Duty to Treat During Covid-19 – Ethical Issues and Nursing Students' Perspectives

Miriam Walter, RN, PhD, MSN, PHN[1]

[1]School of Nursing, California State University, Chico, United States.

RESEARCH

Please cite this paper as: Walter M. Duty to treat during covid-19 – ethical issues and nursing students' perspectives. Archives of Healthcare [2021] 2(2): 42-49.

***Corresponding Author:**

Miriam Walter,

School of Nursing, California State University, Chico, USA,

E-mail: mnwalter@csuchico.edu

ABSTRACT

Hospitals worldwide were overwhelmed by the abrupt onslaught of COVID-19 in March 2020; contingency planning, preparations, and provisions were often inadequate. And nursing programs came to a sudden halt at a time when healthcare workers were needed most. Nurses, being at the frontlines of this battle, have a high risk of exposure to the virus due to the nature of their work. As a result, they are at an increased risk for long-term mental health issues as well as illness, isolation, and death. Ethical dilemmas surround the duty to treat vs. duty to self and family. Nursing students were caught amid this chaos, many initially anxious to go to hospitals to help, but also sometimes suffering extreme anxiety themselves due to the evolving dangerous situation, along with the uncertainty of their being able to graduate. By early March 2020, the California Nurses Association was already decrying the lack of personal protective equipment [PPE] and the mistreatment of nurses.

Nursing students were assigned to write a paper on ethical and legal issues related to COVID-19 and the nurses' duty to treat. Topics raised by students included the inadequate preparation of the U.S., the American Nurses Association Code of Ethics, mental health concerns, communication issues, relevant laws, and the need for public policies to protect nurses as well as the public. This article explores the issues surrounding duty to treat and some solutions to assist nurses in making difficult decisions during such times. Minimizing nurses' risk during pandemics includes adequate personal protective equipment, staffing, and training. Focus is given to the students' perspectives. The category of the article is a regular paper.

Key Words: COVID-19, nurses, duty to treat, ethics, risk, nursing students.

The pandemic hit the [U.S.] in three waves, with everything…schools, churches, stores, transportation, theaters — closed during the second wave and truth-telling was in short supply. —Regarding the 1918 Spanish flu [1].

INTRODUCTION

2020 was Florence Nightingale's bicentennial year and was designated the Year of the Nurse and Midwife by the World Health Organization [WHO]; this has continued into 2021 due to COVID-19 [2, 3]. Perhaps never have nurses been more needed or been in such danger. They are America's most trusted and essential health care professionals [4]. Hospitals worldwide were overwhelmed and most ill-prepared for the abrupt onslaught that COVID-19 caused in March 2020. And nursing programs came to a sudden halt at a time when caregivers were needed most. At the forefront of this pandemic threat are healthcare workers, especially nurses caring for patients with possible and confirmed COVID infections; they have an increased hazard of exposure to the virus due to the nature of their work [5]. The demands and uncertainty that come with fighting on the front lines also place them at an increased risk for long-term mental health issues, as well as emotional

distress, illness, isolation, and even death. Additionally, they risk infecting their loved ones. Ethical dilemmas surround the duty to treat vs. duty to self and family. Nursing students were caught in the midst of this storm, many initially anxious to go to hospitals to help, but also sometimes suffering extreme anxiety themselves with the uncertainty of their being able to graduate as well as dealing with family and other responsibilities [6].

I teach 5th semester BSN nursing students and coordinate their leadership medical-surgical clinical. Early in March of 2020, I began researching ethical issues surrounding the novel Corona virus and caring for patients. I was especially interested since in 2015, I had an article published on nurses' duty to treat during the Ebola epidemic [7]. The California Nurses Association and National Nurses United, the national nurses union, were already decrying the lack of PPE and the mistreatment of nurses [8]. This was one week before our Spring Break and days before the California Governor declared a stay-at-home order. The university and the nursing department had begun contingency planning; faculty focus immediately turned to planning for the students' continuation and scrambling to accommodate online learning.

