Physicians for Human Rights

Silenced and Endangered

Clinicians' Human Rights and Health Concerns about Their Facilities' COVID-19 Response

February 2021

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Acknowledgments

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PHR leadership and staff contributed to the writing and editing of this report, including DeDe Dunevant, director of communications; Donna McKay, executive director; Karen Naimer, JD, LLM, MA, director of programs; Joanna Naples-Mitchell, U.S. researcher; Michael Payne, senior advocacy officer; and Susannah Sirkin, MEd, director of policy. The report benefited from review by PHR board member Kathleen Foley, MD. It was reviewed, edited, and prepared for publication by Claudia Rader, MS, PHR senior communications manager, with assistance from Isa Berliner, communications intern. Hannah Dunphy, MA, digital communications manager, prepared the digital presentation.

Health care workers protesting outside UCLA Medical Center in Los Angeles in December 2020. Photo: Patrick T. Fallon/AFP/Getty Images

Executive Summary

Health care workers have been fired, faced new restrictions, and even been detained for voicing their safety concerns. Many governments and employers have praised health care workers as heroes, while silencing their voices and denying them basic, life-saving protections.

Public health and health care systems throughout the world were woefully unprepared for the COVID-19 pandemic. As hospitalizations surged, frontline health care workers caring for patients with COVID-19 have grappled with shortages of protective personal equipment (PPE) and of necessary resources and equipment for patient care, often with little guidance to inform their allocation decisions. Many health care workers have been infected with and died from COVID-19. And many more have experienced high levels of stress, anxiety, and burnout. Such stress may be compounded by moral distress, defined as knowing the right thing to do but finding it impossible due to institutional or other constraints. This results from clinical decision-making in a resource-constrained environment without clear ethically grounded guidance. And in the face of all these threats and challenges, health care workers who have spoken out about their safety concerns or allocation decisions have faced reprisals and retaliation worldwide, from both their employers and their governments. Health care workers have been fired, faced new restrictions, and even been detained for voicing their safety concerns. Many governments and employers have praised health care workers as heroes, while silencing their voices and denying them basic, life-saving protections. Such reprisals have created a climate of fear for health care workers and have had a chilling effect on their freedom of expression – all at a time when the world needs to listen to its medical and public health professionals more than ever.

Early in the pandemic, from May to June 2020, a team of researchers from Physicians for Human Rights (PHR) and the University of California, Berkeley sought to better understand the human rights and health concerns of health care workers who provide direct patient care. An online survey was sent to PHR's network of clinicians and through nurse and physician membership organizations. The survey asked about their experiences with 1) access to adequate resources such as PPE and necessary materials for patient care; 2) retaliation or reprimands from employers or government officials for speaking out in defense of the safety and rights of patients and health care workers; and 3) provision of clear, transparent guidelines and training around resource allocation. Almost all of the 901 health care workers who completed the survey were physicians and nurses practicing at urban or semi-urban U.S. academic medical centers and private health systems, a majority in California, Massachusetts, and New York. These are relatively highly resourced health care settings, far more privileged than most health care facilities in the world and compared to other settings, such as rural health care systems or most health care facilities in low- and middle-income countries.

Yet, even in these high-resource health care settings, 63 percent of health care workers reported PPE shortages at their place of work. Of those respondents who worked in health facilities that faced PPE shortages, 76 percent were worried about their personal health. Twenty-five percent of the surveyed health care workers reported the rationing of disinfectants, sanitizers, and other cleaning supplies in their workplace. Health care workers also commonly reported an insufficient amount of diagnostic testing, such as COVID-19 tests or antibody tests, with 23 percent of respondents experiencing active rationing and limiting of these tests in their workplace.

While 68 percent of health care workers reported feeling comfortable communicating internally with their health system administrations about safety concerns, only 37 percent reported that they would feel confident speaking publicly about safety issues without facing retaliation from their institution. One New York hospitalist physician described a "pervasive and chilling fear of reprisals from management" that created a great deal of moral distress for hospital workers.

In the face of widespread shortages of essential resources, a majority of health care workers felt unprepared for allocating scarce resources to their patients. Some 54 percent of respondents stated that they had not received sufficient training or preparation in how to allocate scarce resources to patients during the COVID-19 pandemic. In contrast, only 26 percent reported that they had received sufficient training. Similarly, 46 percent of respondents felt that their health care facility had not given them clear information about how scarce resources would be allocated, if necessary, in order to prevent the burden of making decisions from falling on the bedside team. Only 32 percent felt that they had, in fact, been given clear information on this process. In contrast, more than half of health care worker survey respondents were concerned that their belief in what is right would conflict with institutional constraints or procedures when allocating limited resources. At the time of this survey in May-June 2020, 17 percent of respondents reported that they already had concerns and conflicts of this type, while 49 percent of respondents were worried about such conflicts in the future.

This snapshot of experiences from the first wave of the pandemic illuminates the lack of preparation and the shortages of PPE and medical resources even at high-resource health care facilities. As many countries and U.S. states continue to experience additional surges of COVID-19 cases and increased hospitalizations, it becomes even more crucial to ensure that the human rights and safety of health care workers are protected.

Health care workers are protected by international human rights law and various domestic laws and are entitled to workplace safety and a right to health. In the context of this pandemic, these rights are being violated and employers and governments are failing to meet their legal obligations to the rights of health care workers. The following measures continue to be urgently needed.

Recommendations

- Governments worldwide must set and enforce emergency standards for worker protections, workplace safety standards, transparency, accurate reporting, and accountability. National, state/provincial, and local

governments need also to act to implement clearly defined and universally enforceable workplace safety standards for health care settings.

