equipment (PPE) and limited formation, combined with poor sanitation resulted in a disaster. Health care facilities became dangerous places for outbreak amplification among staff and patients and transmission back to communities. Evidence is that the COVID-19 virus spreads through close contact and droplets, thus people most at risk of infection are those who are in contact with a COVID-19 patient and/or who care for COVID-19 patients as health-care workers. They don't respect social isolation and go to clinics and hospital, putting themselves at high risk for COVID-19. It was described that about 10-20% of responding health-care workers were infected [12]. Besides global assessment, the safety of health-care workers must be warranted[13].We can postulate that the health-care workers security could be assured by: first, training about diagnosis, triage and clinical management responsibilities ; second, through availability of PPE [14]; third, by using practical measures in family and psychological support since as, in addition to the risk of infection, medical personnel describe physical and mental stress relatively to their personal safety and family members[15].

Based on other countries' experiences, health care workers are among the more cases affective by COVID-19. Only some of the health care occupations workers are most likely to be on the frontline of the COVID-19 pandemic because they provide direct patient care.

[10] "*The researches theorize that countries weak democratic governance rarely bother with derogation because they are not concerned about domestic repercussion*", cf. *The European Convention on Human Rights*: A Commentary, Di William A. Schabas.
[11] The relevant part can be read in Schedule 21, §§ 14-17.
[12] A. Remuzzi, G. Remuzzi. COVID-19 and Italy: what next (2020), Lancet, 395(10231):1225-1228.
[13] L. Gostin. Public Health Emergency Preparedness: Globalizing Risk, Localizing Threats (2018) Jama, 6;320(17):1743-4.
[14] https://www.who.int/docs/default - source/coronaviruse/situation -reports/20200306 Last visited 03/10/2020.
[15] Y. Zeng, Y. Zhen. Chinese medical staff request international medical assistance in fighting against COVID-19 (2020) The Lancet Global health. PubMed PMID: 32105614.

A recent study on "How many health care workers are at risk of being sacrificed to COVID-19 in the US?" estimated that nearly one in six health care workers may be at risk of testing positive for COVID-19[16]. In the United States of America, in fact, of the 13.6 million health care workers assumed to be on the frontlines of COVID-19, 2.8 million will be tested positive assuming a rate of 16.6%.

The Chinese Center for Disease Control and Prevention recently published a study[17] in which emerges that Health care personnel infected in China are 3.8% (1716 of 44 672) while are 63% in Wuhan (1080 of 1716), of which 14.8% cases classified as severe or critical (247 of 1668).

In Italy, according to data from the "Istituto Superiore di Sanità" the official cases of health workers positive to COVID-19, on April 22, would be 18,553, with a percentage equal to 10. 7% of the total cases. The ISS public health institute did not report fatality figures, but a study released by the country National Federation of Orders of Surgeons and Dentists (FNOMCeO) medical association said COVID-19 has killed in Italy. A list of clinicians who have died, during COVID-19 pandemic, is being updated daily resulting about 155 deaths among medical workers, on 8 May 2020. In UK, it has been declared that there are about 49 verified deaths National Health Service (NHS) staff from COVID-19 during the pandemic, although media intimate that many others have died in hospitals, surgeries and care homes during the coronavirus outbreak. Many family members of those who have died have complained that health professionals are not being given adequate protective equipment as they deal with coronavirus cases[18].

Recently, Yoshida et al. performed a cross-sectional, observational study using news reports on the websites among some countries. It evidenced that 120 medical doctor died to the COVID-19 in Western Europe and East-countries with an overall proportion of dead medical doctors amounted to 1.9 per 10,000 confirmed cases and 30.2 per 10,000 dead cases, respectively[19]. Notably, deaths were common among general practitioner (GPs), suggesting a higher risk among doctors who may have frequently visited COVID-19 patients. Similarly, to global population, most of fatality were seen among elderly male doctors. The proportions of deaths in Italy and China were significantly higher compared to other countries as Australia, Germany, Canada and Japan, as described by Yoshida in this paper[15]. Since as in Italy high number of medical doctor died in COVID-19 era, patients associations call to protect medical doctors and all hospital workers, including nurses, therapists, technicians, and support staff and elaborates an accurate analysis of characteristics of medical deaths[20].