One of the assignments created in lieu of clinical was to write a paper on ethical and legal issues related to COVID-19 and the nurses' duty to treat. Approximately half of the students completed this assignment, and of those, approximately half [ten] wrote papers on nurses' duty to treat. Topics included the inadequate preparation of the U.S., the American Nurses' Association's [ANA] Code of Ethics, mental health concerns, communication issues, relevant laws such as the Emergency Medical Treatment and Active Labor Act [EMTALA]. The purpose of this article is to explore the issues surrounding duty to treat and some solutions to minimize the risk to nurses during this and future pandemics. Lessons learned can be translated to broader disaster management. I have included excerpts from students' papers in discussing the ethical issues surrounding COVID-19 and nursing care. Permission to include these quotes was obtained from the students.

CONTRIBUTIONS OF THIS PAPER TO THE WIDER GLOBAL CLINICAL COMMUNITY

- Explores ethical issues surrounding nurses' duty to treat during pandemics and other disasters.
- Provides graduating students' perspectives of the issues around duty to treat during the COVID-19 pandemic.
- Investigates legal and ethical frameworks for analyzing duty to treat.
- Offers guidelines and solutions to ameliorate hazards and stressors faced by nurses during disasters and pandemics.

SCOPE OF PROBLEM

Statistics

According to Kaiser Health News and The Guardian [9], as of the first of June, 2020, nearly 600 healthcare workers had died in the U.S., almost twice that reported by the Centers for Disease Control [CDC] [10]. As of July 17, 2020, the CDC reported 540 deaths among healthcare personnel and 101,789 total cases among healthcare workers [5]. In addition, national Nurses United [NNU] reported on July 1, 2020 that more than 950 medical personnel had died, including at least 144 registered nurses [11].

Preparations came late. On January 30, 2020, days after China announced the novel virus, the NNU wrote a letter to the WHO demanding that it provide more substantial guidance on infection prevention [8]. At the beginning of March, the NNU stated that the "Centers for Disease Control is not doing enough to help protect and test healthcare workers who are exposed to patients with the COVID-19 virus" [12]. Also, many nurses felt that hospitals were not doing enough to prepare employees for the surges. A survey in March 2020 of more than 6,500 nurses in 48 states showed that only 29% of nurses reported that their employers had a plan to isolate patients with a possible COVID-19 infection, and 23% were unsure if there was a plan in place at their hospital [12]. In addition, as of March, the national emergency stockpile only had about 1% of the estimated 3.5 billion N95 respirators needed [13].

Healthcare workers across the nation continued to voice their concerns regarding lack of information and education and the ability to be tested, as a survey in May demonstrated [14]. The NNA continued to call on the U.S. government to provide more and better PPE, stating on July 1 2020, "This pandemic has shown clearly that we do not have a coordinated, transparent, or efficient medical supply chain system" [9 p. 3].

Psychosocial Effects on Healthcare Workers

Working during a pandemic such as COVID-19, Ebola, or SARS-CoV-1 can have adverse psychosocial effects on nurses. For example, according to a study completed during the SARS pandemic through questionnaires across three hospital sites, "64.7% of the respondents reported concerns about their own health during the SARS outbreak, and almost the same proportion [62.7%] reported concerns about their family's health" [15 p. 795]. Workers have a legitimate worry about the potential physical harm to themselves and their family; a "total of 29% of the respondents experienced emotional distress" [15 p. 797] during the SARS outbreak. This emotional distress may lead to impairment in the ability to function in the workplace. In addition, there can be a stigma surrounding healthcare workers during a pandemic [although they are also viewed as heroes], further impairing these workers' mental health. During the same study [15], nurses who felt that they were being treated differently by people because of working in a hospital reported more health concerns than those who did not feel they were treated differently. The effect on nurses of having to isolate, fear of transmitting the infection to their loved ones, and not having the needed supplies to decrease infection risk are all contributing factors to mental health issues, as well as a possible reluctance to work.

