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Moral distress among healthcare providers and mistrust among patients during COVID-19 in Bangladesh

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Abstract

The COVID-19 pandemic has shaken the world through its first wave, and we have yet to experience the second wave. Even resourceful countries have failed to adequately prevent epidemics in their country, and for countries like Bangladesh, which already has strained an ineffective healthcare system, the challenges to contain the SARS-CoV-2 virus are that much more severe. Due to the scarcity of resources and systematic failures the Bangladeshi people deeply mistrust the healthcare system. The mistrust is further magnified as healthcare providers are hesitant to treat the patients because of the lack of proper protective gear. Physicians have a moral obligation to serve and treat patients; however, they have a moral obligation to protect their families. This dilemma places healthcare providers in situations where they experience moral distress. This article specifically discusses the importance of interpersonal relationships in driving change, using the framework of Responsiveness, while stating the need for complementary systematic change in order to rebuild trust in the Bangladeshi healthcare system.

KEYWORDS

care, developing world, health care, medical ethics, patient, treatment, COVID-19, SARS-CoV-2

1 | INTRODUCTION

The COVID-19 disease pandemic presents the world with unprecedented challenges. Even wealthy countries, with highly sophisticated healthcare systems, struggle immensely to tame this novel SARS-CoV-2 virus. And the second wave of infections has yet to arrive. The situation is much worst in resource-limited countries like Bangladesh, where the existing healthcare system faces a scarcity of resources, systematic failures, and normative corruption. Compounding the ethical issues of equity and fairness in healthcare, the people of Bangladesh overwhelmingly mistrust both its healthcare institutions and care providers. The COVID-19 pandemic only exacerbated this mistrust. Healthcare providers are hesitant to treat patients because of the scarcity or absence of proper protective gear. Thus, patients who require care are denied care or must search for other providers. This confusion gives rise to frustration, anger, and further distrust in healthcare providers. The lack of protective equipment also places physicians in an untenable position: to serve the patient and risk infection or to not serve the patient to protect personal wellbeing and the wellbeing of their families? As a result of this dilemma, physicians are experiencing moral distress and patients' elevated levels of frustration, anger, and mistrust. This situation often has patients and providers standing against one another in a time requiring unity, cooperation, and solidarity. This broken relationship—the schism between physician and patient—must be addressed without further delay, with the systematic changes. This article specifically discusses the importance of interpersonal relationships in driving change, while noting the need for complementary systematic change in order to rebuild trust in the Bangladeshi healthcare system. This article recommends that by using the framework of Responsiveness, care providers can re-establish, improve, and strengthen patient-physician relationships while reducing moral distress and rebuilding trust with the community.

2 | HEALTHCARE SYSTEM IN BANGLADESH

Bangladesh—which is about half the size of Germany—is a densely populated and emerging country. Bangladesh is ranked as the eighth-most populated country in the world. As of June 4, 2020, the population of Bangladesh was 164,564,713.[1] The lack of resources, combined with mismanagement and corruption, severely challenges the country's healthcare system.[2] As a result, the needs of the healthcare sector remain woefully unaddressed. In Bangladesh, there is virtually no Universal Health Coverage (UHC), which means most people are without healthcare.[3] Also, there is virtually no health insurance structure or safety net. Currently, the population exceeds available resources and infrastructure capacity. Without a visionary plan, the situation will only get worse. The poor find that access to healthcare services is nearly nonexistent. The poor often die without treatment for easily diagnosed ailments. Currently, Bangladesh is unable to provide the minimum healthcare facilities to its people.[4]

The healthcare system in Bangladesh has multiple actors, with the government as the primary actor. Private-sector hospitals provide significantly better service than government hospitals. However, the aim of private providers is profit, and they lack a clear functional or mandated mechanism to serve those without the means to pay for individual care.[5] Furthermore, there is no coordination between the government and the private sector; each acts in its own perceived best interest. In fact, the government and the private sector exacerbate the problem by competing with one another. As a result of this competition—a type of business war—the most vulnerable and most needy patient population is left without healthcare, both in routine and emergencies.[6]

