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Duty to Care

ABSTRACT

The potential threat of a pandemic influenza outbreak has placed emergency preparedness in the health care spotlight. Hospitals are increasingly gearing up readiness plans in preparation. Most of these plans are related to the implementation of protocols and stockpiling of supplies, medications, and equipment. These plans are dependent on staff for implementation, but will nurses' duty to care for patients outweigh their competing obligations to their families and the risk of their own exposure?

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The nursing community routinely responds to various types of catastrophic events. In many of these cases, there is no shortage of nurses willing to respond to the call to duty. The severe acute respiratory syndrome (SARS) outbreak of 2003, with its high rate of infection among health care workers, raised the issue of whether nurses would place their duty to care above their familial commitments if the possibility of contracting illness or transmitting disease to their family was great.

In the event of an influenza pandemic, public health needs will overwhelm available human and material health care resources. It is imperative that ethical issues likely to arise, such as nurses' duty to care, be examined and addressed. The issue of duty to care is not exclusive to pandemic influenza; it has also been recently discussed in relation to Ebola, smallpox, and monkeypox outbreaks.

BACKGROUND

In the late 1980s, duty to care became a topic of vigorous debate regarding the care of patients with HIV/AIDS. The debate centered on risk and obligation. Reid (2005) summarized two ethical questions for health care workers that can be specifically applied to nursing: to what degree is the risk of acquiring the disease through occupational exposure; and is that level of risk greater than the risk one accepted in choosing nursing as a profession? The ethical consensus at the time was if the risk was comparable to the risk of an infectious disease that nurses would already be exposed to, that would fall within their duty to care.

The discussion of duty to care for patients with HIV/AIDS diminished as the limited transmission became known and understood. Nurses and other health care workers could easily protect themselves using basic infection control precautions. In retrospect, many of the refusals to care for patients with HIV/AIDS were based on prejudice and not merely fear.

LESSONS FROM SARS

The SARS outbreak of 2003 renewed the discussion on duty to care. SARS had many transmission routes, no cure, and no quick diagnostic tests. Individuals with SARS presented with benign flu-like symptoms and were infectious at presentation. Nurses were placed in extraordinarily stressful patient care situations and exposed to serious risk of morbidity and mortality.

Chung, Wong, Suen, and Chung (2005) detailed the emotional tribulations, specifically the profound sense of hopelessness in facing an unknown disease, of the nursing staff in Hong Kong who cared for individuals with SARS.

In the HIV/AIDS duty to care debate, that risk and obligation were inversely proportionate, the risk of caring for patients with HIV/AIDS was low and the obligation to care was therefore high. Reid (2005) noted that this framework did not hold true for the SARS outbreak. The level of risk rose significantly and nurses and other health care workers did not abandon their duty to care en masse.

Many have commented on the exceptional care provided by nurses and other health care team members during the SARS outbreak in Hong Kong, Taiwan, and Canada. Nurses labored long hours and were exposed to significant risk. Some health care workers were reluctant to care for patients infected, at the time, with what was an unknown disease. Limited failure to report for duty resulted in termination of employment for some health care professionals (Ruderman et al., 2006). Others aggressively questioned their duty given the backdrop of unknown risk.

Although many health care workers responded heroically, extreme heroism should not be considered the behavioral norm. Hsin and Macer (2004) point out that many nurses and physicians in Taiwan involuntarily cared for patients with SARS

due to their hospitals being quarantined without warning to prevent further spread of the disease. Others cared for patients due to fear of losing their jobs.

DO NURSES HAVE AN ETHICAL OBLIGATION TO CARE FOR PATIENTS IN A PANDEMIC?

The ethical foundation of the duty to care is rooted in several ethical principles, notably beneficence and nonmaleficence. These define the moral obligation of nurses to further patients' welfare and advance their well-being, by doing both good and no harm (Schroeter, 2008). Beneficence is generally accepted as the core principle of the patient-provider relationship (Ruderman et al., 2006).