The majority were on the front-line contracted the illness at the start of the emergency when protective kit was lacking and when healthcare workers knew nothing about COVID-19 pandemic. Overall, 23 (38%) of the 61 doctors who have died were general practitioner (GPs) that provide provides preventive care and health education to patients. Then, there are specialists, who presumably would have been seeing the more severely affected patients treated in hospitals. The list includes pulmonologists, anaesthesiologists, epidemiologists and doctors who were working in nursing homes as well as dentists and ophthalmologists. In addition, the majority of the deceased doctors are male, as it has been reported for the overall COVID-19-related deaths in Italy (one analysis found that 70% of COVID-19 deaths were male, and mean age was 80).

Moreover, a recent study on "What factors are associated with mental health outcomes among health care workers in China who are treating patients with COVID-19?" [21] have showed that 50.4 percent, 44.6 percent, 34.0 percent, and 71.5 percent of all participants reported symptoms of depression, anxiety, insomnia, and distress, respectively.

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[16] Bk. Frogner. How many health care workers are at risk of being sacrificed to COVID-19 in the US? [Internet Blog] Center for Health Workforce Studies, University of Washington, Mar 31 2020. http://depts.washington.edu/fammed/chws/how-many-health-care-workers-are-at-risk-of-being-sacrificed-to-covid-19-in-the-us, Last visited 03/31/2020

[17] Novel Coronavirus Pneumonia Emergency Response Epidemiology Team. Vital surveillances: the epidemiological characteristics of an outbreak of 2019 novel coronavirus diseases (COVID-19) China, 2020. China CDC Weekly. http://weekly.chinacdc.cn/en/article/id/e53946e2-c6c4-41e9-9a9b-fea8db1a8f51. Last visited 03/31/2020

[18] www. Guardian.com last visited on 2 may 2020

[19] Yoshida I. Tanmoto T. et al. Characteristics of Doctors Fatality due to COVID-19 in Western Europe and Asia- Pacific countries (2020) An International Journal of Medicine.

[20] Anelli F. et al. Italian doctors call for protecting healthcare workers and boosting community surveillance during covid-19 outbreak (2020) BMJ

[21] L. Jianbo, Ma. Simeng, W. Ying, et al Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019 (2020), JAMA Network;3(3):e203976.

These findings suggest that, among health care workers exposed to COVID-19, women, nurses, and front-line health care workers have a high risk of developing unfavourable mental health outcomes and may need psychological support or interventions[22].

It needs to protect all of our health care workers, especially those at the frontline, because otherwise many COVID-19 patients will not receive the necessary care[23].

Protection of healthcare workers under international law principles

International health law has developed under the impulse of increasingly pressing health security needs in distinct phases: an initial phase, in which the management of health issues has passed from the reserved domain of the State to intergovernmental collaboration; a subsequent phase, characterized by the institutionalization of international cooperation in compliance with the so-called State "health sovereignty"; another phase, moving from the state-centric cooperation model to global health governance. From a regulatory point of view, these phases correspond to a phase in which health protection was entrusted to institutions and subjects other than the State, which mediated by applying unilateral quarantine measures only in the event of an epidemic or pandemic spread of serious infectious diseases, (plague or smallpox). Initially, the States, in the health sector, were engaged in protecting against the risks of importing highly infectious pathogens; the outbreak of the first cholera epidemic in Europe and the growing threat of the spread of particularly serious contagious diseases led the States to classify infectious diseases among issues of international interest, adopting the first forms of international cooperation, aimed primarily at overcoming the existing regulatory vacuum, primarily with the establishment of the WHO and the approval of the International Health Regulations (2005). These are moments that marked a fundamental stage in the consecration of an international public health management model in accordance with the globalization and global governance process that gave rise to a genetic investigation field of "global health governance", ruled by international standards (WHO), unlike the "global governance for health", which concerns the methods of implementation of global governance processes also beyond outside the health field.

The WHO has tried to meet the pressing needs of international health security through the international health regulation that has allowed the development of prevention strategies. These are the adoption of criteria of timeliness and effectiveness (the provision of new rules and procedures on surveillance, alert and rapid reaction), flexibility (adaptability of these rules and procedures to the different transmission dynamics of new or emerging diseases and to advances in the fields of epidemiology, biotechnology, information technology and sharing of data) and universality (guaranteed not only by the mandatory nature of the Regulation for all Member States of WHO 30, but also by the opportunity offered to non-Member States to adhere to it and by the possibility of involving non-state actors). The Regulation is based, in essence, on harmonized rules and procedures for sharing epidemiological information and the necessary technical-operational support, imposing constant epidemiological surveillance and, in the case of health emergencies of international scope, also the obligation of immediate notification to the WHO, in line with the provisions of the aforementioned art. 15 ECHR. By "global health", we mean that set of "aspects of collective health that transcend national borders, can be influenced by circumstances or changes that occur in other countries, and can be better addressed by cooperative actions and solutions". The doctrine has attempted to propose a univocal and shared definition of global health, despite the objective difficulty of enclosing the multiple facets of global health in a single definition, also due to the continuous transformations of the very concepts of health and disease. The concept of global health is also connected with another important phenomenon, that of the so-called "epidemiological transition", as the continuous process of change over time in the distribution of the causes of disease and death in a population, which records the decline of some pathologies prevalent (many infectious and malnutrition diseases) and the progressive spread of others (new or emerging infectious diseases, chronic and degenerative diseases, non-communicable diseases).