Given this disorder and corruption, the lack of regulation and oversight, overt mismanagement and ineptitude, and blatant profiteering, patients—even those with resources—no longer trust the competence, honesty, or ethics of physicians. The title of 'doctor' which was once most revered, is now sullied. While being a physician was previously perhaps the most respected profession in Bangladesh, today the profession is now roundly criticized and often reviled.[7] This tension only further weakens the healthcare system. To tame this chaos and to construct a trustworthy healthcare system that equitably serves the people of Bangladesh requires a better allocation of resources, efficient systematic changes, mutual cooperation, and a healthy relationship between patients and physicians. Moreover, the vision of and will to make changes are perquisites. All is not lost. Bangladesh remains, at heart, a proud country. The reconstruction and stewardship of the Bangladeshi healthcare system can be achieved through visionary governance, firm oversight and accountability, and the commitment to reform by all leading actors.[8]

3 | IMPACT OF COVID-19 IN BANGLADESH

The obvious culprits for Bangladesh's healthcare calamity are systematic inefficiencies and mismanagement. However, beyond the system-level inefficiency, and perhaps more insidious, are the incidents of physician malpractice, the exploitation of the uneducated, and the predatory practices of the pharmaceutical industry. In short, Bangladesh's healthcare system is in crisis, ethically and structurally.[9] COVID-19 further unsettled an already fragile healthcare system due to the rapid spread of the SARS-CoV-2 virus and the severe toll it has had on the populous.

The Bangladesh government imposed a country-wide shut down on March 26, 2020, which negatively and abruptly affected the economy.[10,11] The country-wide lockdown further stressed the underprivileged and places the populous in situations where their survival is in question. The number of cases of suicides has risen due to the sudden recession, and the economic disruption felt throughout the country.[12] Given population density, the stalled economy, and the lack of planning or structure, a highly-controlled, Chinese-like response strategy cannot be instituted in Bangladesh. In response to the problematic and negative socioeconomic situation, the government re-opened the country's economy on May 31, 2020.[13] Doing so effectively ended a nationwide attempt to limit the spread of the SARS-CoV-2 virus.

Dhaka, the capital of Bangladesh, is the world's most densely populated city, with 20 million people; this translates to 45,700 people per square kilometer.[14] Millions live in slums. In Dhaka, it is common for ten or more households to share the same toilet. Bangladesh is also home to the world's largest refugee camp, where more than

[1]Bangladesh Population. Worldometers.info. Retrieved May 9, 2020, from https://www.worldometers.info/world-population/bangladesh-population/.

[2]Chaos, Corruption persistent in the Health Sector. (2019, January 19). New Age Bangladesh. Retrieved May 9, 2020, from http://www.newagebd.net/article/62172/chaos-corruption-persistent-in-health-sector/.

[3]Chaudhury, T.Z., & Mannan, I. (2019). Universal Health Coverage in Bangladesh: Activities, Challenges, and Suggestions. Advances in Public Health, 1-12.

[4]Shafique, S., et al. (2018). Right to Health and Social Justice in Bangladesh: Ethical Dilemmas and Obligations of State and Non-state Actors to Ensure Health for Urban Poor. BMC Medical Ethics. 19(S1), 61-63.

[5]Talukder, M.M.H. (2016). Developing a Context-Sensitive Patient-Physician Relationship Model for Health Care in Bangldesh. Eubios Journal of Asian and International Bioethics. 26(3), 95-96.

[6]Shafique, et al., op cit. note 3, pp. 64-67.

[7]Talukder, op.cit. note 5, p. 97.

[8]Shafique, op.cit. note 6.

[9]Talukder, op. cit. note 5, pp. 96-97.

[10]Opu, M.H. (2020, April 13). In Pictures: The Effects of Coronavirus Lockdown in Bangladesh. Aljazeera.

[11]Shawon, A.A., & Mamun, S. (2020, May 2). Bangladesh Likely to Extend Shutdown Till May 16. Dhaka Tribune.

[12]Bhuiyan, A. K. M. I., Sakib,N., Pakpour, A.H., Griffiths, M.D., & Mamun, M.A. (2020). COVID-19-Related Suicides in Bangladesh Due to Lockdown and Economic Factors: Case Study Evidence from Media Reports. International Journal of Mental Health and Addiction, 1-6.

[13]Bangladesh Lifts COVID-19 Lockdown, Logs Record Deaths on Same Day. (2020, June 1). CNA. Retrieved June 3, 2020, from https://www.channelnewsasia.com/news/asia/bangladesh-covid-19-coronavirus-lockdown-logs-record-deaths-12789440

[14]New Geography. (2017). The 37 Megacities and Largest Cities: Demographia World Urban Areas. Retrieved June 2, 2020, from https://www.newgeography.com/content/005593-the-largest-cities-demographia-world-urban-areas-2017.