- National, state/provincial, and local governments need to coordinate and work together to ensure an adequate supply of PPE and other critical resources to maintain the safety of health care workers and patients. If necessary, legislation providing emergency powers needs to be passed or strategically deployed, such as the Defense Production Act in the United States, to increase supplies for the current response to COVID-19 and to restore stockpiles for future epidemics.
- Employers, state/provincial, and local governments, and all other relevant actors, must refrain from taking retaliatory actions or any form of harassment against health care workers, including those speaking out publicly about workplace safety concerns. Whistleblower protections need to be strengthened to safeguard health workers' ability to raise the alarm about dangerous conditions without fear of discrimination or retribution.
- Health care facilities must be required to develop and communicate clear training and explicit guidance for scarce resource allocation;
- Health systems must operate under the principle that transparency and regular communication, internally and externally, regarding shortages and protection measures in the face of the COVID-19 emergency are the best way to build and ensure trust and safety in an environment of severe constraints.

Health workers protest over lack of protective equipment outside a hospital in the Bronx, New York in April 2020.
Photo: Giles Clarke/Getty Images

Introduction

Since December 2019, when reports of the novel coronavirus SARS-CoV-2 first appeared in Wuhan, China, the virus has spread rapidly across the globe. In March 2020, the World Health Organization (WHO) declared COVID-19 a pandemic, and, in the months since, the highly infectious respiratory disease has disrupted the social, economic, and political fabric of countries and sickened and killed people worldwide. As of February 1, 2021, the WHO has documented 102,399,513 confirmed cases of COVID-19, and 2,217,005 people have died from the illness.[1] As the virus continues to spread and many governments continue to fail to implement appropriate policies to stem the rate of infection, the coming months will continue to be a time of great loss and uncertainty.

Health care workers who engage in direct patient care have tirelessly fought to save lives amidst a global pandemic. But since the beginning of the pandemic in early 2020, their governments and employers have, in many cases, failed to protect them adequately. In addition to the existing occupational health hazards in their regular professional duties, health care workers have faced shortages of personal protective equipment (PPE), resulting in even greater risk of infection while providing care to COVID-19 patients. Health care workers also, in some cases, have faced insufficient numbers of ventilators and other critical medical supplies, raising concerns about whether and how scarce resources should be prioritized. As a result, many health care workers have had to labor in unsafe environments without appropriate protections for themselves or adequate care resources for their patients.

Since the start of the pandemic, health care workers have provided care and essential services to those in need, often at great risk to their own personal health and safety. Health care workers without adequate protective garb such as face shields and appropriate masks are particularly vulnerable to infection, both in the current COVID-19 pandemic and in previous health crises. A study published in *The Lancet* found that front-line health care workers had at least a threefold risk of contracting COVID-19 in comparison to the general population.[2] In mid-July 2020, the WHO reported that more than 1.4 million health care workers were infected with COVID-19, representing a stunning 10 percent of all global cases at that time.[3] In mid-September, the International Council of Nurses released a report that similarly found health care workers made up 10 percent of global cases, on average, and constituted 32 percent of cases in at least one country.[4] Over the course of the pandemic, health care workers have remained at risk and continued to become infected and die from the virus. While there remains no systematic tracking of COVID-19 infections or deaths among health care workers in the United States or globally, as of December 2020, it was estimated that more than 3,300 health care workers had died in the United States alone and nearly 400,000 had been infected by February 2021.[5] Although 60 percent of American health care workers are white, almost 60 percent of health care workers whose lives were taken by the virus were people of color: among those, 27 percent were Black, 14 percent were Latino, and 18 percent were Asian or Pacific Islander.[6]

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An emergency room medic takes a break at a hospital in Colmar, France in March 2020. Photo: Sebastien Bozon/AFP/Getty Images

This situation is particularly serious among U.S. nurses, many of whom belong to immigrant communities. For example, about a third of deaths in the nursing workforce have occurred among Filipino nurses, who make up only four percent of the workforce.[7] While there is no systematic documentation of the global pandemic-related death toll among health care workers, in September 2020, Amnesty International was able to document at least 7,000 health care worker deaths worldwide from COVID-19. That figure was an undercount at the time, and the numbers have continued to grow since then.[8]

As COVID-19 cases again surged in late 2020, after months of heavy workloads and health risks, health care workers are experiencing even greater levels of stress, anxiety, and burnout, with deleterious effects on their mental as well as physical health.[9] Such health care worker stress may be compounded by moral distress, defined as knowing the right thing to do but finding it impossible due to institutional or other constraints. This results from clinical decision making in a resource-constrained environment without clear ethically grounded guidance. Without a sufficient supply of key material and human resources – and often with a lack of clear institutional guidelines – health care workers are exposed to situations of moral distress when determining how to allocate these limited resources to patients in need. Some health care workers may be facing a complete lack of guidance, while others may experience distress when their institutions' resource allocation guidelines differ from the moral calculus and decisions they would personally make.

In the face of all these threats and challenges, health care workers who have spoken out about their safety concerns or allocation decisions have faced reprisals and retaliation worldwide, from both their employers and their governments. Health care workers have been fired, faced new restrictions, and even been detained for voicing their safety concerns.[10] Many governments and

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employers have praised health care workers as heroes, while silencing their voices and denying them basic, life-saving protections. Such reprisals have created a climate of fear for health care workers and had a chilling effect on their freedom of expression – all at a time when the world needs more than ever to listen to and rely on its medical and public health professionals.

