



# NURSES' ETHICAL CONSIDERATIONS DURING A PANDEMIC

*Whether we nurse at the level of populations or people, the capacity to apprehend the impact of conditions upon individual experience is and always will be at the heart of nursing.*

*SALLY THORNE, SCHOLAR OF CANADIAN NURSING, (2015)*

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# Opening cases

- ▶ Mikaela is a registered nurse working in an emergency department (ED) in an urban area. As the pandemic spreads and health-care settings prepare for a surge in cases, she worries about her own safety. Mikaela has a chronic health condition that compromises her immune functioning; she therefore perceives a significant risk to her health and even her life if she continues to work in the ED during the pandemic.
- ▶ John is a licensed practical nurse working in a long-term care setting in a rural area, where a significant number of persons receiving care live with moderate to severe dementia. Staffing was already an issue in this setting before the pandemic began, but in recent weeks it has reached crisis proportions. John currently finds himself responsible for an impossibly high number of residents every shift. Every day, an increasing number of residents are left for many hours without adequate help to bathe, eat or take their medications.
- ▶ Shoshanna is a clinical nurse specialist working for a palliative care program of a community hospital. Since the onset of the pandemic, there have been restrictions placed on the number of visitors who are allowed to enter the hospital. Shoshanna is struggling to find ways to comfort persons receiving care and their family members, who are not able to be together at this time. She is particularly distressed to realize that many of these patients will likely die before the pandemic is over, meaning that their last days and hours will be spent in isolation from the people they love most.
- ▶ Kirima is a registered nurse working with families in a remote community that has experienced high levels of unemployment because of the pandemic. She recognizes that unemployment and stress are key contributors to family violence, which goes vastly unreported because of the stigma associated with it. Since the onset of the pandemic, Kirima worries about advising persons receiving care to stay home because she knows that home is not always a safe place to be.
- ▶ Colleen is a registered nurse who works with First Nations, Inuit and Métis people in a large urban centre, many who have travelled great distances from rural and remote communities for cancer care. Colleen recognizes the importance of providing culturally safe care that respects traditional approaches to healing and well-being. She is concerned that the isolation and physical distancing restrictions that have been put in place during the pandemic are having harmful effects on cultural safety for First Nations, Inuit and Métis people.
- ▶ Georgia is a nurse manager of a medical unit. The pandemic has led to a nationwide shortage of personal protective equipment and she is concerned that her staff will not be able to properly protect themselves or persons receiving care. Although she feels she is doing everything she can to advocate for her unit and her staff, she is disheartened to realize that some nurses blame her for the current shortage of resources.

# Introduction

Nursing ethics is a way of thinking about our practice by focusing on the values — such as safety, dignity, and social justice — that we are committed to in promoting health and well-being. Nursing ethics helps us to think through situations that involve making difficult choices, where we feel torn between two or more compelling courses of action. But nursing ethics is also broader than difficult dilemmas. According to the Canadian Nurses Association (CNA) *Code of Ethics for Registered Nurses* (2017), the primary focus of nursing ethics is “everyday ethics.” This means that in all contexts, our everyday practice has important implications for the values that matter to us. This is especially true during a pandemic. In a global public health emergency, we may find ourselves questioning whether our existing ideas about what is good, right, and just continue to hold true, or whether we need to adjust our ethical beliefs because of the extreme situation we find ourselves in. This can be very unsettling. When we do not feel that we are able to practise in a way that upholds our ethical values, we are vulnerable to experiencing moral distress. At the same time, when we are able to identify and speak about ethical issues, we strengthen our capacity for moral community and for moral agency (see Box 1).

## BOX 1

**Moral distress:** feelings of anger, frustration, or guilt when nurses are unable to act on their ethical judgment.

**Moral community:** a workplace in which individuals feel safe to be heard, and where there is alignment between publicly professed values and the lived reality.

**Moral agency:** the ability to direct one’s actions toward an ethical end, such as good outcomes for patients.

(CNA, 2017)

The opening cases presented above demonstrate a multitude of ways that a pandemic influences the everyday ethics of nurses across a wide spectrum of care settings. Such influences happen on at least two levels: new ethical issues that are specific to a pandemic context, *and* an unveiling of existing ethical issues that are brought into fuller view by the pandemic. Of course, the cases above do not speak to *all* the relevant ethical issues. Rather, by raising some ethical questions that arise in a pandemic, this paper aims to prompt individual reflection and stimulate conversation between nurses and their colleagues, employers, and the general public (see Box 2).