During the current COVID-19 pandemic, healthcare workers are being put under similar stressors and sometimes without proper PPE. The frontline healthcare workers at the start of the pandemic in China reported significant mental health problems. A study published in March 2020 [16] found that out of 1,257 healthcare personnel working with COVID-19 patients, 50.4% reported depressive symptoms, 44.6% anxiety symptoms, 34% insomnia, and 71.5% reported distress. Nurses and other frontline workers experienced the most severe symptoms. Reasons for these results were fear of infecting their families, lack of PPE, feelings of hopelessness regarding patient outcomes, exhaustion from long hours, and an unknown ending to the situation. Clearly, working during a pandemic can have drastic debilitating effects on healthcare workers' mental health.

Other stressors are the emotional toll of caring for dying patients and the effect of self-quarantining after potential exposure. One study [15] found that quarantined staff were more likely to report exhaustion, anxiety, irritability, insomnia, poor work performance, and reluctance to go to work. Some nurses have taken mental health leaves. In a *Time* article [17] on mental health and COVID-19, one nurse discussed her own experience with the emotional toll of passing on messages to dying patients from their families. We continue to hear stories like this on the news and from our colleagues. Such stressors need to be recognized and treated to prevent nurses from post-traumatic stress syndrome and even leaving the healthcare profession. Another distressing issue is the politicizing and denial—denial that the virus is real and rejection of the need for masks. This burdens medical personnel psychologically in addition to the physical toll of the work. Still, in the face of long-term emergencies, most nurses feel an inherent sense of duty and self-sacrifice and view their profession as a calling. Refusal to accept assignments is an ethical issue more than a legal one. We will now look at ethical and legal guidance in making such decisions.

LAWS

The only legislation in the U.S. forcing medical care is the 1986 federal Emergency Medical Treatment and Active Labor Act [EMTALA]. "Under EMTALA, all hospitals that participate in Medicare and their physicians are duty-bound to stabilize and provide medical screening examinations for each patient who comes to the facility for emergency care, regardless of the patient's ability to pay [18 p. 332]." Many patients present to the hospitals with

unclear diagnoses that are not emergent. And most nurses do not work in emergency departments.

There is a law that allows reciprocity across state lines in crises such as COVID-19 so that volunteering medical professionals do not have to meet state-specific licensure regulations. However, only 19 states participate in this initiative. "The Uniform Emergency Volunteer Health Practitioners Act [UEVHPA] provides legal safeguards for practitioners acting within their scope and in good faith, clarifies some interstate practice differences, and deems the legal scope of practice authority to the state requesting the practitioners to maximize their participation [19]." In addition, states have developed their own paid volunteer health worker initiatives where nurses, physicians, students, and others can sign up to assist if needed within their state. For example, California formed the California Health Corps in March 2020 in response to the COVID-19 surge [20]. These government organizations and the UEVHPA act help provide the needed staffing during the pandemic, relieving some of the burdens of duty to treat by improving the staffing ratios and covering for nurses who are either unable or unwilling to work in certain dangerous environments. However, the issue of inadequate numbers and quality of PPE remains a primary reason for nurses' reluctance to work and was a common theme in the students' papers. National Nurses United repeatedly urged the federal government to require OSHA to mandate a temporary emergency standard and increase the manufacture of PPE [21]. On July 1, 2020, in a letter to the House Select Subcommittee on the Coronavirus Crisis, NNU stated that 85% of nurses were still being directed to reuse masks and gowns, and 71% have been exposed to COVID-19 [11].