To better understand the concerns and experiences of health care workers during the COVID-19 pandemic, a team of researchers from Physicians for Human Rights (PHR) and the University of California, Berkeley from May to June 2020 queried health care workers who provide direct patient care through an online survey to PHR's network of clinicians and through nurse and physician membership organizations. We asked frontline health care workers about their perceptions of risks, challenges with supply shortages, and experiences with allocating resources and addressing concerns in their workplaces during the first few months of the COVID-19 pandemic. We augmented the survey with open-ended interviews with a subset of the health care workers who agreed to be interviewed to gain more insight into their concerns. Almost all of the 901 health care workers who completed the survey were physicians and nurses practicing at urban or semi-urban U.S. academic medical centers and private health systems. These are relatively highly resourced health care settings, far more privileged than most health care facilities in the world and compared to other settings, such as rural health care systems or most health care facilities in low- and middle-income countries. The findings of this survey shed light on the challenges facing frontline health care workers at even the most well-resourced health care facilities in the course of their vital work to inform the development of a more just and effective response to this crisis – one that protects the safety and wellbeing of the people providing life-saving care to those with COVID-19. Specifically, we examined respondents' experiences with the following:

1. Access to adequate resources such as PPE and essential equipment and materials for patient care;

2. Retaliation or reprimands from employers or government officials for speaking out in defense of the safety and rights of patients and health care workers; and

3. Provision of clear, transparent guidelines and training around resource allocation.

As COVID-19 cases are again overwhelming hospitals and health workers, this snapshot of experiences from the first wave of the pandemic illuminates how the lack of preparation and the shortages of PPE and medical resources continue to

be problematic. While at the time of this writing in February 2021, frontline health care workers have begun to be vaccinated with highly effective vaccines and the promise of these vaccines is raising new hope that the worst of the pandemic may be soon be over, many public health experts warn that we can still expect many difficult months ahead. Given this, it is critically important to reflect on the experiences of frontline clinicians in the first months of the pandemic and glean key lessons from how their health care institutions responded. Such an inquiry can help us better understand how we can support health care workers more effectively in the months ahead and better prepare for emergencies in the years ahead.

Methodology

The team of investigators from Physicians for Human Rights (PHR) and the University of California, Berkeley conducted an online, cross-sectional survey and a follow-up open-ended interview with a small subset of the surveyed health care workers. We aimed to better understand the concerns and experiences of health care workers addressing the COVID-19 pandemic.

The anonymous survey contained 26 questions asking health care workers about their demographic information; their perceptions of risk when treating COVID-19 patients; their experiences making decisions about limited resources; their comfort expressing safety concerns about their workplace; and other related topics. All health care workers who reported providing clinical care to patients during the pandemic – including physicians, nurses, paramedics, respiratory therapists, and medical assistants – were eligible to participate in the survey. Participants were included regardless of geographic location, practice setting, or medical specialty. To reach survey participants, the team used purposive sampling through electronic listservs for health care institutions and professional medical associations. The team also used snowball sampling by encouraging participants to forward the survey link to other health care workers in their professional and personal networks. The survey was conducted for one month from May to June 2020, and survey data was collected using Qualtrics software.

PHR also conducted more in depth, open-ended interviews with 10 health care workers who noted on the survey that they had personal experiences to share and agreed to be contacted for a semi-structured interview. While the health care workers interviewed were few in number and not representative of all survey participants, their responses provided greater detail and insight into the experiences described in the results of this survey.

The demographic information provided by respondents offers important context for analyzing and interpreting the survey results. The majority, 69 percent, of respondents were physicians, and 76 percent of all respondents delivered direct clinical care, either in person or via telemedicine, for patients with or suspected of having COVID-19. Respondents worked in a variety of facility types; however, most provided care in either academic medical centers – 35 percent – or in private health care facilities in their communities (31 percent). Women comprised the majority of respondents (67 percent). Lastly, the survey drew responses from health care workers employed in 27 countries, though the vast

majority – 91 percent – worked in the United States. Canada and Kenya were the next most common countries where respondents worked, with three percent and one percent of participants, respectively. Of surveyed health care workers within the United States, 37 percent practiced in California, 16 percent worked in New York, and 7 percent practiced in Massachusetts.

While the survey drew respondents from a wide range of health care professions, countries, and care facility types, a majority were physicians practicing in academic medical centers or private health systems in California, Massachusetts, and New York. Because respondents were disproportionately in these relatively privileged U.S. settings, the findings of this study are limited in their ability to broadly represent the experiences of health care workers globally. As a cross-sectional survey administered over only one month, this data is able to provide a snapshot at a single point in time of attitudes of health care workers during the COVID-19 pandemic; however, the ever-changing nature of this global health crisis across time and geographic regions limits the survey's generalizability.

This research was approved and deemed exempt by the Institutional Review Board of the University of California, Berkeley and the PHR Ethics Review Board.

Findings

We surveyed 901 health care workers between May and June 2020 and conducted in-depth telephone interviews with 10 health care workers who noted on their surveys that they were willing to be interviewed about their personal experiences. The results of the survey and the interviews are broken down into three sections: (1) availability of adequate resources; (2) ability to voice concerns and (3) availability of guidelines on resource allocation.

