COVID-19 Ethics Analysis: What is the Ethical Duty of Health Care Worker to Provide Care During COVID-19 Pandemic?

Provincial COVID-19 Task Force

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Introduction

The COVID-19 pandemic presents a number of significant ethical issues regarding safety for healthcare personnel (HCP). Some HCP may be concerned that if they become infected themselves, they in turn may infect patients, their co-workers, as well as their own family members and children. These HCP are caught at a difficult intersection: navigating these fears with their ethical sense of duty to patients and to society, and their sense of solidarity with fellow HCP.

This discussion focuses on the HCP's ethical duty of care in circumstances where there is a risk of harm to their own person. As such, a key ethical question related to duty of care during COVID-19 is:

- **How should HCP and organizations approach the ethical duty to care in the context of the COVID-19 pandemic?**

Since the degree of potential harm to HCP can include serious morbidity and death, it is necessary to consider the degree to which HCP have an ethical duty to care and the circumstances under which that duty can be discharged. **The analysis does not, however, consider any legal or professional (i.e. regulatory and college) aspects.**

Facts & Relevant Information

HCP are bound by an ethic of care which dictates that patients' well-being should be primary[1].. Simultaneously, HCP are also bound by competing relational obligations such as parenting duties and other compulsory caregiving commitments. Tensions between these multiple realms of responsibility may be irreconcilable.

The ethical foundations of the duty to care are grounded in several ethical principles—primarily, the principle of beneficence to patients and to the public. The ethical obligation also stems from three features:

1. The ability of HCP to provide effective care is greater than that of the general public and thus there is a greater obligation to provide this care.
2. HCP freely choose to enter into their professions and thus inherently assume some degree of risk when they choose their profession.
3. Health professions are legitimized by society on the basis of a social contract that expects they are available in times of emergency, such as the COVID-19 pandemic.

Thus, while it is the case that an ethical duty to care exists, the degree to which it holds in the

[1] Ruderman, C., Tracy, C. S., Bensimon, C. M., Bernstein, M., Hawryluck, L., Shaul, R. Z., & Upshur, R. E. (2006). On pandemics and the duty to care: whose duty? who cares?. *BMC Medical Ethics*, *7*(1), 5.

context of COVID-19, and the degree to which the duty extends to all healthcare activities, exists in relation to the facts about what is currently known about COVID-19. Accurate assessment of the facts, and assumptions, based on the best available information, are crucial in any analysis of the duties of HCP.

The importance of grappling with the notion of discharging the duty of care illuminates the balance on which HCP should weigh any immediate benefits to an individual patient *with their ability to care for patients in the future*[2].

Actual and assumed facts regarding the COVID-19 pandemic:

- COVID-19 is currently understood to be highly infective and easily transmittable from person to person through droplet and contact spread.
- The transmission of COVID-19 is primary through droplet spread[3]. Some healthcare activities and procedures may also generate aerosols composed of particles suspended in air (e.g. CPR before intubation)[4]. Appropriate PPE has been defined for both droplet and airborne risks. Appropriate PPE is considered an effective risk mitigating strategy when used properly. Thus, in the absence of appropriate PPE, or in cases of improper PPE use, HCP face heightened risks of harm to their person.
- Some HCPs engage more frequently in the provision of patient care that poses higher risks to their personal safety. The process of caring for severe COVID-19 patients and performing AGPs in this group presents an increased risk of infection to healthcare workers.
- Some HCPs may face increased personal risks in relation to COVID-19 (e.g. those who are older adults with comorbidities). HCP with personal characteristics where COVID-19 is known to cause substantial harm (including death), face greater risks of harm.
- There are key sectors of the healthcare system (e.g. acute and critical care HCP, specialty services), where losses of HCP due to COVID-19 would substantially disrupt the ability of the healthcare system to respond to the COVID outbreak. The impact of such disruptions would thus impair the ability of the healthcare system to care for all types of future patients, including those with COVID-19 infections.