## BOX 2

### EVERYDAY ETHICS: QUESTIONS THAT ARE IMPORTANT TO NURSING DURING A PANDEMIC

- ▶ How should we decide between our personal and professional responsibilities?
- ▶ When we do show up, how should we be supported?
- ▶ How do we honour the dignity of persons receiving care?
- ▶ How do we uphold culturally safe care for First Nations, Inuit and Métis Peoples?
- ▶ What leadership is needed?

# How should nurses decide between their personal and professional responsibilities?

## THROUGH SELF-REFLECTION

Ethical reflection and decision-making are embedded in nurses' everyday practice and professional identity. Nurses continually weigh their personal responsibilities to self and family alongside their professional responsibilities to persons receiving care and colleagues. A common example is when nurses choose between returning home to expecting family members after a long and difficult shift, or working overtime to help colleagues who are short-staffed.

In a pandemic situation, decisions between a nurse's duty to provide care and their own, or their family's, health and safety become more complex. These are decisions that are personal and difficult. In the first scenario above, Mikaela must decide whether to go to work or not. In her particular situation, she has a chronic health condition that places her at high risk of complications should she become infected.

The CNA *Code of Ethics* defines nurses' duty to provide care as a professional and legal obligation, while also acknowledging that "there may be some circumstances in which it is acceptable for a nurse to withdraw from care provisions or to refuse to provide care" (p. 21). As Broom & Broom (2017) note in their exploration of health professionals' experiences during the 2014 Ebola outbreak, "while these health professionals are driven to 'care', the nature of the threat unsettles this social contract, revealing the contingencies of duty" (p. 213). A nurse's duty to care is therefore not absolute. In Mikaela's case, she may base her own decision to work on whether other actors have fulfilled their responsibilities to her, such as providing her with adequate personal protective equipment so that she may safely provide care (CNA, 2020).

Self-reflection and discussion of the specific risks and benefits that nurses face while working during a pandemic are valuable strategies. Nurses may find it helpful to ask themselves certain questions.

For example:

- ▶ Given my personal and professional circumstances, how much risk to my own (or my family's) health do I face by continuing to go to work?
- ▶ How does my family feel about my working during a pandemic?
- ▶ If I continue to work during the pandemic, how will persons receiving care and my colleagues benefit?

Although Mikaela has made a commitment to practise emergency nursing, the exceptional circumstances of the pandemic may cause her to reconsider the risks and benefits.

# When nurses go to work, how should they be supported?

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*“In the face of fear and isolation, nurses demonstrated incredible commitment to patients, to the healthcare system and to the profession. Even though they recognized personal risk, their duty to care took priority” (Registered Nurses’ Association of Ontario [RNAO], 2003, p. 18).*

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This quote, from RNAO’s report on the Ontario government’s SARS commission, highlights that nurses *do* show up to work and contribute immensely to our health-care system’s capacity in situations of public health crisis. The fact that nurses (and other care providers) will step up during times of crisis is clearly evident once again during the current COVID-19 pandemic. Therefore, the essential moral question is not *“must nurses show up?”* but rather, *“when nurses show up, how should they be supported?”*

The responsibility of nurses to provide safe, compassionate, competent and ethical care is not theirs alone. To the contrary, the CNA *Code of Ethics* clearly states that governments, regulatory bodies, employers, unions and professional associations share in this responsibility; all must help ensure that appropriate safety precautions are evidence-based and clearly communicated and that nurses are trained and well supplied with appropriate equipment.

## BY EMPLOYERS AND GOVERNMENTS

Under provincial and territorial occupational health and safety legislation, employers have a responsibility to provide a safe work environment. However, based on our relatively recent experiences with SARS (2003) and Ebola (2014) outbreaks (and now again with COVID-19), we know that the appropriate safety precautions may be unknown, unclear or unavailable (Broom & Broom, 2017; McGillis Hall et al., 2003). Such uncertainty may lead nurses to withdraw from providing patient care, as they are forced to decide between the heightened risk of providing patient care and the need to protect their own (or their family’s) health and safety.