Table 1: Survey of health care workers' COVID-19 concerns – Aggregate Findings N=901*

I. Demographic Characteristics				
Location (Country - 27 total):	United States: 91 %	Kenya: 3 %	Canada: 1 %	Other: 5 %
Location (of U.S. respondents - 40 states and territories total)	California: 37 %	New York: 16 %	Massachusetts: 7 %	Other: 40 %
Profession:	Physician: 69 %	Registered Nurse: 10 %	Psychologist, clinical social worker, or other mental health care provider: 7 %	Other: 14 %
Facility Type:	Academic: 35 %	Private health system: 31 %	Government health system: 15 %	Other: 19 %
Gender:	Female: 67 %	Male: 32%	Other: 1 %	
II. Lack of Adequate Resources				

Personal protective equipment (PPE) shortages in workplace:	Yes: 63 %	No: 26 %	Unsure: 11 %	
Worry about own personal health:	In facilities facing PPE shortages: 76 %	In facilities not facing PPE shortages: 64 %		
"It is my professional duty to provide in-person care to patients with COVID-19 even if I cannot be provided with adequate personal protective equipment (PPE)."	Total Disagreement with statement: 53 %	Disagreement in facilities facing PPE shortage: 51 %	Disagreement in facilities with adequate PPE: 56 %	
III. Voicing Concerns and Fear of Retaliation				
Comfort communicating with administration about safety issues	Strongly Agree/Agree: 68 %	Neither Agree nor Disagree: 12 %	Strongly Disagree/Disagree: 20 %	
Comfort speaking out publicly without facing retaliation	Strongly Agree/Agree: 36 %	Neither Agree nor Disagree: 26 %	Strongly Disagree/Disagree: 37 %	Prefer not to answer: 1 %
IV. Lack of Transparency and Training; Resource Allocation				
HCW's workplace actively rationing resources:	PPE: 37 %	Disinfectant/Sanitizer / Cleaning Supplies: 25 %	Diagnostic testing: 23 %	
Received sufficient training in how to allocate scarce resources amidst current pandemic:	Strongly Agree/Agree: 26 %	Neither Agree nor Disagree: 20 %	Strongly Disagree/Disagree: 54 %	
Facility has given clear information about how scarce resources will be allocated	Strongly Agree/Agree: 32 %	Neither Agree nor Disagree: 22 %	Strongly Disagree/Disagree: 45 %	Prefer not to answer: 1 %

Lack of Adequate Resources

Widespread PPE Shortages

A majority of health care workers surveyed faced shortages of personal protective equipment (PPE) and other essential resources in their workplaces. Sixty three percent of health care workers reported PPE shortages at their place of work. The proportion of health care workers facing these shortages was consistent across the three countries with the most respondents – the United States, Kenya, and

"No one was taking this seriously…. [it seemed] that marketing, that optics were what [was] most important, not my health and not really the health of patients."

Tennessee emergency medicine physician

Canada – with 63 percent, 64 percent, and 60 percent reporting insufficient PPE, respectively. Respondents from the U.S. states with the highest survey participation – California, Massachusetts, and New York – reported similarly high rates of PPE shortages: 60 percent, 77 percent, and 67 percent, respectively.

Each type of care delivery setting in which respondents worked experienced PPE shortages. A majority of health care workers reported a shortage of PPE at their workplace in all care settings except for long-term care facilities. Shortages of PPE have increased health care workers' perceptions of risk and their concerns for their own health. Of those respondents who worked in health facilities that faced PPE shortages, 76 percent were worried about their personal health, whereas, among those who did not report PPE shortages in their workplace, 63 percent expressed concerns for their own health. Without the proper resources to protect themselves from infection, health care workers treating COVID-19 patients are fearful for their safety.

A majority of health care workers, 53 percent, believed that it was not their professional duty to provide in-person care to COVID-19 patients without adequate PPE. This was true both of health care workers in facilities with PPE shortages, 51 percent, and in those without, 56 percent.

"No one was taking this seriously": Restrictions on Health Care Workers' Resourcefulness

In addition to shortages, some facilities actively restricted the ability of health care workers to wear what PPE they themselves possessed. A Tennessee emergency medicine physician reported that her workplace did not provide adequate PPE, and, to stay safe, she purchased her own. Her workplace then tried to prevent her from wearing it. In mid-March 2020, she felt that "no one was taking this seriously." In her facility, it seemed "that marketing, that optics were what [was] most important, not my health and not really the health of patients." Her facility had been sending the message that "if people think they should be wearing PPE or more extensive PPE, they will panic."

After spending $6,000 of her own personal funds on three powered air purifying respirators (PAPRs) to "be able to keep caring for patients but not risk [her] health," she was denied the ability to wear her own PPE. Her department chair told her she could not wear her gear and must only wear what management was telling her to wear. "At that point," she told PHR, "we were given an N95 mask that you are supposed to wear until it falls apart." When it came to her PAPR, "He said I could not wear it because I would cause panic, I was going to make my patients afraid and make my colleagues afraid."

A medical assistant at the University of Nevada LasVegas Medicine puts on personal protective equipment before conducting COVID-19 tests in April 2020.
Photo: Ethan Miller/Getty Images

Willingness to Perform Tasks Outside of Formal Training in Context of Insufficient Human Resources

When asked if they would complete tasks outside of their own formal training to care for patients with COVID-19, a majority of health care workers, 67 percent, agreed that they would be willing to do so. This widespread willingness to perform tasks outside of formal training did not, however, extend to situations in which health care workers did not have PPE. Half of respondents, 50 percent, were unwilling to provide in-person care to patients with COVID-19 if their workplace ran out of adequate PPE. Only 26 percent reported that they would be willing to do so.

Ability to Voice Concerns and Fear of Retaliation

Health care workers identified myriad concerns about their safety and the safety of others stemming from shortages of life-saving medical equipment, and a lack of training to allocate scarce resources during this pandemic.