Recently, the Bioethics Committee of the International Organization has highlighted how, also in an emergency context and management of a health crisis, the rights of individuals must be protected first, guaranteeing assistance to the weakest and that the health data useful for fight against the virus must be protected, as well as the rights of people during the search[24].

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[22] E. Dong, H. Du, L. Gardner. An interactive web-based dashboard to track COVID-19 in real time (2019) Lancet Infect Dis.

[23] It was extracted by previous citation into the text Remuzzi A. Lancet 2020

[24] Cf. Strasbourg, 14 avril 2020, Comite de Bioethique (dh-bio), Déclaration du dh-bio sur les considérations en matière de droits de l'homme relatives à la pandémie de Covid-19.1: "Les systèmes de santé sont soumis à des contraintes extrêmes et font face quotidiennement à des situations très aigues et complexes. Le nombre croissant de cas graves soulève des problèmes éthiques majeurs auxquels les professionnels et les autorités compétentes ont à répondre dans le cadre des soins aux patients.

The legal principles that emerged from the aforementioned declaration are related primarily to access to healthcare, with particular regard to the distribution of scarce resources and the need to follow protocols and medical criteria, making sure not to create discrimination to the detriment of vulnerable subjects, such as the disabled, the elderly, refugees or migrants. As for the collection and processing of health data, essential in the fight against COVID-19, they must be subject to specific protection conditions; likewise, restrictions on the exercise of rights must be prescribed by law and aim to protect collective interests, primarily that of public health, thus guaranteeing special interventions in certain clinical emergency situations, such as those faced by health workers in the context of the COVID-19 crisis -19. The objective is to facilitate the exchange of information and analyze the ethical issues raised during the pandemic and its consequences, in accordance with the strategic action plan on human rights and biomedicine (2020-2025) and on the legal reference base of the Council of Europe in the field of human rights, based on the principles adopted by the Oviedo Convention.

The European Parliament Resolution on coordinated EU action to combat the COVID-19 pandemic and its consequences (2020/2616 (RSP) also praised and thanked health professionals who, endangering their health and that of their loved ones, have worked tirelessly and in particularly difficult conditions to combat the spread of the virus and treat patients with COVID-19, calling on the Member States to guarantee sufficient resources, protective equipment and personnel in all their systems. health care.

Health workers are at the front in the daily struggle to contain the virus and save lives. Their safety is a fundamental requirement to allow them to work in adequate conditions during the crisis and in this sense it was essential that the health personnel could have protective material and be aware of the correct methods of use, as well as access to the tampons control should then have been made as easy as possible, to promote the health of both the operators and the patients themselves. The pandemic also exposed health workers to conditions of unprecedented pressure determined both by heavy workloads (excessive workloads and hours and lack of rest periods) and by the drama of some decisions, and by the need to face fear to contract the disease or pass it on to your family. The dramatic experience of the ongoing epidemiological infection must make us think about the extent of investments in all health sectors, both in terms of the need to create a truly efficient health system and a sufficient workforce in numbers and training, for a adequate prevention in the event of future health emergencies.

Conclusive reflections and perspective futures

An urgent and thoughtful reflection is needed above all on the framework of these violations and serious defaults. The inviolable human rights, the spirit of solidarity and the value framework of Charter of Fundamental Rights of the EU and Italian Constitution require a severe obligation on the part of the State, an effectively conduct, so that in the future there will be no further phenomena of isolation and abandonment of entire professional categories[25]. A civil and democratic management cannot allow such a high mortality rate to be recorded in the future towards those who have been exposed to a real "civic sacrifice", to safeguard the life and health of others and in deference to that fundamental right to health that saw them philanthropists before and immediately after victims. The solidarity projection of the right to care and health cannot go beyond being interpreted in its most extreme individualistic form, as said the brocardo *vita mea, mors tua.*

The updated report of the COVID-19 epidemic leads to a definition of "unprecedented catastrophe" which involved a number of aspects related to health protection and put health policy under review, highlighting some serious weaknesses in the approach and in the management of viral epidemics.