The CNA *Code of Ethics* highlights the reciprocal duty of employers and governments to protect and support nurses during disasters, outbreaks and pandemics:

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*“When demands on the health-care system are excessive, material resources may be in short supply and nurses and other health-care providers may be at risk. Nurses have a right to receive truthful and complete information so they can fulfil their duty to provide care. They have a clear understanding about the obligations and expectations around their role. They must also be supported in meeting their own health needs. Nurses’ employers have a reciprocal duty to protect and support them as well as to provide necessary and sufficient protective equipment and supplies that will “maximally minimize risk” to nurses and other health-care providers.” (p. 39)*

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Therefore, nurses should expect that federal, provincial, territorial and municipal governments and employers will honour their responsibility to be sufficiently prepared for pandemics and other crises. This responsibility of preparedness includes:

- ▶ Established processes to communicate truthful and complete information
- ▶ Appropriate staffing levels that can accommodate crisis situations
- ▶ Evidence-based policies and procedures
- ▶ Sufficient supplies of personal protective equipment and access to testing
- ▶ Financial and instrumental support for child/family care, pet care and provision of basic needs such as food, water and shelter while nurses are working or self-isolating

## BY THE PUBLIC

The public shares an ethical responsibility to support nurses and other health-care workers who show up to work during pandemics. The impressive response of these workers to the current COVID-19 pandemic has inspired the public to express their respect and appreciation for nurses and others (Globe and Mail, 2020). However, this public display of appreciation must be accompanied by specific actions by communities that contribute to these workers’ well-being during the pandemic. Canadian nursing ethics scholar Wendy Austin, in writing about SARS, asks:

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*What can communities do to make it possible for nurses to stay, to make the risks endurable during an epidemic (e.g., quality equipment, life insurance, a voice in policy decisions)? What strategies (e.g., provision of accessible, coordinated child and elder care) could help nurses and other health-care workers deal with their competing relational responsibilities (to parents, spouses, children, neighbours, other nurses)? (Austin, 2008, p. 20)*

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Community leaders should also ensure that nurses and their family members are not shunned by neighbours or their children’s schools — as happened during the SARS crisis (McGillis Hall et al., 2003). Individual members of the public can demonstrate genuine support and respect for nurses working during pandemics, for example, by adhering to public health instructions regarding self-isolation as much as possible.

# How can we honour the dignity of persons receiving care?

## BY RAISING OUR VOICES

The CNA *Code of Ethics* establishes dignity as a primary nursing value. The cases at the beginning of this paper show how dignity can be undermined in a pandemic situation. For example, in the case of John, who was working in long-term care, the neglect of frail residents who are unable to accomplish their own activities of daily living without assistance is an affront to their dignity. Importantly, this case highlights a caregiving situation that was already precarious, where staffing was inadequate even before the pandemic began. As mentioned above, while a pandemic introduces many new ethical challenges for nursing, it also unveils longstanding systemic issues that predate it (Tomlinson & Robertson, 2020). Nurses and nursing students are acutely aware of such issues and have been sounding the alarm while others turn a deaf ear. Indeed, while nurses and nursing students are the primary whistleblowers in health care, too often they face negative consequences for speaking up about ethical issues in their practice (Gagnon & Perron, 2019). This potential for negative reprisal has a silencing effect on nurses' voices. And yet, the final report of Ontario's SARS commission is clear: ethical practice is supported when health system administrators and governments listen to — and act on — the concerns raised by nurses, other care providers, and the unions that represent them (Campbell, 2006). Nurses' voices are an essential resource in preventing and mitigating the harms a pandemic will cause to the dignity of people receiving care.

Although nurses are sometimes lauded for their heroism in situations of health crisis, they are also excluded from decision-making at various levels (from direct-care through to health systems planning) (Austin, 2008). Nurses are not heroes; they are skilled professionals whose knowledge is crucial at all levels of a pandemic response. Individual nurses therefore need to be encouraged and supported to speak up when they become aware of ethical issues in their practice, such as the situation described in John's case. Vulnerable people, such as residents in long-term care, do not lose their right to be treated with dignity and respect, even in pandemic circumstances. In all situations, and especially during a pandemic, it is essential that health-care environments encourage nurses to use their voice. Such an environment "sponsors openness, encourages the act of questioning the status quo and supports those who speak out in good faith to address concerns" (CNA, 2017, p. 16).

During the COVID-19 pandemic, some nurses are speaking out through the media (e.g., Greenaway, 2020). Nurses must not be made to fear using their voice in this way. Because nursing is one of society's most trusted professions, nursing administrators, regulators, and professional associations all share the responsibility to support nurses in speaking the truth about what is happening at the forefront of a pandemic response.