"We were given an N95 mask that you are supposed to wear until it falls apart… [My department chair] said I could not wear [my own PPE] because I would cause panic, I was going to make my patients afraid and make my colleagues afraid."

Tennessee emergency medicine physician

"The staff members berated me for asking them to wear a mask. One of the senior physicians told me I was creating fear by wearing a gown."

Ohio family medicine doctor

Lack of Ability to Address Concerns Internally

A majority of respondents, 68 percent, felt comfortable communicating internally with their administration about safety issues in their institution related to COVID-19 care. While these findings are largely positive, a significant 20 percent of respondents reported that they did not feel comfortable discussing these concerns internally with their administration.

A family medicine doctor in a private practice in Ohio faced consequences for insisting on wearing and requesting others to wear PPE. The health care workers in the practice fortunately had all received N95 masks; however, there was no consistent policy and staff were often not wearing masks. "The staff members berated me for asking them to wear a mask," this doctor told PHR. "One of the senior physicians told me I was creating fear by wearing a gown," and human resources and a supervising physician in the owning health system "have reprimanded me for 'fearmongering.'"

This Ohio doctor reported being called in for disciplinary action and accused of "creating a toxic environment" after requesting that staff members wear masks in communal spaces. "They said that I was 'not following the rules'. But there are no rules [in their system] for public health. They have no limits on how many people can come into the clinic, no screening before people coming into urgent care." The doctor was given 30 days to "clean up [their] act." They explained to PHR, "I just want people to wear masks and be careful about the patients we see in person and what practices are when we are seeing patients face-to-face."

"A pervasive and chilling fear of reprisals": Speaking out Publicly

Though a majority of health care workers felt comfortable communicating their concerns internally, a much smaller proportion would feel confident speaking publicly about safety issues without facing retaliation from their institution – only 37 percent of respondents. Another New York hospitalist physician described a "pervasive and chilling fear of reprisals from management" that created a great deal of moral distress for hospital workers. This physician explained how health care workers trying to advocate for their patients felt they "weren't getting any traction through the system," and, as a result, "lots of people started talking to the press." However, this physician told PHR that they and their colleagues faced a type of "corporate authoritarianism," where they "felt it was not okay to speak out." Stories of a medical director losing their directorship after speaking on television helped further produce a chilling climate that stifled dissent in this New York hospital.

"There was a pervasive and chilling fear of reprisals from management and that created a lot of moral distress. You want to advocate for your patients when what is going to help them is better management and redistribution of resources. We would speak out and they would say that 'you need to simmer down.'"

New York hospitalist physician

Lack of Transparency and Training for Resource Allocation

Rationing Critical Medical Supplies for Providers

Facing widespread shortages of PPE and other critical supplies and equipment, medical facilities have turned to rationing or limiting these resources. All health care workers who responded to at least one of PHR/Berkeley's survey questions about limiting and rationing resources reported limited availability in their workplace of at least one of the seven listed critical medical supplies or equipment.

PPE was the most commonly rationed resource, with 37 percent of respondents reporting that their workplace was actively limiting or rationing its use. Twenty-five percent of the surveyed health care workers reported the rationing of disinfectants, sanitizers, and other cleaning supplies in their workplace. Health care workers also commonly reported an insufficient amount of diagnostic testing, such as COVID-19 tests or antibody tests, with 23 percent of respondents experiencing active rationing and limiting of these tests in their workplace.

While these three types of resources were the most widely rationed, other respondents reported that their inpatient facilities were actively rationing hospital beds, therapeutic equipment, ventilators, respirators, and other modes of assisted ventilation (such as bilevel positive airway pressure [BiPAP] and continuous positive airway pressure [CPAP]).

Lack of Guidance on Resource Allocation

Facing such widespread shortages of essential resources, a majority of health care workers felt unprepared for allocating scarce resources to their patients during a crisis of this scale. Though similar proportions of health care workers had training or significant experience in priority setting with limited resources (44 percent agreed or strongly agreed, while 44 percent disagreed or strongly disagreed), 54 percent of respondents stated that they had not received sufficient training or preparation in how to allocate scarce resources to patients during the COVID-19 pandemic. In contrast, only 26 percent reported that they had received sufficient training for this crisis.

"We have no guidance on how to allocate resources…. I can see very clearly that I am not going to be able to provide the care that I know patients will need when we run out of capacity and resources. There is nothing worse than standing in front of a patient and not being able to help them."

Tennessee emergency medicine physician

Similarly, 46 percent of respondents felt that their health care facility had not given them clear information about how scarce resources would be allocated, if necessary, in order to prevent the burden of making decisions from falling on the bedside team. Only 32 percent felt that they had, in fact, been given clear information on this process.

Despite insufficient training, a larger proportion of health care workers did not feel worried that they would be required to personally make decisions about allocating limited resources, such as determining which patients get ventilators or other life-saving resources, based on their own judgment in the moment. Thirty-four percent of respondents were worried about personally making resource allocation decisions, while 47 percent did not feel worried about such situations.

In contrast, more than half of health care worker respondents were concerned that their belief in what is right would conflict with institutional constraints or procedures when allocating limited resources. At the time of this survey, 17 percent of respondents reported that they already had current concerns and conflicts of this type, while 49 percent of respondents were worried about such conflicts in the future.

"We have no guidance on how to allocate resources," the Tennessee emergency medicine physician told PHR. She reported that it was incredibly difficult to know who to call and what to say in the event that resources needed to be rationed. She expressed how the personal responsibility and weight of these decisions affected health care workers in this context: "I can see very clearly that I am not going to be able to provide the care that I know patients will need when we run out of capacity and resources," she told PHR. "There is nothing worse than standing in front of a patient and not being able to help them."

