

Beyond Ebola Ethics: Do Nurses have a Duty to Treat?

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ABSTRACT: *This article explores a significant issue facing nurses. Legal and ethical considerations are explored, looking at the relevant new Rhode Island and California laws, which mandates both a duty to treat and employer responsibilities. The ethical framework of beneficence is discussed. The ANA Code of Ethics is examined and the revisions in 2015 are introduced. Nurses' rights are outlined, as well as the responsibilities of employers and society. The article ends with additional considerations for nurses and the U.S. It will help nurses to clarify their own beliefs about the current crisis as well as in general regarding the ethics of mandating duty in the face of a pandemic or highly lethal disease.*

Keywords: *Ebola, ethics, beneficence, duty to treat*

INTRODUCTION

Nurses in America have protested the treatment (or lack thereof) for their own who are stricken with Ebola and the lack of preparedness in the U.S. for this disease (Demoro, 2014; National Nurse, 2014), which is the new AIDS or Avian Flu of the 21st century. The West and U.S. are now forced to confront the killer that they had previously responded slowly to and mismanaged (Ebola: a failure of international collective action, 2014). We have seen media-fueled over-reaction and stigmatization directed toward American nurses and doctors struck with the disease, as was the case in the AIDS era. Unnecessary quarantining of health care professionals believed to be possibly infected with the virus highlights the need for education – of the public, public health and government systems as well as health care providers. Recent articles in *The National Nurse* (2014) highlight the controversy and the push to stop blaming the nurse victims. Nurses may be understandably afraid of getting infected by this highly lethal disease of which much is still unknown, and consider refusal to care for Ebola patients.

An issue that warrants addressing is whether nurses have a duty to treat (DTT). What does society owe nurses and what do nurses owe society? Literature review does not provide many arguments for or against DTT. It seems--as with most ethical issues--to be multifaceted and with few precedents. There are logical limits to DTT expectations, including when the nurse's life is truly endangered. But what constitutes significant risk? In the 1980's during the HIV-AIDS epidemic in the U.S., and only ten years ago during the Avian flu epidemic in Toronto, many nurses refused to care for patients (Sokol, 2006). There are unknowns regarding the transmission of Ebola. And even when risks are known, it is difficult to educate away fear and prejudice. I experienced much resistance as a staff educator in the 1990's teaching about AIDS and infection control, in spite of the fact that the chance of contracting HIV with a needle stick is 0.4% or less (Wilton, 2012). With Ebola, the risks are very high. Cynda Rushton, nursing ethics professor at Johns Hopkins University led a team of U.S. nurse leaders to debate such ethical issues ahead of a push by the American Nurses Association (ANA) to revisit and clarify its own Code of Ethics. "We need to strengthen a culture that genuinely supports doing the right thing, at the right time, for the right reason," Rushton explains (Rushton & Broome, 2014). Just how to accomplish this remains elusive however.

This article will summarize findings from relevant research, searching for an answer to the question: Do nurses have a duty to treat patients infected with Ebola? The *four principles framework* (Beauchamp & Childress, 2012) is applied, and primarily the principle of beneficence will be explored. Legal and ethical issues become clearer, as do the practices and policies needed. Healthcare worker rights and the duty of employers are also explored.

BACKGROUND

As of January 13, 2015, according to the CDC (2015), this latest outbreak in Guinea, Sierra Leone, and Liberia, has seen 21,373 cases. Since then, there have been 6,375 additional cases (Boseley, July 31, 2015). The WHO (2014) now reports that mortality rates are up to 90%. Nurses have contracted Ebola at alarming rates and we may see more patients and nurses in the U.S. infected with Ebola. It remains unclear as to the exact manner in which many of the healthcare workers have acquired the infection, and investigation continues. A particular concern regarding infection is the high systemic viral load carried by the infected individual, especially as a patient's condition worsens. Also, unlike HIV, the virus can live for days on a surface (WHO, 2014). There is no vaccine or cure for Ebola yet (Boseley, 2005), although vaccines are now under investigation, and treatment is primarily supportive or palliative.