855,000 Rohingya refugees live stateless.[15] Social distancing, which is one of the most effective preventive measures to reduce the spread of the SARS-CoV-2 virus, is impossible given overcrowded conditions within Bangladesh.

According to a report by the Bangladesh Ministry of Health and Family Welfare, the country has six doctors, nurses, and midwives per 10,000 people.[16] At least 500 doctors have already been infected with SARS-CoV-2 virus, and 600-700 doctors are either at home under self-quarantine or under institutional quarantine.[17,18] Many patients demonstrating COVID-19 symptoms are left untreated at the hospitals due to the administrative procedures or because healthcare professionals refuse to treat them. Seriously ill and infected patients travel from hospital to hospital seeking treatment, many dying without ever having received proper care. As an indication of the frailty of the healthcare system, Bangladesh has less than 1,200 ICU beds for 161.4 million people, and there are only 500 ventilators in the country.[19,20] Most hospitals do not have adequate PPE supplies, so healthcare providers are not treating the patients for fear of being infected.[21,22,23,24]

Currently, there is no effective treatment for COVID-19. The structural way to reduce the number of infections is through testing. The more testing, the easier it becomes to identify infected patients and then isolate them, which, in turn, keep the community safe from further infections. Isolating patients would be a monumental challenge in Bangladesh. Unfortunately, due to the insufficient supply of testing kits and processing facilities, Bangladeshis goes untested, the virus remains undetected, and the infection cycle continues and grows.[25] If Bangladesh is to curb the epidemic, convenient, inexpensive, and rapid-results testing is needed. However, currently, Bangladesh does not have the human or testing resources or the political willpower to make this happen.

4 | PEOPLE'S MISTRUST OF HEALTHCARE PROVIDERS

In general, the mistrust of the healthcare system occurs at three levels: societal, institutional, and interpersonal. Societal uncertainties, faulty institutional practices, and inconsistent interpersonal communications adversely affect the efficiency and effectiveness of the healthcare system.[26] Reliable, honest, and ethical policymakers must step in if general governance is to improve and have a positive and meaningful influence. Policymakers must lay the foundation upon which societal- and institutional-level best practices can be built. However, system-level changes alone cannot create a better healthcare system in Bangladesh. Such change also requires highly focused efforts to improve interpersonal relations between patients and providers. Doctors and caregivers must lead and own the charge to foster change, one interaction at a time. And, yes, this must be accompanied by broader systemic changes; however, the one-to-one reshaping of trust is something each provider can and must do.[27] Individuals, the populace—rightfully warry and mistrustful of all parties involved in healthcare—should follow their lead, give the benefit of the doubt, and participate in remaking and re-narrating the story of the healthcare system in Bangladesh.

People from every stratum of Bangladesh have lost faith and trust in both physicians and healthcare institutions. Because patients have little confidence in the healthcare system, combined with a general lack of education, they are susceptible to believing misinformation appearing on social media and other platforms—particularly about the lack of care within the hospital. This has given rise to mass panic and waves of rising fear. For instance, patients who have gone to the hospital with flu-like symptoms refuse to stay after being diagnosed with COVID-19. They believe they are safer outside of the hospital and will fare better treating themselves.[28] Denial of treatment and medical negligence are routinely reported in the electronic press and social media in Bangladesh during this pandemic. Also, during a press briefing, the prime minister of Bangladesh explicitly threatened to fire physicians who do not come to work for fear of being infected and, if need be, she will replace them with doctors

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[18]Debnath, B. (2020, April 11). 54 Apollo Staff on Quarantine After Doctor Who Visited Her Covid-19 Uncle Also Gets Infected. The Business Standard/ Covid-19 in Bangladesh. Retrieved September 1, 2020, from https://tbsnews.net/coronavirus-chronicle/covid-19-bangladesh/how-doctor-turned-evercare-potential-virus-hotspot-67822.

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[25]Bangladesh Lifts COVID-19 Lockdown, Logs Record Deaths on Same Day. (2020, June 1). CNA. Retrieved June 3, 2020, from https://www.channelnewsasia.com/news/asia/bangladesh-covid-19-coronavirus-lockdown-logs-record-deaths-12789440.

[26]Chan, C.S. (2017). Mistrust of Physicians in China: Society, Institution, and Interaction as Root Causes. Developing World Bioethics. 18(1), 16-18.

[27]Weinkle, J. (2019). Healing People, Not Patients: Creating Authentic Relationships in Modern Healthcare. Monterey, CA: Healthy Learning. 42-43.

