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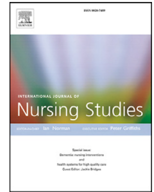
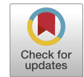


Editorial

Covid-19: Ethical issues for nurses



We are living in unprecedented times and nurses are being lauded globally for putting themselves in the front line against the Covid-19 pandemic. It is but a few months since 15,500 nurses in Northern Ireland went on strike because of a lack of pay parity with their colleagues in the rest of the UK and amidst concerns about standards of patient safety. Leaving their patients to join picket lines raised serious ethical issues for these clinical nurses. These included the principles of 'nonmaleficence', the nurses' duty to do no harm and 'beneficence', the duty to do good for patients. Going on strike meant that nurses could no longer be sure that they were adhering to these two principles. The ethical dilemma facing them was that not going on strike would compromise patient safety due to workforce shortages and low morale. There were reports in the media of nurses crying, not because of the care that they were giving, but because of the care that they were not able to give (Nursing Times 2020).

Fast forward three months and who could have predicted that other more serious ethical issues would face clinical nurses globally. The Covid-19 pandemic has rocked the world's health care systems to their foundations. We hear every day how there are insufficient resources to deliver safe care or in sufficient amounts. One issue has been the inadequate supply of personal protective equipment (PPE) and limited testing, providing front line nurses with another ethical dilemma. They could go to work without these safeguards and put themselves and possibly their patients and families at risk of contracting the virus. Alternatively, they could stay at home, knowing that severely ill patients need nurses to be on duty. Once again, the principles of 'non-maleficence' and 'beneficence' apply.

A foundation of nursing practice is the duty of care with the attendant obligations to alleviate suffering, restore health and respect the rights and dignity of every patient. However, nurses must balance this duty of care for patients with their duty of care to themselves and their family members. These conflicting duties in a pandemic can cause serious moral and emotional distress. A nurse's duty to care for patients is not absolute. If the COVID-19 virus places nurses at serious risk if they contract it, it is unfair and disproportionate to expect them to undertake such heightened health risks to uphold their duty of care.

These are real fears and real dilemmas. According to Fiona Godlee (2020), editor of the *British Medical Journal*, health and social care workers are dying because of occupational exposure to COVID-19, including more than 100 in the UK. The emotional trauma is too much for some to bear. In March 2020, the Italian National Federation of Nurses reported that in Monza, Lombardy, Daniela Trezzi, a 34-year-old Italian nurse treating COVID-19 patients, took her own life for fear of having spread the illness and after being traumatised by her experience of working on the front line (Squires, 2020). Also in March, the Italian Nursing Federation reported that another nurse ended her life through suicide under similar circumstances in Venice (FNOPI, 2020). More recently, a New York doctor took her own life after her experiences of dealing with COVID-19 patients in the emergency room (Watkins et al., 2020).

A further issue has emerged that evokes another ethical principle – justice - ensuring equity and fairness in how patients are treated. There have been reports from across the globe of insufficient intensive care beds and ventilators for the predicted number of COVID-19 victims. In such a scenario, what will determine who gets lifesaving access to treatment and who does not? Can it be on a first come first served basis or will those most likely to benefit from such access take precedence? Inevitably, it will be the latter.

In the COVID-19 Pandemic, it is not easy to find an acceptable justification for such decisions. This may mean a move away from a person-centred nursing approach to a population health approach. This is because ensuring the health of the population often entails imposing limitations on the rights and preferences of individuals. It could be argued that there is an ethical duty to allocate limited resources where they can be of greatest benefit, where the greatest number of lives can be saved. This is reflected in the principle of utilitarianism, where in the face of high demand and low supply, the greatest good should be achieved for the greatest number. In such a scenario, another ethical principle, distributive justice is often sacrificed, where everyone has an unqualified right to the very best health care. Here again, the decision to safeguard one principle may conflict with another, causing tension and stress for nurses.

According to Garrard and Wilkinson (2005), passive euthanasia involves withdrawing or withholding life-prolonging medical treatment. This is a major ethical issue for clinicians. In the current pandemic, teams that include nurses, may be actively involved in using triage principles that will lead to the withholding of potentially lifesaving equipment or facilities from some patients with COVID-19. They may also be involved in decisions regarding 'reverse triage'. In effect, this means that existing intensive care unit patients may be re-assessed on their likelihood of benefiting from further treatment to make way for other patients, who would be more likely to benefit. These are difficult decisions that threaten to undermine the very essence of person centred nursing care.