Dr. Craig Spencer with Doctors Without Borders (DWB) was criticized for not quarantining himself upon return to the U.S. Armand Sprecher (2014) with DWB denounced multiple counts of misinformation published about the physician and the over-reaction of U.S. airports and states in instituting new regulations, which led to the quarantining of Kaci Hickox, the DWB nurse who returned from Liberia. Hickox experienced days of being quarantined, first at the New Jersey airport and then in her own home by the Governor and State of Maine. Both Dr. Spencer and Nurse Hickox reportedly followed DWB and Centers for Disease Control (CDC) protocol (Sprecher, 2014).

Nina Pham was the first nurse to contract the disease in the U.S. from the first patient diagnosed in America. She still states that she does not know how she contracted the disease and that she followed the protocols. She was initially blamed by the CDC for not following "protocol". Pham has spoken out about the lack of training and the marginalization she experienced (Associated Press, 2015). The second nurse infected in Dallas was criticized for traveling to Ohio although she also said that she had followed protocol and was not symptomatic.

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ETHICAL FRAMEWORKS

When the Liberian patient, Thomas Duncan, was sent home from Texas Health Presbyterian hospital and then subsequently treated in Dallas, articles started emerging with nurses saying that they were unprepared to care for Ebola patients (Steenhusen, 2014). This is very relevant because the responsibility of DTT would presumably increase when appropriate resources are available and provided. Demoro (2014) asserts that hospitals are guided by profits and have refused to adopt minimal safeguards. The federal government has not compelled them to do so. 85% of nurses surveyed said that their hospitals were not prepared at all, and “training” consisted of being given written material (Demoro, 2014).

Nurses are joining together to raise public awareness about protecting American nurses caring for patients with Ebola, rather than blaming them. The September/October issue of *National Nurse* (2014) highlighted protests about this issue, leading to increased awareness of legal and ethical issues compelling nurses to treat in the face a highly contagious and lethal virus.

There is no law or mandate for DTT if the risk to the nurse is great for illness, injury or death. Alternately, anyone could be morally obliged to treat or rescue if the risk to self is minimal; and during a crisis, everyone’s obligation increases. There is an inherent or implied consent to treat by virtue of being a nurse. Still, nurses do have an obligation to care for themselves first. And medicine is so specialized that it is not reasonable to view treating a (very) infectious disease as part of the job for all nurses (Malm et al., 2008). Perhaps an accepted risk level needs to be adopted in developing DTT mandates. The 0.4% risk of contracting HIV even with exposure is certainly minute. Is 5% a high risk, or 50%? We do not know for certain the actual risk for contracting Ebola if proper precautions are strictly followed.

A significant question raised is whether Ebola presents as an emergency. The Emergency Treatment and Labor Act (EMTLA) mandates that emergency rooms screen and, if medically indicated, stabilize all persons. It was “designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, providing a medical screening examination to ensure they were stable for transfer. Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions” (American College of Emergency Physicians, 2014; Social Security Administration, 1986). Therefore, emergency department staff members are legally obliged to treat Ebola patients if they present in a clinically emergent state. This raises the question: Do many hospitals have legal grounds to claim that they do not have the capacity to treat Ebola patients? In a situation such as the Thomas Duncan case, and in hypothetical similar situations, the diagnosis is initially unknown.

New Rhode Island Law

Based on Emory Hospital’s attitude of caring and volunteerism (See Wallis, 2014), Rhode Island (RI) is the first state to pass a licensing law mandating nurses to provide care for all patients, including Ebola victims. This law is based on beneficence concepts. The risk of disease transmission, according to the Rhode Island Public Health department, does not negate DTT. The mandate is additionally based on the American Medical Association’s (AMA) ethics opinion from 1992 stating that MDs must treat HIV/AIDS patients and people with such blood borne diseases, claiming “The applicability [to] Ebola is unambiguously clear” (Twardowski et al., 2014). It applies to all professional licensed healthcare workers. While the spirit of the law to deliver quality care to everyone is laudable, this author disagrees with it on grounds that the risk of infection for HIV, hepatitis B and the like is minute compared to that of contracting Ebola (Wilton, 2012).

