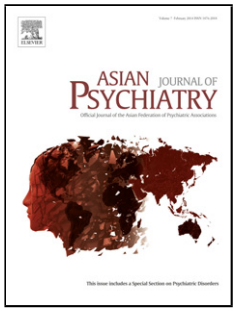

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Hospital suicide due to non-treatment by healthcare staff fearing COVID-19 infection in Bangladesh?

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Introduction

The novel coronavirus-2019 (COVID-19) pandemic has had a large effect on mental health globally and has led to individuals fearing COVID-19 infection alongside conditions such anxiety, depression, trauma, and stress (Ahorsu et al., 2020; Islam et al., 2020; Sakib et al., 2020a; Tandon, 2020a; 2020b). For a small minority, such mental health factors can contribute to suicidality (Dsouza et al., 2020; Jahan et al., 2020; Mamun & Griffiths, 2020a; 2020b; 2020c). Additionally, other COVID-19-related issues such as economic crisis, poverty, and lockdown-related movement restrictions can be proximal factors in suicidal behavior (Bhuiyan et al., 2020; Mamun et al., 2020a; Rafi et al., 2020).

However, there is already evidence highlighting a wide range of COVID-19 reasons for suicide, in which the fear of COVID-19 infection is prominent (Dsouza et al., 2020). Other reasons for COVID-19-related suicides have been reported including: (i) economic distress and recession, (ii) social boycotting and xenophobia towards those suspected of being infected with COVID-19, (iii) testing positive for COVID-19, (iv) being forced to live in a quarantine center due to being suspected as having COVID-19 infection, (v) feeling lonely and isolated as a consequence of lockdown, (vi) being unable to come back home as of lockdown, (vii) COVID-19 work-related stress, and (vii) alcoholics being unable to buy alcohol (e.g., Bhuiyan et al., 2020; Dsouza et al., 2020; Griffiths & Mamun, 2020; Mamun & Griffiths, 2020d; Mamun & Ullah, 2020). Here we report a novel reason for suicide and seemingly COVID-19-related – negligence in getting treatment by Bangladeshi healthcare providers.

Case report

On 20 May, a 40-year-old woman named Sojni was found dead hanging from the women's ward bathroom window grill of a hospital in Hili, Dinajpur. Eyewitnesses at the hospital said that once the patient was admitted, nurses and doctors refused to treat her because they suspected she was infected with COVID-19 and did not want to get infected themselves (although the hospital refuted the claims). The same eyewitnesses claimed that the hospital staff also told them not to help the women or go near her. Two days before the incident, she had been vomiting blood on the side of a road and complained of a sore throat. It is not known whether the woman thought she had COVID-19 but she committed suicide because she was unable to get treatment for her condition by anyone at the hospital allegedly due to the fear of COVID-19 transmission (Somoy News, 2020).

Discussion

The COVID-19 crisis has pushed healthcare professionals (HCPs) worldwide into an unprecedented situation resulting in extreme pressure which affects individuals psychologically (Greenberg et al., 2020). There are a number of reasons that have contributed to the psychological burden of HCPs reasons including: (i) lack of appropriate and quality personal protective equipment, (ii) being exposed to a potentially deadly virus, (iii) being a carrier of the virus and worrying that they will infect their families, (iv) not having rapid access to testing if they develop symptoms and a concomitant fear of propagating infection in the workplace, (v) uncertainty as to whether their employer will support and/or take care of their personal and family needs if they develop infection, (vi) lack of access to childcare during increased work hours and school closures, (vii) lack of support for other personal and family needs as work hours and demands increase (food, hydration, lodging, transportation), (viii) worrying whether they can provide competent medical care if deployed to a

new area (e.g., non-ICU nurses having to function as ICU nurses), and (ix) lack of access to up-to-date information and communication concerning COVID-19 (Shanafelt, et al., 2020; Usama et al., 2020). Any one of these reasons could significantly affect the mental health of frontline HCPs globally (see Pappa et al. [2020] for a recent review of the associations between depression, anxiety, and insomnia among 33,062 HCPs during the pandemic).

It is not an unusual reaction for individuals to avoid those suspected as having COVID-19 and to experience xenophobia in such circumstances (Mamun & Griffiths, 2020d), and some HCPs will experience such feelings even though it is their job to treat such individuals. In Bangladesh (from where the present suicide case was reported), two-thirds of the HCPs (65.3%) reported being uncomfortable treating patients who they thought had COVID-19 symptoms (Sakib et al., 2020b). Moreover, 45.0% reported that they remained at least one meter away from patients they were treating, and 6.0% said they had refused to examine patients they suspected of having COVID-19. Over 90% of the Bangladeshi HCPs felt insecure for themselves and/or their family members because of the potential risk of COVID-19 infection (Sakib et al., 2020b). These statistics are concerning if they are the norm in Bangladeshi healthcare facilities, and suggests that some suspected COVID-19 patients are going without emergency treatment. In the case reported here, not getting treatment led to the woman committing suicide and the HCPs' fear of being infected with COVID-19 appear to have had a contributory role irrespective of whether the woman had COVID-19 or not.

Conclusions

This suicide case suggests some patients may be mentally suffering as a consequence of treatment-related negligence. Most suffering resulting from a proximal cause such as not being treated is unlikely to lead to a life-threatening situation such as suicide. Also, there are many other distal factors that may have played a role in the suicide (although not getting treatment appears to have been the 'final straw' in this case).

To help allay the fears among HCPs and the patients they are treating with COVID-19, a number of initiatives need to be in place: (i) the families of HCPs should be given priority access to testing and treatment so that the fear of HCPs passing on the virus to their families can be lessened; (ii) hospital staff should have standardized procedures to minimize the chances of infecting their families (e.g., not bringing work clothes home, showering at work before coming home, using separate bathrooms at home); (iii) strict adherence by all hospital staff to engage in mandatory COVID-19 preventive behaviors (hand hygiene using alcohol-based sanitizers particularly after coughing or sneezing, wearing of surgical masks, gloves, gowns, head covers, shoe covers, etc. at all times on site; immediate risk assessments on patients such as their recent travel history); (iv) delaying all elective inpatient/outpatient visits and elective inpatient/outpatient surgeries; (v) immediate dissemination of all the latest developments and information concerning COVID-19 from trusted sources such as the World Health organization and national Centers for Disease Control rather than social media; and (vi) any HCP wanting psychological help to deal with resultant mental health problems should get it free and on demand from their employer (Usman et al., 2020).

Conflict of interest: No conflict of interests is available.
Ethic statement: Not applicable to this study.
Compliance with ethical standard: Not applicable to this study.
Statement of human rights: Not applicable to this study.
Hazards and human or animal subjects: Not applicable.
Use of patient images or case details: Not applicable.
Originality and plagiarism: Originality is strictly maintained, while plagiarism is applicable.
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