
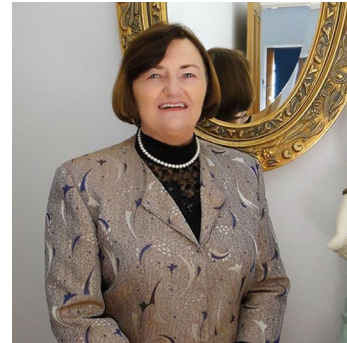



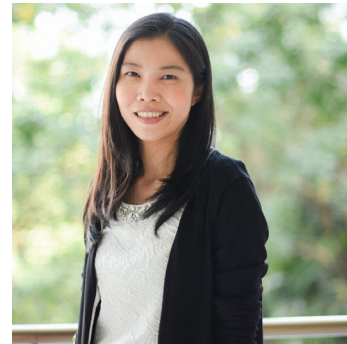
# Nursing and Health Policy Perspectives

## Challenging times: ethics, nursing and the COVID-19 pandemic

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## Abstract

Globally nurses and midwives are working hard to detect cases of COVID-19, to save lives or give comfort in the face of death, to educate themselves and the public about protective measures to stop the viral spread, while still caring for those not infected with the virus. In many countries nurses are working under virtual siege from this pandemic, with not enough resources or personal protective equipment, overwhelming numbers of patients, staff shortages, underprepared health systems and supply chain failures. Nurses and other health and emergency workers are suffering physical and emotional stress, and moral distress from conflicting professional values. They are faced with unpalatable and complex ethical issues in practice, with moral conflicts, high levels of acuity and patient deaths, and long working hours. A rising number of nurses are infected with SARS-CoV-2 or dying in the line of duty. Nurses need strong moral courage, stamina and resilience to work on the front lines of the pandemic, often while separated from their loved ones.

*Keywords:* COVID-19, Ethics, Global health emergency, Moral courage, Moral distress, Nursing ethics, Pandemics, SARS-CoV-2

In December 2019 reports surfaced about a potentially dangerous respiratory disease detected in the city of Wuhan, Hubei Province, China. On 31st December, China alerted the World Health Organization (WHO) about several cases of an unusual pneumonia caused by an unknown virus, believed to have originated from a wet market in Wuhan. The disease was originally known as 2019 novel coronavirus, but the official name later became COVID-19 (WHO 2020). Then, the responsible virus was identified and named by Chinese scientists as 2019-nCoV, and it was listed in the International Classification of Diseases as severe acute respiratory syndrome coronavirus 2 or SARS-CoV-2 (WHO 2020).

Over the next 4 months, the virus spread across countries, regions, and communities, despite repeated warnings and advice from WHO about controlling and dealing with this infectious disease.

The accurate global number of those infected or dead from the disease is yet to be estimated or accurately counted. Many people have not been tested for COVID; autopsies have not been carried out on many of those who have died; and accurate data reporting systems are not in place in many countries. (see the WHO COVID-19 Dashboard: <https://covid19.who.int/> and John Hopkins University & Medicine Coronavirus Resource Centre: <https://coronavirus.jhu.edu/map.html>).

A serious problem during this pandemic has been poor planning, preparation, organization and leadership from some governments and health systems, including the failure to ensure adequate stockpiles of needed medical supplies, including personal protective equipment for nurses and others. All of these have doubtlessly contributed greatly to the moral questions surrounding this global public health emergency, and to consequent human rights issues.

Added to this mix, the pandemic has been politicized and economized by various leaders. And blame games, conspiracy

theories and fake news proliferate the media, causing further distress to those on the front lines and societies. If ever there was time for global solidarity and collaboration across borders, it is now.

Life as we know it is very different to the end of last year.

COVID-19 is having its most profound effects on older people and those with complex health problems, the poor, the disadvantaged and the disenfranchised. Early successes controlling the viral spread have occurred in a number of countries, due to testing of large numbers of people and tracing techniques, quarantine measures, locking down countries/regions early and restricting movement of populations.

At the time of writing, epicentres are now springing up among vulnerable indigenous groups such in the Amazon, and in countries with long histories of war and poverty, like Afghanistan. In such settings that there are few health care workers and poor health resources, so nurses are at their most vulnerable in providing care and helping to control infection rates.

Nurses' ongoing work in the pandemic is making nursing history. This was meant to be our year - our time to celebrate and share our achievements in the 2020 International Year of the Nurse and Midwife. Instead, many nurses, doctors and other health and emergency workers are receiving accolades for something very different. They are being called heroes, superheroes, or martyrs for their work during the pandemic – for something they never wanted or imagined – and for what many believe as just doing their job. The language of today is reminiscent of war time: *working on the frontline, facing battles, making sacrifices, being sacrificed, being resilient, doing our bit and joining forces.*

In the early stages of the pandemic, several videos circulated on social media, showing confronting images of hospitals in chaos, of dead bodies still on beds or floors, or of health staff, patients and relatives pleading for help, or

displays of angry assaults on staff by distressed families. This is reminiscent of caring during disasters. Increasing numbers of videos are now circulating showing nurses in tears or in anger, telling their stories.

But stories of inspiration and innovation, and successes in giving nursing care have emerged from the gloom of the pandemic. This should not be a surprise to anyone, given that nurses have been at the historical centre of the recognition, prevention/health promotion, education, and care and control of infectious diseases from before the days of Florence Nightingale.