## BY ATTENDING TO FAMILY RELATIONSHIPS

The case of Shoshanna in palliative care highlights another concern relevant to dignity: the harm that can result from restricting visits to limit viral spread. It is important to not underestimate the ethical significance of such harms. For many people, their social networks are fundamental to who they are as human beings. Depriving them access to those with whom they share their lives therefore threatens dignity. As Canadian nurse ethicist Franco Carnevale recently stated in an article about such restrictions during the COVID-19 pandemic: “Family are not visitors” (Carnevale, 2020). He explains that visiting restrictions create harm not only because of the loneliness that they create, but also because they deprive vulnerable people of vital support in safeguarding their well-being in health care. For example, many hospitalized people rely on their family members to interpret medical information, to help them make decisions, and to advocate on their behalf to their professional caregivers. According to the CNA *Code of Ethics*:

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*“When a community health intervention interferes with the individual rights of persons, nurses use and advocate for the use of the least restrictive measures possible for those in their care” (p. 10).*

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Nurses should therefore implement and advocate for family visiting policies that *balance* the need for physical distancing with the rights of persons receiving care and their families to be together. Nurses can do this by ensuring that any limitations or prohibitions on family visiting, if absolutely required during a pandemic, are as “least restrictive” as possible.

## BY EMPHASIZING A PALLIATIVE APPROACH

The case of Shoshanna also highlights a broader ethical question: what is the impact of a pandemic on the availability and quality of palliative care? In a pandemic, the need for palliative care increases, in part because of the inherent risk of death associated with the illness and also because of limited availability of life-saving resources (Arya, Buchman, Gagnon, & Downar, 2020). Any patient whose life is threatened by a pandemic must be able to access quality palliative care. As stipulated in the CNA *Code of Ethics*:

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*“In all practice settings where nurses are present, they work to relieve pain and suffering, including appropriate and effective symptom management, to allow persons receiving care to live and die with dignity” (p. 13).*

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The issue of palliative care, however, extends far beyond people who may die from the pandemic; it includes *all* people whose nursing care is affected by a pandemic. It is useful here to think about palliative care as an overall nursing *approach*, one that focuses on personhood, quality of life and alleviation of suffering, regardless of whether someone is imminently dying or not (Canadian Nurses Association, Canadian Hospice Palliative Care Association, & Canadian Hospice Palliative Care Nurses Group, 2015). There are many ways that such an approach is threatened in a pandemic context. During COVID-19, for example, some nurses have felt compelled to limit their physical

contact with persons receiving care to “essential” interventions. Making decisions about what qualifies as “essential” is not at all straightforward. There is a serious risk that in a contemporary health-care culture where biomedical values predominate, important nursing commitments — such as entering the room of a patient who appears to be in emotional distress, or administering symptom relief to someone who is in pain or short of breath — will be abandoned. This risk can be mitigated by insisting that attention to dignity is fundamental to ethical nursing care, even in a pandemic context.

## BY ACCOUNTING FOR STRUCTURAL VULNERABILITY

By thinking about a palliative approach as a way of honouring the dignity of *all* people receiving nursing care, we also orient our ethical attention to people who, because of structural vulnerability (e.g., people experiencing poverty, homelessness, or insufficient housing, or individuals who are disabled, racialized, mentally ill, or using illicit drugs) are at highest risk for adverse outcomes in a pandemic. The nursing research of Canadian palliative care scholar Kelli Stajduhar and her team at the University of Victoria about equity-informed palliative care is particularly useful (Stajduhar & Mollison, 2018). Their work establishes that mainstream approaches to health service organization are too often misaligned with the realities faced by structurally vulnerable people. It is important to remember that existing public health crises (such as the opioid crisis or the housing crisis) do not disappear at the onset of a pandemic. Systems and strategies are therefore needed to account for the existence of simultaneous health crises and their overlapping impact (e.g., see British Columbia Centre on Substance Use, n.d.).