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[2] See: Ruderman, C., Tracy, C. S., Bensimon, C. M., Bernstein, M., Hawryluck, L., Shaul, R. Z., & Upshur, R. E. (2006). On pandemics and the duty to care: whose duty? who cares?. *BMC Medical Ethics*, *7*(1), 5.

[3] See: Brewster, D., Chrimes, N., Do, T. et al. (2020). Consensus statement: Safe airway society principles of airway management and tracheal intubation specific to the COVID-19 adult patient group. *Medical Journal of Australia*. (Published online 15 March 2020. Available: https://www.mja.com.au/journal/2020/212/10/consensus-statement-safe-airway-society-principles-airway-management-and)

[4] Brewster, Chrimes, Do et al. (2020) noted the following AGPs: coughing/sneezing, NIV or PPV with inadequate seal, HFNP, delivery of nebulized medications via simple face mask, CPR prior to intubation, tracheal suction, tracheal extubation (see Table 1).

- As is currently understood about the COVID-19 virus, the probability of spread is also very high if not contained. Thus, the risk of harm to the society is high and needs to be factored into any ethical response.

Limits to ethical duty to care

HCP have an ethical duty to provide care, even when it involves potential exposure to some risk of harm5. However, when individual HCP face certain and significant harm to their person—such as may be the case in performing some healthcare activities without appropriate PPE—that duty may be discharged.

In the context of COVID-19, each individual HCP must bear the burden of justifying whether their duty to care is discharged. This justification must be clear and robust in order to avoid the dissolution of the generally high regard that society holds for HCP and continuation of the trust and respect of such relationships. Thus HCP must justify any discharge of their ethical duty to care in relation to:

a) their participation in a ***specific*** patient care activity (or activities) that pose intolerable and unmitigable risk of certain and significant harm; and,
b) their own unique personal circumstances.

For example, some HCP may themselves fit within higher risk categories where COVID-19 is known to cause particular harms including death (e.g. those who are immune compromised, frail older adults) and thus may face both certain and significant harms if they engage in particular healthcare activities where the risks of harm cannot be mitigated (e.g. aerosol-generating procedures (AGPs) for a person with known COVID-19 without adequate PPE). In such a scenario, if the HCP has no available strategy to effectively mitigate the exposure to COVID-19, they can defensibly discharge their duty to provide that ***particular activity*** of care.

Ethical Analysis

The ethical analysis and recommendations in this document follows the *BC COVID-19 Ethical Decision-Making Framework (EDMF): Interim Guidance*.

This EDMF reflects the core ethical principles of public health ethics: respect; the harm principle; fairness; consistency; least coercive and restrictive means; working together; reciprocity; proportionality; flexibility; and procedural justice.

Values grounding an ethical duty to care and the circumstances under which that duty is discharged

[5] See: Damery, S., Draper, H., Wilson, S et al. (2010). Healthcare workers' perceptions of the duty to work during an influenza pandemic. *J Med Ethics, 36*: 12-18. doi:10.1136/jme.2009.032821

- **Reciprocity**
  - If HCP are asked to take increased risks, or face increased/disproportionate burdens, they should be supported in doing so, and the risks and burdens should be mitigated as far as possible. When these risks cannot be mitigated, the safety of HCP must be carefully considered and prioritized in order to preserve the future functioning of the healthcare system.
  - Giving clear guidance on the ethical duty to care—including the circumstances under which the duty to care is defensibly and justifiably discharged in the context of risks to personal safety—is predominantly supported by the principle of reciprocity and for the careful consideration of HCPs' safety. This guidance is also supported by the harm principle (i.e. the right of society to protect itself from harm) as widespread and significant harms to HCP (including deaths) threatens the functioning of the whole healthcare system and the care of future patients.

- **Respect**
  - Treat colleagues with kindness, care, and compassion
  - Communicate in an informed, thoughtful way
  - Each individual HCP must bear the burden of justifying whether their ethical duty to care is discharged

- **The Harm Principle (public safety):**
  - A society has a right to protect itself from harm, real or threatened. The government is justified in intervening and possibly impinging on the rights of individuals to protect the community from harm.