[28]Hossain, Ferdous, & Siddiqee. (2020). Mass Panic During Covid-19 Outbreak- A Perspective from Bangladesh as a High-Risk Country. Journal of Biomedical Analytics, 3(2), 1-3.

from outside the country. Rather than focusing on solving the problem, the blame-game goes on, escalating tensions between government, the public, and care providers.[29]

Negative media coverage keeps the issue to the fore, and doctors respond to direct and perceived "attacks" by defending themselves. Once they begin shielding themselves from the criticism, the problem is exacerbated—neither side feels heard or respected. The physicians' posture of self-protection only serves to further promote widespread fear and distrust of the healthcare system. Thus, all forms of communication between doctors and patients are tarnished by distrust or confusion. It is difficult, even for the best and most honorable doctors to overcome the power of these perceptions. As a result, the Bangladesh healthcare system finds itself facing a downward spiral. As public trust erodes, doctors continue to defend themselves. Patients receive less effective healthcare by avoiding the system, and as they receive less-effective care (even if only perceived), the levels of discontentment rise and trust continues to fade. And the cycles of negativity and futility continue.[30]

5 | MORAL DISTRESS AMONG HEALTHCARE PROVIDERS

During this era of COVID-19, front liners from every part of the world are facing moral distress. Moral distress occurs while delivering care, allocating resources, and maintaining professional integrity. Moral distress is prevalent in Bangladesh, mainly because it is a developing country. Healthcare providers in Bangladesh face increased levels of moral distress because the healthcare system is deficient and broken. The country, also, has no legislative policies or guidelines to support or prioritize the need to address the distress.[31] Bangladesh is listed as a resources-limited country that is under significant threat by COVID-19.[32] Recently, the USA government has put extra caution on passengers traveling to and coming from Bangladesh.[33]

As mentioned above, Bangladesh does not have enough physicians or resources to properly combat the COVID-19 crisis. In many ways, the country is at the whim of the SARS-CoV-2 virus. According to the World Health Organization (WHO) a country's doctor-patient ratio should be one doctor for every 1000 patients. In Bangladesh, there are only five doctors for every 10,000 patients.[34] More so, doctors who test COVID-19 positive are sent home to self-quarantine. This policy reduces the number of available active physicians and nurses.[35] Thus, physicians are already facing challenging and overwhelming situations, confronting higher levels of distress as the caseloads explode, and the COVID-19 pandemic ravages the country.

Beyond the ethical challenge of adequately caring for patients during this crisis, the scarcity of personal protective equipment (PPE) adds further confusion into the decision-making landscape healthcare practitioners face. In the best of times, both the Bangladesh government and the private sector struggle to provide adequate protection to frontline workers. Currently, sufficient supplies of PPE are nearly nonexistent. This current crisis gives rise to a significant ethical dilemma that a healthcare provider must confront. The dilemma raises the question: to care for patients in dangerous settings or embrace my rights and responsibility to care for myself and protect my family?[36] Healthcare providers have families to whom they are obligated to protect. On the other hand, their professional oaths and obligations guide them to serve patients in need. To be forced to pick one pathway over another is difficult, ethically challenging, and stress-inducing. As if to add insult to injury, Bangladesh also has a severe shortage of the COVID-19 testing kits. Physicians simply do not have the tools to test patients suspected of having COVID-19. As a result of lack of PPE, testing kits, and the general distrust of the healthcare system, anxiety is deeply seated in the population, and physicians are overwhelmed, overworked, and live in fear of contracting the virus.[37] And as a note, most front-line workers are conducting tasks and often creating best-practices for which they may not be trained—and which are not part of their job descriptions—in valiant attempts to respond to the emergency and the critical needs of their patients.

As of June 2020, more than 800 healthcare providers have tested positive for COVID-19 in Bangladesh. These numbers are a clear indication of the lack of effective personal protective measures within hospitals. Despite the monumental sacrifices made by healthcare workers to tend to the ill, the general public continues to view them as villains undermining the wellbeing of all.[38] Even though the easy blame is directed at healthcare providers, the system is equally, if not moreover, responsible for the broken state of the Bangladeshi healthcare system. This pervasive mistrust has ongoing and significant adverse effects on healthcare providers, which many experiences as a form of trauma.

[29]Bangladesh PM Talks Tough against Physicians Refusing Patients. (2020, April 7). New Age Bangladesh. Retrieved June 3, 2020, from https://www.newagebd.net/article/103986/bangladesh-pm-talks-tough-against-physicians-refusing-patients.