ROLE OF PROFESSIONAL CODE OF ETHICS

Many have called for professional codes of ethics to further clarify and define the rights and responsibilities of health care professionals in pandemic preparedness. Duty to care is inherent in all health care professionals' codes of ethics. It can be interpreted from the second provision of the American Nurses Association's (ANA) Code of Ethics: "The nurse's primary commitment is to the patient" (ANA, 2001). The fifth provision addresses nurses' obligations to themselves: "The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety" (ANA). It is unclear when the duty to care for patients supplants the duty to preserve the safety of self. This represents the hallmark of a challenging ethical decision, when two values are in tension and there is no clear answer as to which one to choose in making the decision.

Thompson, Faith, Gibson, and Upshur (2006) present and encour-

age adoption of an ethical framework for pandemic influenza planning. They stress that failure to address ethical concerns will lead to loss of public trust and erosion of hospital staff morale. Regarding duty to care, the framework recommends establishment of practice guidelines in advance of an influenza pandemic, development of fair and accountable processes to resolve disputes, provision of supports to ease the moral burden of those with the duty to care, and development of means through which institutions will handle complaints, especially regarding work exemptions or vaccination or prophylaxis of staff.

Reid (2005) calls for a strong duty to care founded from more than a nurse's obligation to a professional code of ethics, comprising a commitment to society to perform in a time of great need. This greater societal duty to care is necessary because nurses will not be the only individuals called on to accept risk and distress in the face of a pandemic. Physicians, paramedics, and janitorial staff served alongside nurses and died during the SARS epidemic (Reid). However, nurses typically spend more time at the bedside in direct contact with patients, increasing their risk of exposure.

CONCLUSION

Nurses recognize that the patient care environment can harbor a variety of infectious diseases, some of which are difficult or impossible to treat. Infection control practices can reduce risk to acceptable levels but cannot eradicate all risk. Although there is no objective level at which risk becomes excessive, nurses must appreciate that their roles cannot be implemented in a risk-free environment.

Due to the risks involved in caring for patients during an influenza pandemic, nurses and their families

should receive the highest priority for vaccination and access to anti-viral agents. Bartlett (2006) stated that the moral obligation to care for these patients is clear, but the reciprocal obligation of health care institutions to provide the maximum protection, including anti-viral agents, vaccination, personal protective equipment, and liability protection, is less obvious.

SUMMARY

The point at which duty to care is outweighed by personal risk remains unclear. The nursing community must discuss and address the issue of duty to care in the setting of pandemic influenza before it occurs.

REFERENCES

- American Nurses Association. (2001). *Code of ethics with interpretive statements*. Retrieved January 3, 2009, from www.nursingworld.org/ethics/code
- Bartlett, J. (2006). Planning for avian influenza. *Annals of Internal Medicine*, *145*, 141-145.
- Chung, B., Wong, T., Suen, E., & Chung, J. (2005). SARS: Caring for patients in Hong Kong. *Journal of Clinical Nursing*, *14*, 510-517.
- Hsin, D., & Macer, D. (2004). Heroes of SARS: Professional roles and ethics of health care workers. *Journal of Infection*, *49*, 210-215.
- Reid, L. (2005). Diminishing returns? Risk and the duty to care in the SARS epidemic. *Bioethics*, *19*(4), 348-361.
- Ruderman, C., Tracy, C., Bensimon, C., Bernstein, M., Hawryluck, L., Shaul, R., et al. (2006). On pandemics and the duty to care: Whose duty? Who cares? *BMC Medical Ethics*, *7*, 5.
- Schroeter, K. (2008). Duty to care versus duty to self. *Journal of Trauma Nursing*, *15*(1), 3-4.
- Thompson, A., Faith, K., Gibson, J., & Upshur, R. (2006). Pandemic influenza preparedness: An ethical framework to guide decision-making. *BMC Medical Ethics*, *7*, 12.

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