Nurses in other states are left to make those decisions independently, hopefully in consultation with their profession’s code of ethics, which are general and vague; it is up to nurses to use their own judgment. Two themes that emerge related to DTT are social contract and moral obligation, as well as risk-benefit considerations. Codes of ethics for nurses mandate a duty to treat if the risk is low, but they are not legally binding (Brewer, 2010; Malm et al., 2008).

Beauchamp and Childress’ (2012) *Four Principles* of biomedical ethics are basic guidelines that leave room for individual choices in decision-making in such cases

Respect for autonomy: respecting decision-making abilities of autonomous persons and enabling them to make informed choices.

Non maleficence: not causing harm; the healthcare professional should not harm the patient beyond what may be inherent in treatment.

Justice: applying fairness concepts to the distribution of benefits, risks and costs; treating everyone equitably.

Beneficence: the balancing of benefits against the risks and costs of treatment; the healthcare professional should perform care so that the patient benefits.

Beneficence appears to be the most logical ethical principle with which to argue a DTT. Yet, nurses are left to weigh the risks to self and others (i.e. family) versus benefits to patients and others (i.e. society). Utilitarianism theory—the greater good—does not play into this equation, because most likely only one patient at a time is helped, whereas potentially many nurses are infected. On the other hand, it could be argued that one person can infect many people.

While not legally binding, codes of ethics function as guides to the highest ethical practice standards and aid in moral reasoning. The American Nurses Association (ANA) code has three primary principles relevant to DTT:

- The nurse practices with compassion and respect for... every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
- The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety...
- The nurse participates in establishing, maintaining, and improving health-care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action (ANA, 2011).

Society grants nurses exclusive access to a title and profession through licensure, what do nurses owe in return? Justice principles should also be considered here. The ANA concedes that while nurses have an ethical DTT by putting patients ahead of themselves, “there is no clear consensus about mitigating ethical considerations” (Brewer, 2010). The ethical issues related to DTT surrounding Ebola have fueled ethical debates. Should nurses risk their lives in futile resuscitation efforts? Surveys have demonstrated that only about 25% of nurse respondents thought that they had a professional duty to respond to infectious disease emergencies (Strangeland, 2006). This is not to say that they wouldn’t volunteer, as many nurses do; inherent in nearly all nurses’ calling is a self-imposed sense of duty and desire to care. Action to aid the afflicted is in the blood. Still, nurses wonder about the legal consequences if they refuse to treat (National Nurses United, November, 2014).

The data suggests that DTT should not be left to personal choice or an appeal to morality based on the obligation of individuals. A wider context transcending these contingencies is called for. *Legitimate*

exclusions have been offered such as pregnancy. However, nurses have expressed a sense of unfairness that people without families were expected to care for the infectious patients while others were not. In epidemics, ambivalence and ambiguity became apparent as nurses reflected on their DTT. “(Nurses) paid a great deal of attention to the broader social context, with societal considerations playing a crucial role in promoting dialogue and education as well as providing compensation” (Bensimon et al., 2007).

Malm et al. (2008) proposed that they were going to provide five arguments supporting DTT in cases of pandemics. However, after extensive exploration and literature review they concluded that maybe there is none. Nurses implicitly accept a level of inherent risk as part of their profession. Perhaps a wiser approach may be to broaden the use of expressed consent...so that many more necessary workers acknowledge the duty to treat during a pandemic or other societal medical emergency as an explicit, voluntarily accepted, and compensated responsibility...this is not a novel idea.(Malm et al., 2008).

NURSES' RIGHTS

The ANA 2006 Position Statement “Risk and Responsibility” states “there may be limits to the personal risk of harm nurses can be expected to accept as an ethical duty” (ANA, 2006). The ANA’s 2001 Bill of Rights for nurses states, “Nurses have the right to a work environment that is safe for themselves and for their patients” (p.4). Organizations are obligated to mitigate hazards. And an ethical environment needs to overcome the human tendency toward blame, shame and rush to judgment (National Nurses United, November, 2014). Nurses have a right to expect from their employer transparency, training, needed supplies, communication, compensation, adequate staffing and respect. Frontline nurses must be involved in hospital, state and federal planning and protocol development. Securing trained and caring nurses to care for Ebola patients should *start* with asking for volunteers. Then, as with the Doctors without Borders’ nurses and nurses at Emory University Hospital (where the first patients in the U.S. were treated) (Wallis, 2014), they will be pragmatic about the dangers and their sense of duty. Some may question the approach of letting volunteers care for risky patients. And nurses *are* obligated and generally do agree to incur some risk in caring for patients. At what point does the risk become great enough that the nurse is no longer obligated? This question remains to be adequately answered.