A pandemic will magnify pre-existing structural vulnerabilities. This puts people at risk of using violence as a strategy to deal with conflict (Jewkes, 2002). According to a recent editorial in the *Journal of Clinical Nursing* about COVID-19 lockdowns and the paradoxical harms that they can cause: “Domestic violence rates are rising, and they are rising fast” (Bradbury-Jones & Isham, 2020, p. 1). In the case of Kirima, who is working with families experiencing high levels of unemployment because of the COVID-19 pandemic, she knows that public health interventions such as social isolation are putting some of the persons receiving care at risk of family violence. This can result in high levels of conflict about what to do, leading to moral distress. Nurses understand that family violence is prevalent in all socio-economic groups; over 170,000 cases were reported in 2018, but the real number is believed to be much higher because the stigma associated with family violence leads to under-reporting (Statistics Canada, 2019).

The CNA *Code of Ethics* explicitly states that nurses should practise in a way that aims to prevent all forms of violence for people receiving care. Although nurses inform their practice decisions with legislation and guidance provided by government and public health authorities during communicable disease outbreaks such as COVID-19, nurses like Kirima know that in some circumstances, these practices will put people at risk of harm. Nurses must therefore be vigilant in assessing client risks of all forms of violence and take action to minimize risk. They must voice their concerns and collaborate with others to establish the safest possible measures for the persons receiving care when they know that public health measures such as physical distancing are putting people in danger.

# How can we uphold culturally safe care for First Nations, Inuit and Métis Peoples?

Nurses like Colleen understand that the root causes of health inequities for First Nations, Inuit and Métis Peoples reside in colonial practices and government policies, including residential schools, that continue to have a troubling and tragic impact on their health and well-being (Truth and Reconciliation Commission of Canada, 2015). Indigenous Peoples already suffer the worst health of any group in Canada (Anderson et al., 2016). They also experience the poorest living conditions with inequitable access to education, food, employment and health services. The public health restrictions enforced during the COVID-19 pandemic essentially *lifted the veil* and magnified the dire living and health conditions that they already experience every day.

Many Indigenous people do not trust mainstream health-care services and feel alienated and intimidated by the western approach to health and healing (Health Council of Canada, 2012). Understanding this, nurses provide culturally safe care to safeguard human rights, including in times of crisis. Culturally safe care upholds and respects traditional and holistic approaches to health and healing and honours the dignity of First Nations, Inuit and Métis Peoples (Greenwood, Lindsay, King, & Loewen, 2017). When community health interventions during a pandemic systemically disadvantages this group and interferes with the provision of culturally safe care, nurses will experience moral distress.

In honouring dignity and respecting the special history and interests of First Nations, Inuit and Métis people, nurses must speak openly to persons receiving care about their commitment to providing culturally safe care and what they can do to honour this commitment during the restrictive measures of a pandemic. They must also express their concerns to their nursing leaders and share their collective wisdom and innovative ways to provide culturally safe care. Consistent with the CNA position statement *Emergency Preparedness and Response* (Canadian Nurses Association, 2018), it is both possible and necessary for nurses to respect the human rights and cultures of Indigenous people during times of public health crisis.

# What leadership is needed?

Moments of crisis present opportunities for nursing leaders to safeguard the well-being of health-care staff. During the rapidly changing and difficult decisions of a pandemic crisis such as COVID-19, nurse leaders also struggle with ethical dilemmas that create moral conflict and distress. The case of the nurse manager Georgia is a clear example. In this situation, Georgia is concerned about her nurses and is doing her best to advocate for them. However, it appears that her concern and advocacy is not visible. This case exemplifies the critical need for openness and transparency in nursing leadership. Such leadership characteristics would alleviate some of the blame that staff may be directing toward Georgia.

Crises also present an opportunity for nursing leaders to connect with direct-care nurses in compassionate ways. Such connection is vitally needed during times of uncertainty. Unfortunately, in crisis situations such as a pandemic, leaders sometimes revert instead to a command and control style of leadership that has the effect of silencing and alienating nurses, when they are most in need of being engaged and supported. As leaders struggle to find solutions in the uncertainty of a pandemic, drawing on the collective intelligence and experience of direct-care nurses is more important than ever. Compassionate leadership is a refuge for nurses in the onslaught of stress and can help them deal with aspects of their work that feel frightening and overwhelming.

To support nurses' wellness in the rapidly changing environments of a pandemic, leaders must be visibly present, understand the fears and exhaustion that nurses face every day, and ask basic but essential questions such as, "How can I help you?" Compassionate leadership means listening to and understanding the reasons for nurses' distress; it also means being honest and transparent when making difficult decisions (West & Chowla, 2017). During a crisis, consistent messages from all levels of leadership are essential so nurses know what is expected of them and feel confident and supported in their decision to show up and provide care.

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