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[34]Hossain, F. (2020). Global Responsibility Vs. Individual Dreams: Addressing Ethical Dilemmas Created by the Migration of Healthcare Practitioners. Global Bioethics. 31, 81-89.

[35]Anwar, S., Nasrullah, M., & Hosen, M.J. (2020). COVID-19 and Bangladesh: Challenges and How to Address Them. Front Public Health. 8, 154-154.

[36]Binkley, C.E., & Kemp, D.S. (2020). Ethical Rationing of Personal Protective Equipment to Minimize Moral Residue During the COVID-19 Pandemic. Journal of the American College of Surgeons. Jun;230(6).

[37]Anwar, S., Nasrullah, M., & Hosen, M.J. (2020). COVID-19 and Bangladesh: Challenges and how to address them. Frontiers in Public Health, 8.

[38]Joarder, T. (2020, May 31). How Can Our Doctors be More Responsive in the Time of Covid-19 Pandemic? TBS News. Retrieved June 6, 2020, from https://tbsnews.net/thoughts/how-can-our-doctors-be-more-responsive-time-covid-19-pandemic-86977.

The level and severity of trauma the healthcare workers face have crossed the boundary from moral distress to moral injury. Understanding that practitioners are incurring moral injury adds another level of crisis to an already chaotic situation. Moral injury, by definition, results from an action that runs contrary to a person's values and leaves a permanent impact.[39] The level of trauma and stress Bangladeshi healthcare workers confront during this crisis will leave permanent scars and require psychological interventions, large and small. If healthcare organizations and the Bangladesh government do not recognize and respond to this moral injury in meaningful ways, earlier rather than later, they will lose the active participation of the healthcare providers and thus will further damage the existing healthcare system.

6 | RECOMMENDATION: THE FRAMEWORK OF RESPONSIVENESS

If the shortcomings above are not appropriately addressed now, the consequences of the SARS-CoV-2 virus will be devastating and debilitating. The future of the Bangladeshi healthcare system is dependent on the best ethical actions of its healthcare providers, concurrent with system-wide process changes. The social, interpersonal, and systemic are tightly bound and interlinked. One area alone cannot re-establish broken trust. Yet, every physician must come to understand and accept the claim of compassion and take responsibility for providing care as if she was caring for herself. Trust cannot be built or re-established when there is no connection with or compassion from a provider to a patient. Also, at the same time, the system needs to react in ways that generate the working environments where physicians can shift and positively reframe the healthcare narrative, and in doing so, reclaim the hearts of patients and trust of the populace.[40]

In the context of Bangladesh, it is urgent that healthcare providers, the government, and healthcare systems embrace and include *Responsiveness* as normative and expected best practices. The conceptual framework of Responsiveness has five components: *friendliness*, *respect*, *informing and guiding*, *trust-building*, and *optimizing benefit*.[41]

Friendliness is encompassed in the manner by which the provider interacts with the patient; this includes such things as warm greetings and asking casual, open-ended questions before starting the consultation. The system must be designed in ways that promote and are founded on friendliness; this is the relational gateway to the other components of Responsiveness. *Respect* is showing regard, explicitly demonstrated by soliciting the patient's active participation and presence in the consultation process. Ensuring active participation by the client opens a dialogue of mutual influence, which fosters truth-telling and trust-building. This congruence guides and supports effective communication and person-to-person discourse.[42] If trust is to be re-established in Bangladeshi healthcare, it is essential that healthcare providers focus on "seeing": the patient as a human "in need," and accordingly respond ethically, morally, professionally, and legally.

Informing and Guiding is another vital component of Responsiveness, which must be undertaken with sensitivity and assurance. Because a large percentage of the Bangladeshi people are illiterate, typical and common methods of informing do not play a significant role for them, but indeed guiding them will. Poor and uneducated patients often struggle to understand how, why, and when to seek medical aid, advice, or support. These patients not only need respectful and understanding guidance in their treatment plan, but they also require assistance to carry out and follow-through on their treatment plans. Effective patient navigation is vital to guide and support the patient along a directed and often time-sensitive care path.[43] Healthcare organizations need to change their information-sharing guidelines in ways that support and are geared to the needs of people from every stratum of the community. The spread of misinformation and false information about the prevention and treatment of the virus only adds further damage to the current struggle Bangladesh faces during the COVID-19 crisis. The circulation of inaccurate news is very harmful in a country like Bangladesh where the literacy rate in 2018 was 73.91%.[44] Therefore, it is very easy for patients to be misled, especially if the system is not as responsive as it should be. Transparency and the obligation to convey accurate and accessible information need to be mandated by the government.[45] The government should acknowledge its resource limitations and transparently and strategically allocate resources through social mobilization, community engagement, and coordination.[46]