In another case, an internal medicine physician working at a New York community hospital told PHR: "We had no ethical guidance." They reported that their ethics department would "tell us to call them about individual cases but they did not give us general guidance about resource allocation. They basically said 'do no harm.'" Overwhelmed and operating above capacity, health care workers were left with incredibly difficult decisions about life-saving care. This physician reported having to make these decisions "at the bedside" and "on the fly." In one case, they had 34 people in an ICU meant for 12 people. In another, the physician had to decide who would be intubated when they had a list of 18 patients and the ICU could only take one that day. In a third case, after a difficult resource

> *"We had no ethical guidance…. They basically said, 'Do no harm.' [The lack of guidance] was really shocking to me, and I still have a lot of anger about [it]."*
>
> Internal medicine physician at a New York community hospital

allocation decision about which patient would get the only negative pressure room, this physician recounted, "I had to deal with wondering if any staff or others got COVID due to that decision." The physician told PHR that this lack of guidance "was really shocking to me, and I still have a lot of anger about [it]."

In diagnosing the cause of this failure, the New York physician felt that the lack of systematic guidelines for prioritizing "was a collective action problem – no hospital wanted to be the first to do it." They argued that it was a form of "brand management," as no facility wanted to be on the front page of the *New York Times*. "In a privatized environment, the first to act pays a penalty – a case of market failure." The physician believed that hospitals should have all been required to release their ethical guidelines or be subject to state guidelines to solve this issue.

"The biggest issue was the lack of human resources."

In addition to the shortages and rationing of PPE and other medical equipment, some health care workers reported that the shortages of health care workers and other staff was a major challenge. "The biggest issue was a lack of human resources," the same New York internal medicine doctor told PHR, who reported that they were "stuck in situations where our patients were taken care of with unsafe nursing ratios and could not get access to respiratory therapists. [The] biggest issue was lack of organization. You only learned that respiratory therapy was not going to come when they didn't show up. You only found out what was missing when there were gaps leading to bad outcomes. There were no announcements that things were not going to be done, you had to find out yourself." They recalled that their facility frequently had unsafe health care worker-to-patient ratios, with five critically ill patients to one critical care nurse in cases where the ratio would normally be one-to-one. According to this physician, this situation created "lots of vicarious trauma" for health care workers.

Despite this New York hospital being overwhelmed, ambulances and patients kept coming and were not diverted elsewhere, including to another hospital in the same system that was bigger and not facing the same staffing crisis. The same physician told PHR "the fact is that expert surge protocols were not developed years ago. This was a policy failure. It was a governmental failure." They explained the source of this failure: "corporatized health care is about the bottom line – doing more with less. If you are able on a shoestring to make problems disappear then you are rewarded… It was infuriating. It wasn't a lack of resources. It was mismanagement of resources."

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New York internal medicine doctor

Continued Issues through Fall 2020

With continuing surges in COVID-19 cases, access to resources, such as personal protective equipment, continues to be an issue in many health care facilities in states throughout the United States.[11] Of even greater concern with the fall 2020 surge of cases is the inadequate supply of trained health care professionals. While some survey respondents already noted the lack of trained personnel in PHR's interviews earlier in 2020, health care workers from health systems throughout the United States now report that while they have adequate medical equipment such as ventilators, they lack trained respiratory therapists and other specialists to staff them.[12] Nursing shortages are acute especially in under-resourced rural health systems.[13] Moreover, unlike in Spring 2020, when trained health care professionals deployed from throughout the country to assist in hard-hit cities such as New York, with surging cases all over the country such deployments from one region to another are impossible.

The months of caring for high numbers of COVID-19 patients have also continued to wear down health care worker morale and resiliency. Due to the impact of long hours of arduous work over months, many frontline health care workers are reporting feeling burnt out and some are reporting depression and PTSD. Especially in states and localities in which elected officials are failing to enact mask mandates and other public health measures, health care professionals have spoken out in frustration and continued to petition governors across the United States to enact more stringent COVID-19 public policies to mitigate the number of sick patients coming to seek health care.[14] As of January 2021, 13 U.S. states still had no mask mandate. There are ongoing reports of health workers being fired for speaking out, at a time when every health worker is needed to fight the pandemic.[15]

Legal and Policy Framework

International Obligations

Right to Occupational Health

International human rights law guarantees all people the right to health. Governments have legal obligations to protect the health and safety of their residents, including through "[t]he prevention, treatment and control of epidemic, endemic, occupational and other diseases."[16] Moreover, Article 7(b) of