Des décisions difficiles doivent être prises à l'échelle individuelle et collective, dans un contexte de rareté des ressources, qui peuvent avoir des conséquences importantes sur les individus.".

[25] The role of the state is also varied as a reflection of the complexity of the content of the object being protected: to achieve the protection of psycho-physical integrity or the healthiness of the environment it engages "negatively", that is, it abstains from actions that would entail infringement of related rights; to guarantee, however, the right to health treatments, the commitment of the institutions is active, because in order for the holders to actually enjoy them, they must prepare the facilities and any other conditions necessary to offer health care. "Properly conceived freedom does not in any way require any form of total independence from the state; on the contrary, a government that intervenes ensures the necessary conditions for individual freedom. A country where freedoms are guaranteed cannot erase the dependencies of individuals and groups on the state.

cfr. on this point, albeit in a parallel perspective, the fight against coronavirus and the solidarity face of the right to health by M. Noccelli, the fight against coronavirus and the solidarity face of the right to health, in Federalismi.it, (emergency observatory Covid), 11 March 2020.

The sacrifice that many health workers, doctors, nurses, technicians and all hospital support staff have had to face, often without adequate and timely training and without the necessary precautions, thus risking their lives, to save that of others, must induce us all to reflect. There has been talk of "modern heroes" of an unexpected war against a difficult enemy, but it is not acceptable that in the future similar "marginalization" phenomena are repeated; the deprivation of even a minimum level of protection of fundamental goods constitutes the most serious failure to observe constitutional values, that spirit of solidarity, an essential nucleus in a civil and democratic society. In the future, a timely multidisciplinary approach must be hoped that involves, with the institutions, health personnel, epidemiologists, researchers, experts in the legal - economic sector, in order to set up a scientific committee that identifies the most suitable emergency policy to make it more efficient. the health system.

The presence of guidelines already written on the occasion of previous epidemics should have alerted and allowed a more rapid and efficient management of the epidemiological emergency, as mentioned through a punctual and univocal training activity for all healthcare personnel, the global distribution of protection, the provision of a good territorial network to manage patients without taking them to hospital to avoid chain infection and last but certainly a priority, the protection of life and psycho-physical health of health workers. The ax that weighs on the professional categories engaged in the front line, however, paradoxically is even more burdensome if one thinks of the responsibility profiles of health professionals in the COVID-19 emergency and the absurd claim that the doctor must respect the precautions routinely collectable.

An example of the univocal spirit of solidarity which, in a civil and democratic country, must represent the rule not the exception, so energetic and direct as to mitigate the painful impact caused by the violations suffered by health personnel and which must constitute a stimulus for the institutions, in the complex process of research of the essential levels of protection of human dignity and the solidarity principle.

The hope is that all citizens can meet and unite in one solidarity afflatus and that the emergency can awaken consciences bringing the sacred concept of "health" within a less selfish perimeter, hinged uniformly on the protection of absolute rights and duties. mandatory cooperation and mutual support.

Based on these evidences, to protect healthcare workers and to extend the capacity of our nation's health care workforce for providing care on the frontlines of the COVID-19 crisis, the Secretary of Health and Human Services urges all state governors to take a number of immediate actions, including shielding health care professionals from medical liability. Relatively to Italian experience, comforting news was recorded by the plenum of the National Forensic Council which resolved to apply disciplinary sanctions for lawyers who offer assistance for legal actions against doctors engaged in the treatment of patients with COVID-19, considered a mere "speculation on the pain "and, therefore, a violation of the ethical principles of advocacy[26].

As said by Cartabellotta, president of GIMBE, Italy's Group for Evidence-based Medicine, the infected health workers were unfortunately the great and unaware protagonists of the infection in hospitals, nursing homes and patients' homes. Therefore, governments must reply to call of medical doctors "*we're not heroes, we're human*" and this paper could illuminate about identification and eradication of inequities inherent in essential principles and globalization of health and human rights.

[26] On this point, see the CNF communiqué of strong condemnation for members of the forensic order who will violate the ethical principles of the lawyer, "Sanctions for lawyers who speculate on pain", in www.consiglionazionaleforense.it/web/cnf-news / - / 687,342.