Trust Building is already crucial, but given the current relationship between physicians and the community, it is difficult, but not impossible. During the COVID-19 or like crises, it is crucial to be transparent, not to withhold vital information from the patient (or community), and widely share scientific findings as soon as possible. The government has to impose rules and regulations to ensure and demand that organizations and physicians provide accurate, understandable information on time. Healthcare providers must recognize their shortcomings and fears, revisit their oaths, and act in service to patients and the community to build and re-establish trust. Fear and anxiety

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[46]Dahab, M., van Zandvoort, K., Flasche, S., Warsame, A., Ratnayake, R., Favas, C., Spiegel, P.B., Waldman, R.J., & Checchi, F. (2020). COVID-19 Control in Low-Income Settings and Displaced Populations: What Can Realistically be Done? Conflict and Health. 14(1), 1-6.

cause overwhelming stress, whether one is a patient or a physician. However, being transparent offers patients a sense of clarity and certainty and serves to reduce stress and to promote, foster, improve trust. Organizations need to provide Cognitive Processing Therapies or Emotional Freedom Techniques to providers to ensure moral distress is attended to and is in check.[47,48] Providing these therapies will address the providers' emotional and psychological needs during the pandemic and beyond. The ultimate goal is to create safe and well-organized environments where providers can perform their duties with less distress.[49]

Also, by *Optimizing Benefit* of the patients, healthcare providers can gain trust. Optimizing benefit, in the context of Bangladesh, is directly linked with financial assistance. However, doing service-oriented actions can also support optimizing benefits. Healthcare providers should ask the patient what is the most suitable way for him to receive the needed care. And, when necessary, direct the patient to low-cost medical care. For instance, options may include prescribing inexpensive medication, providing financial assistance, providing medicine at no or reduced costs, or offering reduced consultation fees. However, healthcare providers cannot do this by themselves. Organizational practices and procedures must be established to support such actions. Therefore, organizations need to create benefit-optimizing strategies that offer flexibility to the providers so they can treat each patient in the best possible manner.[50]

It will be challenging to improve and rectify the current healthcare problems in Bangladesh without implementing long-term, systemic changes. It is, however, possible to prime the system for improvement if individuals commit to change, and then apply those changes through actions. Healthcare providers who understand the underlying causes for the "broken trust" and then reform their own behaviors by consistently demonstrating integrity, honesty, and compassion, can make significant improvements in Bangladeshi healthcare—one patient, one situation at a time. Doing such is the first essential step to reshaping and reclaiming Bangladeshi healthcare. The challenge is daunting, but it is a moral, ethical, and patriotic task to rebuild the broken patient-provider relationships. Also, there is no alternative but to strengthen the healthcare system to avoid the humanitarian crisis COVID-19 will bring to Bangladesh. Sustainable and multisector collaborations between the government and healthcare organizations, along with the individual-level friendliness and ethical resolve, can rebuild a stable healthcare system in Bangladesh.[51]

7 | CONCLUSION

Due to the high transmission rate of the SARS-CoV-2 virus and the fragility and dysfunction of the healthcare system, it is extremely difficult for the people of Bangladesh to feel safe in the face of the COVID-19 pandemic. This is an uncertain and precarious time for Bangladesh and it will become more volatile with the economy now re-opened, and people freely going about their days. Pandemic or not, a poor populous will out of necessity return to common behaviors and work patterns. As a result, Bangladesh will continue to face challenges tending the ill and keeping healthcare workers safe. Besides and beyond the government's attempts to funnel scarce resources into preventative measures and care, a concerted effort must be taken to build, rebuild, and strengthen trustworthy relationships between patients and healthcare providers. And in doing so, reclaim the exalted position providers once held in the country. A renewed focus must be placed on the therapeutic relationship to re-establish trustworthy patient-provider relations in Bangladesh during COVID-19 and beyond, which also include overall system-level changes. That is possible through the framework of *Responsiveness*. The perspective—and ethical behavior—of the individuals, society, and the system must change to rebuild this broken trust. Bold and timely multisector collaborations must take place if the fragile healthcare system is to survive.

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CONFLICT OF INTEREST

None to declare.

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