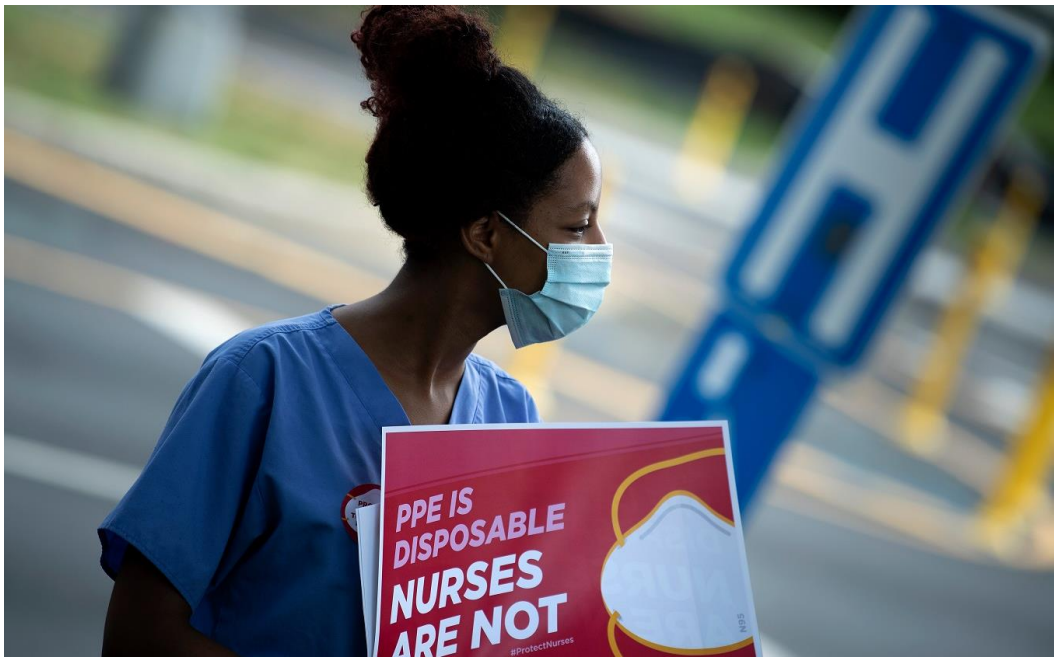
the International Covenant on Economic, Social and Cultural Rights declares the state's responsibility to ensure safe and healthy working conditions. These legal obligations require governments to protect the safety of workers, including health care workers.

In the context of the current COVID-19 pandemic, these rights have been reiterated by relevant international bodies. Interim guidance from the World Health Organization states that COVID-19 should be "considered as an occupational disease arising from occupational exposure," and that health care workers are entitled to protections, compensation, and rehabilitation when it comes to this disease.[17]

In May 2020, the Special Procedures Group of the UN Human Rights Council released a statement urging governments and businesses to ensure all workers are protected from exposure to COVID-19. The statement emphasized that "[e]very worker has the right to be protected from exposure to hazards in the workplace, including the coronavirus," and urged action to protect vulnerable workers:

> "We are concerned at the number of frontline workers who have not been given adequate protection during peak periods of contagion in various countries and economic sectors. And as Governments continue to reduce restrictions and workers begin to return to work, we urge all States and businesses to ensure preventative and precautionary measures are in place to protect every worker."[18]

The UN Office of the High Commissioner for Human Rights' May 2020 guidance on COVID-19 stresses the importance of protecting the occupational health and safety of health care workers and support staff in this crisis: "Health workers and others working in at-risk environments should be provided with quality personal



A nurse protests outside Washington Hospital Center in Washington, DC in July 2020. Photo: Brendan Smialowski/AFP/Getty Images

protective equipment as needed. No one should feel forced to work in conditions that unnecessarily endanger their health because they fear losing a job or a paycheck."[19]

Freedom of Expression

International human rights law also protects the rights of people to freedom of expression without fear of retribution or punishment. Article 19 of the International Covenant on Civil and Political Rights guarantees this freedom of expression, as well as the right to hold opinions without interference.[20] The Human Rights Committee's General Comment 34 elaborated on this right, specifying that this obligation "requires States parties to ensure that persons are protected from any acts by private persons or entities that would impair the enjoyment of the freedoms of opinion and expression to the extent that these Covenant rights are amenable to application between private persons or entities."[21]

The rights of whistleblowers, specifically, are also protected under international law. A 2015 report of the Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression states that whistleblowers "deserve the strongest protection in law and in practice."[22] The report also highlights that "Whistle-blowers must be protected from the threat or imposition of retaliation, remedies should be made available to targets and penalties should be imposed on those who retaliate."[23]

United States Law

National Workplace Protections

Within the United States, the country in which most of the respondents to this survey work, workplace protections for speaking out about safety concerns have traditionally been within the jurisdiction of the Occupational Safety and Health Administration (OSHA), as well as under various state equivalent organizations. Under Section 11(c) of the Occupational Safety and Health Act, private sector workers – including in the health care sector – are protected from retaliation if they raise health- and safety-related concerns about their workplace.[24]

Unfortunately, by all reports, OSHA (or the Department of Labor leadership) has so far either been unwilling or unable to address many of the complaints that have stemmed from the COVID-19 pandemic. Nor, to date, has OSHA issued a further emergency temporary standard to definitively protect health care workers in the current context.

To date, OSHA has only issued voluntary standards for worker protections in health care settings. Thus, these standards are unenforceable, leaving state governments to set and enforce workplace protection standards for health care facilities. The new Biden administration in January 2021 took an important first step toward this end and issued executive orders seeking to tighten OSHA enforcement efforts to better protect workers, including health care workers.

Other U.S. federal labor laws provide for certain protections that many health care workers are not receiving during this pandemic. Under Section 7 of the

National Labor Relations Act, a nonsupervisory employee (even in a nonunionized environment) has the right to engage in concerted activity to effect change to improve working conditions.[25] Retaliatory firings for these efforts are not permissible. Additionally, under Section 502 of the Labor Management Relations Act (the Taft-Hartley Act) of 1947, workers may refuse to work under "unusually dangerous conditions."[26]

OSHA also provides protections for whistleblowers through its multiple statutes on the subject.[27] However, despite these regulations, health care workers have not been safe from threat of retaliation. Although numerous U.S. associations of health professionals have issued statements calling on employers to refrain from such retaliation, the actual protections and recourses for health care workers are not always evident, often varying from state to state and even from one institution to another.