While the ultimate legal responsibility of making such decisions lies with the senior responsible clinician (James et al., 2018), the Royal College of Nursing point out that nurses with appropriate

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knowledge, skills and support may be the senior responsible clinician (RCN, 2020). But no clinician should have to make these decisions alone; rather, it should be a team endeavour, based on the very best ethical and clinical evidence, a view supported by Department of Health guidance (DoH, 2020).

Returning to passive euthanasia, it is clear that the above actions do not fulfil all three necessary conditions. These are: there is a withdrawing or withholding of life-prolonging treatment; the main purpose (or one of the main purposes) of this withdrawing or withholding is to bring about (or “hasten”) the patient’s death; and the reason for “hastening” death is that dying (or dying sooner rather than later) is in the patient’s own best interests (Garrard and Wilkinson 2005). Clinical teams who make difficult triage and reverse triage decisions to withhold or withdraw treatment are not doing so because it is in a patient’s best interests. Furthermore, they are not doing so to purposely bring about or hasten a patient’s death. The principle of solidarity dictates that while all patients may not receive critical care, those who do not should continue to be cared for with alternative levels of care, including palliative care.

These ethical issues have not newly arisen in the current pandemic. Nurses have been discussing death and dying with patients and their families long before this crisis emerged. Palliative nursing care to help people die with dignity and comfort is not something that was invented to deal with COVID-19. In other words, much of the knowledge and skills already exist as part of the realities of clinical nursing practice.

The adage ‘no decision about us without us’ applies to the current pandemic. The risks, benefits and possible likely outcomes of the different treatment options should be discussed with patients, families and carers so that they can make informed decisions (NICE, 2020). However, this brings other stress provoking challenges for nurses. Patients who are considered for admission to intensive care may not be in a fit state to be involved in such decision making. Furthermore, hospital visiting and contact between nurses, families and patients have been stopped in the current lockdown. In such circumstances, involving families in life and death decisions is fraught with difficulties. A key principle to follow is that when people are not able to make a decision, those who have to decide for them do so based on the best interests of the patient, taking account of their rights and their individual needs and circumstances.

The inability of families to visit patients brings another challenge. There have been reports that family members have asked nurses to speak their last words to their dying relative. Being an intermediary between family and patient in such circumstances is emotionally demanding. Further, nurses are acutely aware that the sentiments that a family member asks a nurse to impart to the terminally ill patient may not be agreeable to other family members. This has the potential to make a stressful event for the nurse involved, even more stressful.

Thankfully, in recent weeks different organisations have drawn up ethical guidelines for such scenarios. In the United Kingdom, these include the British Medical Association (BMA, 2020), the National Institute for Health & Care Excellence (NICE, 2020), the Royal College of Physicians (RCP, 2020), British Board of Scholars and Imans (2020), and the Royal College of Nursing (RCN, 2020), to name a few. These are based upon specific ethical principles and evidence-based guidelines. They inform decision-making and can enhance trust and solidarity and strengthen the legitimacy and acceptability of the measures put in place. However, nurses should remain mindful of the obligations and responsibilities set out in their codes of conduct and continue to use their professional judgement in the delivery of care.

Applying these principles and guidelines may not make the aftermath any easier for front line nurses. It is natural that they will reflect on their actions and think about those patients and families who were impacted by the decisions made. This brings threats to their mental health. But good teamwork, the availability of counselling and adherence to ethical principles and the best available evidence may help them realise that they did the very best they could in unprecedented circumstances.

In conclusion, many of the clinical issues encountered in this pandemic involve balancing conflicting rights, principles and values. A consistent feature of any public health crisis, is that it places severe strain on the national healthcare system’s already limited resources and on those delivering care and treatment. It may mean front line nurses having to re-examine the standard of care that they would normally provide and justify a different approach in the face of increased demand and reduce supply of intensive care beds, clinical personnel and personal protective equipment.

At the start of this editorial, I noted that in 2019, nurses in Northern Ireland reluctantly took strike action over concerns about staffing levels and patient safety. Even though this provided them with an ethical dilemma, they did so in the best interests of patients. Less than six months later, their responses to the COVID-19 pandemic, and that of nurses worldwide, demonstrates that in the face of more profound ethical dilemmas they continue to put patients first. Those not yet born will talk about this dystopian time and remember those front-line nurses who risked their lives and those of their families to save as many others as possible.

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