- **Duty to care**
  - Accepting the professional role as HCP in the context of a public healthcare system means accepting the responsibility to put the interests of patients and the public ahead of the HCP's personal interests to a reasonable extent. This duty would be overridden only when the risk of harm to a HCP's person is certain, significant, and cannot be adequately mitigated. The responsibility arises from multiple sources including:
    - The public investment in the education and training of HCP, through subsidized and supported opportunities for professional education and training
    - Special status for governance and oversight of professional practice through healthcare professional organizations
    - The relative power differential between patients and HCP, where patients must trust HCP to meet patient needs–creating a fiduciary responsibility on the part of the HCP

- **Fairness**
  - HCP each consider the circumstances under which their ethical duty to care may be defensibly discharged in the context of threats to HCPs' personal safety in order to ensure they remain alive and remain able to care for future patients. This crucial consideration reflects the principle of fairness for future patient populations and for the healthcare system more broadly.

- **Proportionality**
  - Measures implemented, especially restrictive ones, should be proportionate to and

commensurate with the level of threat and risk.
    - Where limits and restrictions are placed on patient care activities due to intolerable and unmitigable risks to HCPs' persons, these decisions should be communicated clearly and transparently. Especially restrictive limits should be proportionate to the risk HCPs actually face.

- **Least Coercive and Restrictive Means**
    - Any infringements on personal rights and freedoms must be carefully considered, and the least restrictive or coercive means must be sought.

- **Working together**
    - Cooperation is essential to this international threat – between individual citizens, health regions, provinces, and nations.

- **Procedural Justice**
    - There will be accountability to a fair and transparent process throughout the planning and implementation of managing COVID-19. Reflects the best available evidence, and ensures assumptions made are well grounded and defensible.

Recommendations

This section is organized for three groups: individual HCP, organizational-level leaders, and system-level leaders

Individual HCP

1. HCP should acknowledge their ethical duty to provide care and understand that this duty remains even when it involves potential exposure to some risk of harm.
2. Each individual HCP should determine their obligation and willingness to provide care in contexts where they are exposed to risk of COVID-19 infection based on:
    a. The HCP's participation in a *specific* patient care activity (or activities) that pose risk; and,
    b. their own unique personal circumstances
3. When a HCP faces certain and significant harm to their person, such as may be the case in the situations such as the absence of adequate PPE, they may consider their usual duty to provide care met; it would be reasonable to see any service that includes risk beyond this point as voluntary.
4. For HCP who fit within higher risk categories where COVID-19 is known to cause particular harms including death, if the HCP has no available strategy to effectively mitigate the exposure to COVID-19, it would be reasonable for that provider not to provide that *particular activity* of care.
5. If an individual HCP is unwilling to accept the responsibility to provide care based on the balancing of their value commitments and weighing their personal circumstances, they should:

a. Work with/support their supervisors or appropriate colleagues such that there can be a further effort towards meeting any of their unmet needs, and
b. Find alternatives to support patients and the system that allow them to balance their value commitments

Organization-level leaders (e.g. Hospitals)

1. Organizations representing HCP should give clear indication to what standard of care is expected of their members in the event of a pandemic[6]. As discharging the ethical duty to care is almost never an absolute discharge, organizations and HCP should collaborate closely to examine activities that pose potential risks of harm to HCP. To the greatest extent possible, examinations of risk should consider all the available evidence and should be re-examined when new facts become available. In some circumstances, organizations may collectively endorse the discharge of a particular duty of care. These decisions must be communicated transparently and openly in order to preserve trust in HCP and in order to demonstrate respect for others.

2. Organizational leaders have an obligation to consider and recognize the power differentials and vulnerabilities that impact staff differently across the range of personnel who make up the healthcare workforce (e.g. care aides vs. physicians). The ethical duty to care that arises out of the special characteristics of health professions may justify greater expectations for certain HCP.