ETHICAL GUIDANCE

There are many guides to ethical practice; a few are mentioned here, and this article focuses on the American Nurses Association [ANA] Code of Ethics [22]. For example, the ANA states that during catastrophic events such as pandemics, nurses may subordinate their duty "when there is both an increase in the number of ill, injured, or at-risk patients and a decrease in access to customary resources and health care personnel." [p.2] The ANA uses examples of inadequate PPE and concern for the welfare of one's family as excessive risk of harm. So, nurses are justified in relinquishing their duty to care if not provided adequate PPE. Still, nurses are expected to provide for their patients' safety. Nurses are obligated to provide care if the following criteria are met:

1. The patient is at significant risk of harm, loss, or damage if the nurse does not assist.

2. The nurse's intervention or care is directly relevant to preventing harm.

3. The nurse's care will probably prevent harm, loss, or damage to the patient.

4. The benefit the patient will gain outweighs any harm the nurse might incur and does not present more than an acceptable risk to the nurse. [22 pp. 18-19]

The ANA guides nurses in deciding their moral duty to treat during disasters [20, 23], but these are challenging situations, and the ANA guidelines are not necessarily legally binding. Nurses need to maintain morality throughout their decision-making process about providing care and carefully assess their intentions. It is an extremely difficult decision if protections, policies, and political support are not in place to safeguard nurses. There have long been warnings as well as various resources to assist nurses in decision-making regarding the duty to treat. The Precautionary Principle is one which the ANA adopted in 2003 [24]. Another is a book written at the request of the U.S. Assistant Secretary for Preparedness and Response during the H1N1 epidemic over twelve years ago by the Institute of Medicine [IOM] [25], which provides detailed recommendations for decision-making, planning, and policies in situations such as we currently face.

The decisions surrounding the duty to treat should be guided by principles such as express and implied consent, reciprocity, beneficence, and the principles of justice and fairness. Provisions 2 and 5 of the ANA Code of Ethics [22] are especially applicable: duty to the patient and duty to self. There must be a balance between the need to treat patients and healthcare workers' safety. This is

primarily to protect the public: “the public’s welfare could be compromised if healthcare providers succumb to disease and can no longer attend to their patients” [21 p. 1459]. Various viewpoints come into play here. Nurses and other healthcare workers do have a duty to treat their patients even if there is a risk to their own safety. Healthcare workers are aware of their duty to treat during a disaster and the potential threat to their own health. Regarding physicians, Orentlicher [26] states that they “also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future” [p 1460], quoting the American Medical Association Code of Ethics. If nurses believe that providing care to patients may put them in permanent danger of not being able to perform their duty in the future, they may choose not to treat the patient. However, employers might not allow such refusal, as we have seen during this pandemic. Nurses need to judge the situation appropriately to ensure optimal safety for all. The ANA code Provision 3.5 states that nurses have a duty to act if they witness any questionable practices that pose a risk to public health and safety [22]. Students were able to see this happening firsthand.

STUDENTS’ ANALYSIS AND SOLUTIONS

The following are statements made by graduating nursing students in their papers. They aptly sum up common sentiments among nurses. Student S.C. said, “Rather than spewing empty promises, there must be clear communication amongst all levels so that we can keep nurses safe and patients alive.” According to P.K., “When the breakout of a deadly pandemic meets an ill-prepared society under unclear and indecisive leadership, the healthcare workers’ duty to serve and institutions’ responsibility to provide a safe working environment can come into conflict.” K.M. argued, “Even with what is known about the lasting effects of trauma, such as a pandemic, there is nothing in place to combat the often-lasting problem of mental anguish and burnout within healthcare.” E.B. added, “There seems to be a lack of application of the [precautionary] principle when it comes to nurses, doctors, and other health care workers... [there] still seems to be a lack of leadership, collaboration, and support from government agencies and other organizations.” K.P. said that his decision was based entirely on his facility’s preparedness and actions- “If I was not practicing in a safe environment, I would refuse to work. I have the right to refuse and to keep myself and my loved ones safe.” M.K. called for “Changes to policies and guidelines that aim to protect healthcare workers and to produce and distribute PPE so that nurses and fellow healthcare personnel do not face the difficult conflict of whether to solely uphold their duty to treat or their duty to self. A.H. called for wider support: “There is a reciprocal obligation of the public to protect its healthcare workers and do the best they can for us.” Although pleas and warnings to the public by doctors and nurses are plentiful, the U.S. is in a uniquely tragic situation where the outgoing president and many citizens feel that they do not need to wear masks and distance, putting an enormous strain on the health care systems, and further jeopardizing the safety and health of nurses. Some other students raised such concerns about mishandling at the executive and other federal government levels and called for more robust mandates.