Additionally, employers ought to address the issue of conflicting loyalties nurses may face. Participants in a study conducted by Bensimon et al., (2007) of the perceived duty to care in communicable disease outbreaks identified four employer responsibilities necessary in order for nurses to fulfill their DTT: reciprocity, distribution of risk, coercion (negatively viewed) and management of tension among providers. Definitions of risk and its limits in relation to expectations need to be outlined (Bensimon et al., 2007). What are nurses to do if they feel conflicted about caring for patients? They should talk to their manager, the ethics committee at their facility, and perhaps their union. Nurses need to know the policy in their institution regarding refusal to care for a patient. Generally, once a patient assignment is accepted, refusal is considered abandonment.

ADDITIONAL CONSIDERATIONS FOR NURSES AND THE U.S.

The U.S. is still underprepared for potential pandemics, and the dilemma of DTT remains unclear. There is a need for dialogue, and this should begin in nursing and medical schools; students are ill prepared for providing care in a pandemic or situation such as treating Ebola patients. Perhaps younger, less experienced nurses should be exempt from such care; a higher level of knowledge and experience may decrease the risk of infection. Duty is a continuum. A study by

Bensimon et al., (2007) found the most important finding is that DTT is a relative concept, and as such there are no easy answers.

In November 2014, California OSHA and the California Department of Public Health issued guidelines for health care workers and other professions that may be exposed to Ebola (Cable, 2014). “The California regulations exceed existing federal guidelines, close the biggest loopholes in the CDC regulations, and replicate the demands NNU has made across the nation for two months” (National Nurses United, 2014).

The new guidance recommends that employers:

- Involve nurses in developing exposure control plans.
- Ensure that workers at risk of exposure to Ebola wear appropriate PPE, including *nitrile* gloves.
- Train employees in the use of all applicable protective equipment, including respirators. Clear instructions on how to safely put on and take off equipment requires face to face and hands on training and practice.
- Provide dedicated, separate areas for the application and removal of PPE.
- Use a buddy or similar system to assist employees in donning and removing PPE. “Buddies” must also use PPE.
- Provide additional PPE in situations where copious fluids are likely to be encountered.
- Isolation rooms are to be used when conducting aerosol-generating procedures such as intubation or bronchoscopy, and employees are to wear NIOSH-approved respirators.

CONCLUSIONS

I have outlined some responsibilities of nurses, employers and society. All these stakeholders along with lawmakers and ethicists are needed to address the containment and management of this dangerous disease and the next epidemic. Resources are needed to develop public health infrastructure. Society owes the care providers care and resources. I agree with Tomlinson (2008) that if we can begin by setting aside legal duty, something else emerges. Many nurses are willing to care for highly infectious patients and this is a noble and selfless act, exemplifying the highest ideals of medical professionals. Not all nurses should strive for such work, but hopefully enough will. Those willing to serve will serve as role models of empathy, altruism, morality and virtue. However, fear for one’s life or that of her/his family cannot be minimized.

Nursing schools should provide instruction on issues such as this and a forum for discussion. Nurses need to educate themselves on ethical codes and concepts. Employers should provide real training, including simulation and genuine support, including compensation. Discussions and simulation exercises are now occurring. The government should mandate employer provisions and employee protections, but not DTT. Most nurses do not consider remuneration the highest priority in decision-making, but do expect fair compensation for increased risk as well as safety and freedom from blame. Dialogue, not dictatorship from employers and the government, will aid in treating nurses as well as patients humanly. Ebola may soon be controlled with a vaccine, but there will be another Ebola-like disease. Patients have an expectation and right to competent, compassionate and fair treatment; and nurses deserve the same.

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