3. Provide health authorities with the following guidance:

    a. HCP have an ethical duty to provide care, even when it involves potential exposure to some risk of harm.

    b. However, when an individual HCP faces certain and significant harm to their person, such as may be the case in the absence of PPE, that duty may be discharged. This ethical duty is discharged *only* when the risk of harm to a HCP's person is certain, significant, and cannot be adequately mitigated.

    c. Willingness to work despite personal risk to themselves is a largely contextual and personal decision (e.g. caregiving duties for family members, unique personal health needs). Leaders should proactively and transparently explore this context by strategizing their workforce and seeking to identify those who face both the least and greatest risk from COVID-19.

    d. Health authorities should re-deploy HCP who are available and willing to work despite personal risk to areas of greater need, or to relieve higher risk individuals from exposure (See: Ethics SBAR Staffing models - in draft 21 Mar 2020). Should HCP's willingness to assume the risk of harm relate to any type of service (e.g. childcare, pet care) or incentive (e.g. additional compensation), ensure all HCP are offered options equally.

[6] See: Ruderman, C., Tracy, C. S., Bensimon, C. M., Bernstein, M., Hawryluck, L., Shaul, R. Z., & Upshur, R. E. (2006). On pandemics and the duty to care: whose duty? who cares?. *BMC Medical Ethics*, *7*(1), 5.

e. Any individual HCP who decides to continue to work, despite personal risks to themselves, should do so in a fully informed manner, and should not be pressured or coerced to do so.

    i. The notion of discharging ethical duty of care—particularly in the context of risks to HCPs' personal safety—is important. Such importance illuminates the balance on which HCP should consider immediate benefits to an individual patient with t*heir ability to care for patients in the future.* As such, organizational and system-level leaders should consider whether there are particular care activities and/or specific services that will be temporarily suspended in the context of COVID-19 on the basis that they pose too great of a risk to HCP broadly and thus may threaten their ability to provide care in the future.

4. Respect for privacy and confidentiality is essential. As such, personal health or social information that may be disclosed during discussions between leaders and staff members must be confidential. Any form of public shaming or pressure should be avoided.

5. Governments and the healthcare sector should develop human resource strategies for communicable disease outbreaks that cover the diverse occupational roles, that are transparent in how individuals are assigned to roles in the management of an outbreak, and that are equally with respect to the distribution of risk among individuals and occupational categories[7].

System-level Leaders (e.g. Health Authorities, Provincial Governments)

1. Specific criteria should be developed to establish what constitutes an acceptable reason for duty to be discharged. These criteria should be consistently and transparently applied and special attention paid to the harms to consistency if exceptions are allowed.
    a. There should be provincial consistency in the application of these recommendations and criteria to uphold the values of *consistency* and *working together*.

2. The risks to HCP may extend beyond physical threats to their personal safety. Threats may also include psychological, mental, and emotional harms[8]. Senior decision-makers will have to make difficult decisions about staff assignment. To do so they need to have support of the highest levels of administration, including the Ministry of Health. Ethics consultation services are available to assist with this decision making, as required.

3. Disability insurance and death benefits must be available to staff and their families adversely affected while performing their duties recognize the need for additional benefits and protections for those HCP who are more vulnerable in the healthcare system.

[7] See: Upshur, R., Faith, K., Gibson, J., Thompson, A., Tracy, C., Wilson, K., Singer, P. (2005). Stand on Guard for Thee. Ethical Considerations in Preparedness Planning for Pandemic Influenza. A report of the University of Toronto's Joint Centre for Bioethics, Pandemic Influenza Working Group.

[8] See: Upshur, R., Faith, K., Gibson, J., Thompson, A., Tracy, C., Wilson, K., Singer, P. (2005). Stand on Guard for Thee. Ethical Considerations in Preparedness Planning for Pandemic Influenza. A report of the University of Toronto's Joint Centre for Bioethics, Pandemic Influenza Working Group.

4. All decisions related to duty to care should be communicated openly and transparently.

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