Additional solutions proposed by the students as well as others:

- Improving PPE preparedness and stockpiling at all levels, from the federal government to individual facilities.
- Following the ANA guidelines to have policymakers and governing bodies set protocols for disaster medical responses, which consider the constraints of a disaster situation.
- Implementing a utilitarian framework to guide decisions and actions that focus on ‘transparency, protection of the public, proportional restriction of individual liberty, and fair stewardship of resources” [19].
- Addressing the gravity of the situation seriously early at the executive government level. Clear and correct information based on science is needed,

understanding that recommendations change as more research comes forth.

• Enacting more federal laws both to prepare for such events and to protect HCWs. The Defense Production Act is an example in the U.S.

• Invoking a federal mandate regarding staffing ratios. California remains the only state in the U.S. to mandate nurse-patient ratios [27].

• Instituting the UEVHPA for all states.

• Increasing compensation to healthcare workers [HCWs] on the "front line."

• Providing preference to HCWs for testing and treatment and use of workers' compensation for time off rather than nurses having to use their own sick time.

• Ensuring that all states have whistle-blower protection laws, such as California [27]. Such laws encourage open communication and reporting about healthcare facilities from those within their system. HCWs should speak out against unsafe conditions in facilities and public practices, even if policies and procedures are the problems.

• One student suggested more government funding of medical and nursing education; thereby, an increased claim of duty to treat could be invoked.

There is hope; nurses will answer the call to duty, now and in the future. New York Governor Cuomo began his press briefing on July 20, 2020 [28] with news of New York's lowest hospitalization rate since March 18. He ended with three important points that both negatively and positively impact nurses' stress level and sense of duty: "30,000 [health care workers from across the U.S.] came to help us…when we needed them most. Talk about love, courage, generosity, heroism…We will reciprocate… The federal government is still in denial and refuses to follow the science. Five months later, the country is still totally unprepared". Nurses' call to duty is also to act at the political level, as National Nurses United, the American Nurses Association, and other groups have done for us. Employers bear responsibility "to create, maintain, and constantly improve disaster plans that help meet the medical needs of the community within a system that protects registered nurses and other employees or volunteers. This should include the provision of sufficient, appropriate personal protective equipment, immunizations, physical security, and operational protocols" [19 p. 4]. Further, "It is incumbent upon the particular health care institution to provide adequate safeguards such as risk-reducing equipment, enforce protective procedures that minimize risk, educate staff concerning risks, and engage in research to identify actual and potential risks that impact nursing care" [19 p. 2].

CONCLUSION

This article discussed the issues surrounding the duty to treat during the continuing COVID-19 crisis, bringing in the graduating BSN students' perspectives. The views of the students are not necessarily generalizable to a larger population, but the ethical frameworks and guidelines and solutions presented are applicable globally. The results of this study will be shared with the graduates and nursing schools and will be presented internationally.

The role of National Nurses United, The ANA Code of Ethics, and relevant laws were a focus. Necessary and potential solutions were presented, of which adequate PPE and training are critical. The decision to treat is ultimately up to the individual nurse, but it is also incumbent upon the nurse collectives to push for improved conditions. As student K.M. stated, "If I have learned anything from the public policy and public health courses during nursing school, it is that nurses have the power to influence policies and legislation. This situation is no exception". Also, A.H. made a salient point regarding the public's responsibility: "This means giving medical staff priority for treatment and focusing the stream of PPE to hospitals. If this does not happen, the truly scarce resource during this pandemic may become medical staff rather than PPE or ventilators." Hopefully, this paper will help nurses navigate the challenging terrain of protecting the patient, the public, their own health, and the health of the ones they love. For

in the end, it is love that will get us through this pandemic—love for our patients, our comrades, and our neighbours.

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PEER REVIEW

Not commissioned. Externally peer reviewed.