The international Code of Ethics (ICN 2012, p.1) states that within nursing 'there is a respect for human rights including cultural rights, the right to life and choice, to dignity and to be treated with respect'. Many aspects of this pandemic have caused and are causing moral distress, and unexpected challenges to the ethical values of nurses and health professionals including complex human rights issues in many settings.

An emergency room nurse in New York where infections and deaths soared, powerfully described her experiences on public Facebook posts:

*Nurses working 60 hours a week with bruises on the bridges of their noses from respirator masks, doctors shedding tears as they inform the staff about the difficult decisions that will be made in the coming weeks about who to resuscitate because we don't have enough ventilators, environmental services teams scrubbing and scrubbing isolation rooms, all of us fielding phone calls from terrified family members who aren't allowed in the hospital.*

*... coming around the corner to find that one of my DNR/DNI\* patients had passed. Alone. While I and everyone else was too busy to be by her side. Living with the guilt that I couldn't honor her and her family by being beside her. I did not "sign up for this". It's a catastrophe. (Farmer 2020)*

(\*DNR: do not resuscitate; DNI: do not intubate)

Under such circumstances, nurses have to balance their professional duties and their competence with urgent ethical choices and decisions to be made in practice. A complex matter indeed when pressure of work is high, and team meetings for ethical decision-making are time-limited or non-existent.

Shortages of protective personal equipment (PPE) or test kits around the world have left nurses and other healthcare workers scared to go to work, to live with the knowledge that they might be the next victim in the statistics – or alternatively to feel shame and guilt at being a possible vector of the virus. In some cases, nurses whistle-blowing about the lack of PPE have been silenced or suspended from duty for taking a stand against the shortages. In one case, a nurse who was a whistle-blower about low PPE supplies, became infected and died one week before

retirement (see Rahman 2020). This whistle-blowing is in a just cause. The appalling news announced by Howard Catton, CEO of the ICN in early May revealed that an estimated 90 000 healthcare workers have been infected, and >260 nurses have died. The stark reality is that this pandemic may just be in its early stages (ICN 2020) and at the time of going to press many more nurses have become infected or died.

Unbelievably, in the midst of the pandemic, there are nurses out of work. For example, in Australia and the USA, private hospital nurses were stood down or put on leave as elective surgery lists were suspended. One Australian nurse explained her sense of helplessness and frustration to the first author:

*How can this be? I want to work. I can't help. I have never been out of work as a nurse, and I am so damn frustrated. They're short-staffed in public hospitals, in A and E. The public hospitals are not employing private hospital nurses, although they might if the number of COVID cases go up. And what happens in wintertime? Just crazy stuff going on!*

Xiang et al. (2020) argue for health workers to receive timely mental health assessment and treatment, since this pandemic has parallels to the 2003 outbreak of severe acute respiratory syndrome (SARS) where workers suffered from post-traumatic stress disorder (PTSD). The assumption here is that the COVID-19 crisis will inflict psychological trauma on nurses, doctors and other frontline health and emergency workers, although to our knowledge no studies have been published on this yet. A physician reporting from the intensive care unit of a New York hospital graphically illustrated his fragile state:

*My mind has taken photographs of the horror wrought by Covid-19 and they replay at random. I wake up from haunting dreams of being smothered by my N95 mask and face shield. I get through the day by holding reality at a distance. When I allow it to penetrate my mind on my walk home from work, I often cry. I am moving in slow motion through a trauma that has no end or escape in sight (Farrell 2020).*

### Into the future

There are significant opportunities to learn from this pandemic, to find better ways of doing things in practice, and contributing to policy-making through evidence-based research and empowerment strategies. We also 'need to improve understanding of the ethically justified expectations regarding what the public, employers, and co-workers can reasonably expect from nurses (their role and responsibilities) during public health emergencies' (Johnstone & Turale 2014, p.69).

The ethical problems being experienced by nurses and other health workers in the current pandemic are complex and require multi-disciplinary thinking and policies and strategies

to guide future practice and education. Relevant ethical frameworks need to be revised or developed and adopted widely in nursing practice, with support and input from national nursing organizations, nurse educators, and nurse leaders. We also hope that nurses, governments and health systems learn more about health care worker experiences and data arising from 21st century outbreaks of viral diseases: severe acute respiratory syndrome (SARS), the H1N1 influenza pandemic, the ongoing Middle East respiratory syndrome coronavirus (MERS-CoV) and Ebola virus disease (EVD).

In conclusion, nurses will continue to need strong moral courage and resilience to work during this COVID-19 pandemic, in hospitals, clinics, care homes and communities around the world, and across borders and cultures. There is no doubt that nurses are continuing to rise to the challenges of caring in this pandemic, but questions surround their ethics education and preparedness to be able to deal with public health emergencies on this scale. Nurses need to argue for and be involved in policies to receive solid ethics education to assist in their work, as well as in risk management during emergencies and disasters. They also need strong leadership, clear direction and continued support from each other, their employers, the public and their nursing organizations to continue to protect communities, save lives and prevent suffering in this pandemic and for new and emerging diseases.

In the months and years ahead, we hope that there will be research studies analysing these ethical issues and challenges, and much discussion in the profession and with other disciplines to be better prepared for public health emergencies.

All of us have a duty to protect and sustain nurses' well-being and competency, so that they in turn can undertake their roles and responsibilities in caring for the world's populations.

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