State Workplace Protections

Various U.S. states have their own occupational health requirements and workplace protections.[28] Since the start of the COVID-19 pandemic, many states have adopted additional regulations and legal safeguards for health care workers and other essential workers. In June, Virginia proposed the country's first-ever pandemic emergency workplace safety standards, a necessary response to OSHA's neglect of its own duty to protect health workers.[29] The new state regulations include mandatory guidelines for PPE, sanitation, and other workplace safety guidance, as well as protections from retaliation for health workers who speak out about safety concerns.

Other states and municipalities have since passed additional COVID-19 worker safety protections. These include laws that prohibit employers from retaliating against workers for raising COVID-19 safety concerns, for refusing to work in unsafe conditions, and for taking time off to minimize transmission of the virus; other laws require the provision of adequate PPE and that workers be notified when workplace COVID-19 cases are found. As of late October 2020, 14 states had adopted significant COVID-19 worker safety protections.[30] Cities like Chicago, Philadelphia, and Raleigh have also issued their own laws and ordinances to protect workers from COVID-19 and employer retaliation.[31]

Other states, such as California, Maryland, and New York, already have various forms of OSHA-approved state plans that meet or exceed federal OSHA standards.[32] These can be used to protect state and local workers, and in some states these protections extend to cover private and federal workers. In states where there is no state plan, governors and state legislatures have the authority to institute emergency standards for worker safety and enforcement that go beyond OSHA's ineffective voluntary standards and enforcement mechanisms and that provide enhanced whistleblower protections.

Under the 2009 California OSHA Aerosol Transmissible Disease Standards, there are standards set and generally enforced by the state for social distancing, face masks, hand sanitizing, washing, and gloves.[33] California also boasts regular workplace disinfection, increased ventilation, and notification of infections. National Nurses United has compiled a state-by-state list of whistleblower protection laws for health care workers.[34]

In both the United States and the rest of the world, health care facilities and governments need to be legally required to ensure that health care workers are protected and not vulnerable to disease or retaliation if they speak up about unaddressed safety concerns.

Given the failure of the U.S. federal government to enact emergency OSHA standards, it is incumbent upon states and cities to enact further protections to ensure the safety of health care workers as they provide essential aid during this deadly pandemic and beyond.

In countries such as Kenya, where three percent of survey respondents work, while individual laws offer some protections for whistleblowers, to date there are no comprehensive national laws providing whistleblower protections. In both the United States and the rest of the world, health care facilities and governments need to be legally required to ensure that health care workers are protected and not vulnerable to disease or retaliation if they speak up about unaddressed safety concerns.

Conclusion

This study finds that health care workers, many of whom, remarkably, work in some of the best-resourced health care settings in the United States, have concerns about their own safety and report not receiving all the workplace protection and equipment to which they are legally entitled. While our survey provides only a snapshot of the experiences of health care workers early in the pandemic, from May to June 2020 among a self-selected sample of U.S.-based clinicians, many of the issues and concerns raised continue to be of concern more than half a year later. Moreover, although due to the nature of our sampling, this study's findings cannot be generalized to all health care workers, the results demonstrate how the experiences of many health care workers during the early months of the COVID-19 pandemic have been defined by a lack of adequate resources, guidance, and protection from their employers and governments and that many of these issues persist today.

Health care workers have faced and continue to face widespread shortages of PPE and other critical resources. They have been asked to provide care without the workplace protections to which they are entitled, putting themselves, their loved ones, and patients at risk. They have had to ration critical resources, often without sufficient guidance or training from their employers. Some have faced retaliation from their employers for speaking out about their health and safety concerns; others have remained silent about their concerns for fear of retaliation. This all occurs in a climate of great insecurity, as health care workers are disproportionately affected by COVID-19 and have suffered harassment, and even detention, from governments around the world.

Health care workers are protected by international human rights law and various domestic laws and are entitled to workplace safety and a right to health. In the context of this pandemic, these rights are being violated and employers and governments are failing to meet their legal obligations to the rights of health care workers.

As many countries and U.S. states are experiencing additional surges of COVID-19 cases and increased hospitalizations, it becomes even more crucial to ensure that the human rights and safety of health care workers are protected.

Recommendations

- Governments worldwide need to set and enforce emergency standards for worker protections, workplace safety standards, transparency, accurate reporting, and accountability. National, state/provincial, and local governments also need to act to implement clearly defined and universally enforceable workplace safety standards for health care settings.
- Governments worldwide and the World Health Organization should systematically track and report on work-related infections, injuries, and deaths of health care workers to better inform necessary responses.
- National, state/provincial, and local governments need to coordinate and work together to ensure an adequate supply of PPE and other critical resources to maintain the safety of health care workers and patients. If necessary, legislation providing emergency powers needs to be passed or strategically deployed, such as the Defense Production Act in the United States, to increase supplies for the current response to COVID-19 and to restore stockpiles for future epidemics.
- Employers, state/provincial and local governments, and all other relevant actors must refrain from taking retaliatory actions or engaging in any form of harassment against health care workers, including those speaking out publicly about workplace safety concerns. Whistleblower protections need to be strengthened to safeguard health workers' ability to raise the alarm about dangerous conditions without fear of discrimination or retribution.
- Health care facilities must be required to develop and communicate clear training and explicit guidance for scarce resource allocation.
- Health systems must operate under the principle that transparency and regular communication, internally and externally, regarding shortages and protection measures in the face of the COVID-19 emergency is the best way to build and ensure trust and safety in an environment of severe constraints.

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