Ethical Viewpoint Paper

'We are all in this together': Nurses and ethical issues during the COVID-19 pandemic

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Introduction

Nurses are at the forefront of health care systems and services world-wide, keeping the health, wellbeing, and safety of patients and families a priority. However, coronavirus disease-19 (COVID-19) has brought pressing issues with unclear guidelines, misinformation, and scarce resources. Nurses are facing dehumanizing situations, stigma and judgment, and many fear for their own lives and the lives of their families.[1] Feeling like the 'last thread of compassion' for patients, nurses have tried to exercise an ethic of commitment and cooperation with other valued members of interdisciplinary health care teams. However, nurses' voices have been barely audible in the rush of pandemic best practices and practically absent in emerging policy work. In an act of solidarity, 14 nurses from 10 countries (see Table 1) recently dialogued about ethical 'brass tacks' over a span of two webinars. The first webinar began 90 minutes after Melbourne, the COVID-19 epicentre of Australia, went into its first night of curfew with a stricter lockdown protocol in place. Summarized here are the common ethical issues that were discussed in the webinars with suggestions for potential next steps forward.

Table 1- Countries represented and their COVID statistics

Country (population)	Confirmed Cases*	Deaths*	Recovered Cases*
Australia (approx. 25 million)	26,692	816	23,573
Canada (approx. 38 million)	137,249	9,172	120,724
Hong Kong (approx. 7.5 million)	4,976	101	4,635
India (approx. 1.4 billion)	4,926,914	80,808	3,856,246
Israel (approx. 9 million)	156,596	1,119	115,122
Kenya (approx. 53 million)	36,157	622	23,067
Sultanate of Oman (approx. 5 million)	89,746	780	83,771
United Arab Emirates (approx. 10 million)	80,266	399	69,981
United States of America (approx. 330 million)	6,624,395	197,209	3,578,670
Wales (approx. 3 million; United Kingdom [UK], approx. 67 million)	371,125 (for UK)	41,637 (for UK)	n/a
Global (approx. 7.8 billion)	29,114,477	925,596	19,673,071

*as of September 14, 2020, from https://www.bing.com/search?q=covid+stats&cvid=c1d79aa9f6c64f42a6339d5557e6008e&pglt=43&FORM=ANNTA1&PC=HCTS

With over four hours of discussion about key ethical issues during the COVID-19 pandemic, a dedicated group of committed global nurse leaders identified four general areas of serious concern. One panelist shared a four E's approach with the group: Equip; Engage; Empower; and, Expand (see Figure 1). Upon collating these discussions, panelists' experiences have been combined with this approach and are presented here using that creative context.

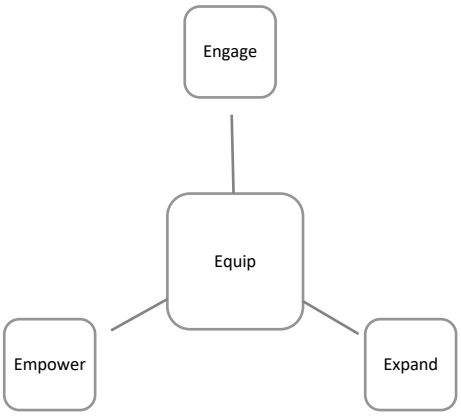

Figure 1- 4E's Approach

Equip- decision making and resources

Nurses have duties to their profession and to their patients, and also have duties to self-protect. Further, health care organizations have a duty to EQUIP nurses and other health care workers to do their work safely. Nurses have never been strangers to the risks of infectious diseases however COVID-19 has presented high risks to individual nurses, their colleagues, and their loved ones. Struggles to accept these new risks while adequately meeting personal and professional fiduciary duties were noted as ongoing sources of distress among nurses globally.

It is well documented that nurses have been inconsistently included and conspicuously absent in critical (crisis/emergency) decision making and planning during the pandemic [2]. Restrictive family visitation policies at most hospitals have created highly emotional roles for nurses as the

sole support for patients left alone as a result of pandemic requirements. With concerns about respect for patients' autonomy and informed decision making, nurses are faced with the need to be advocates for goals of care and advanced care planning conversations. Witnessing patients dying alone and knowing that patients are being buried quickly without family presence brings additional issues of grief and bereavement for many nurses and their colleagues.

Even after the outbreak of SARS (2003), the world was caught unaware of the potential of COVID-19. Recent experiences of limited essential resources, namely personal protective equipment (PPE), have brought the ethical principle of justice into reality for nurses. Nurses are left wondering about how scarce resources might be fairly and equitably allocated across organizations, communities, and nations. Also, nurses have reported unjust procedures and processes for decision making regarding which patients should receive care (e.g., upper class or white patients receiving priority status; uninsured or under insured patients being denied care), the type of care patients receive (e.g., futile or non-beneficial care, palliative/end-of-life care, intensive care unit admissions, access to ventilators, etc.), and the use of untested medical therapies.

Engage- beneficence versus fear

Distress about the lack of resources and rapidly changing decisions with little nursing input, has fueled fears and continues to contribute to the depletion of health and wellbeing among nurses on the frontlines [3]. Health care organizations have a duty to ENGAGE with nurses and other health care professionals to establish common goals, build trust, and address emerging and ongoing fears and concerns. While many countries called nurses out of retirement to assist, some nurses chose to leave nursing all together especially if they were not able to decline circumstances that they perceived to be unsafe. For those who stayed, their duty to care extended into long shifts and overtime contributions. Thus, nurses continue to face the ethical challenges between the benefits of caring versus fears of contamination.

Nurses worried about becoming ill, not being paid while off sick, the potential for losing their job, and of dying of COVID-19 [1]. These are legitimate concerns that are supported by recent research [4]. Some health care organizations reassigned staff away from high risk areas, offered job surety, provided insurance, and/or put hazard pay in place. Many organizations set up surveillance programs [5] to monitor both health care workers and patients, recognizing that asymptomatic carriers may inadvertently add to the burden of disease. Programs that supported free COVID-19 testing of all health care workers at any time served to ease worried minds.

Nurses heard patients' stories firsthand; about being very afraid to come to the hospital to seek care and risk exposure to the virus. In some countries, nurses and other health care workers felt stigmatized by their community members and were perceived to be 'COVID-19 transmitters'. Many nurses wanted to return to their home countries during the pandemic to help their community, but they experienced shunning of themselves and their families.

Real time statistics of health care workers lost to the virus do not accurately reflect the number of nurses who have died. The International Council of Nurses estimates that by June 2020, over 600 nurses across the world have been lost to infection from virus [6]. These experiences of grief and loss are being addressed in some organizations through existing or newly instituted supports (e.g., use of pastoral care and psychologists, hotlines, webinars, call centres with counselling services, ethics rounds, extra paid vacation time, wellness rooms, online church services, etc.).

Empower- nurses as heroes

The COVID-19 pandemic has created a space of moral imperative. Health care organizations need to seek to EMPOWER nurses and other health care professionals to perform their full scope of practice. During the pandemic, nurses have been described as reluctant heroes and COVID-19 warriors. Media has shown the public images of the scars of PPE worn for many hours beyond how it was ever intended to be used. The war is being fought on many fronts. Nurses have been isolated from their families and have been left to their own devices to adapt to daily protocol changes. Their ability to be flexible and responsive has often been tapped to its limits.

The saying 'knowledge is power' is true. Power comes from having good and reliable information communicated in a timely manner and then being able to carry out practices that support desired

outcomes. This pandemic has been rife with misinformation, changing information, and, at times, no information. Nurses were told not to routinely wear masks, to use one mask per shift, to bring their own mask from home, to reuse PPE as much as possible, and then to always wear a mask. The rules for acceptable and safe practice appear as a moving target during the pandemic.
In many countries, outpourings of gratitude and acknowledgment for our heroes, health care providers and essential services workers, were a great morale boost to those on the front lines. Donated meals and free hotel accommodations provided much needed sustenance and support. Across the world, messages of hope and solidarity were shared in windows of people's homes, on public billboards, via online cards and messages, and through cheer campaigns (e.g., community handclapping, pot banging, bell ringing, etc.).

Expand- nurses and resilience
Last but not least is the topic of nurses' responses to the trauma of the COVID-19 pandemic and the need for holistic approaches to support physical, mental, emotional, and spiritual health and wellbeing [7]. Health care organizations need to support and build capacity to EXPAND the resilience of nurses and other health care professionals. During this pandemic, well studied concepts such as compassion fatigue, burnout, moral distress, and moral injury have found new relevance in light of nurses' recent experiences with moral exhaustion in places of moral hazard. Strategies that focus on health promotion, prevention, and early intervention need to be prioritized in the months and years to come. As online programs have been put in place to upskill nurses into critical care positions, upskilling in self-care and holistic health promotion strategies are essential for nurses in all areas of nursing practice to support and enhance resilience and wellbeing.

Potential next steps forward
Global nurse leaders have expressed a need to get 'back to basics'; for nurses, organizations, and health care systems. The time has come to support a shared decision-making model that includes the voices of nurses at many levels and across health, social, and education systems. Positive changes may include the following:

- Organizational information that flows to and from nurses and is transparently communicated in a timely manner.
- Nurses have a voice and a place 'at the table' in decision making and policy development at every level of health care organizations.
- Nurses routinely advocate on political levels to address ongoing and emerging issues in health and illness care.
- Nursing has a dedicated space in the structure of health care systems with representation across health care sectors.

Further, new and expanded roles for nurses using tele-media, tele-health, and tele-medicine have occurred as a result of the pandemic. Technology is also being used more fully to deliver education and continuing professional development. Once considered essential, didactic nursing training (e.g., traditional classroom lectures) and hands-on clinical experiences have been largely suspended and replaced with online learning and simulation activities for health care professions students including student nurses [8].
However, new roles and responsibilities require ongoing education and training opportunities for nurses in clinical practice and in academia. Nursing curricula will need to be evaluated for the ability to prepare graduates with necessary skills in pandemic management, including psychosocial aspects of patient care and palliative/end-of-life care. Training needs to include, and also extend beyond, disaster nursing, infection control, and managing crisis. There will likely be attention to the development of evidence-based simulation and standardized training tools in these areas.
Further, nursing students who are currently learning while living in a pandemic environment will be evaluated on the additional skills (or lack of) that they must bring to clinical practice areas upon graduation. Dubbed by some as "coronials" [9], the next generation of nurses (those currently in training) will face nursing practice realities that nurses before them did not experience. Perhaps new graduate nurses will present a call to action to health care organizations to fulfill their duties and more fully support the 4E's for nurses and other health care professionals.

Conclusions

Responsive (versus reactive) planning and the implementation of evidence-informed strategies to address COVID-19 are among the global priorities in the current and foreseeable future. To meet this challenge, the voices of nurses across the world need to be heard. Nurses are at the forefront of health care delivery and they must have a voice in policy and decision making at all levels. Nurses need to be recognized for having advanced knowledge in their profession and for their unique scope of practice; an invaluable vantage point of sage wisdom. As the largest global health care workforce [2,10], nurses are important stakeholders who can identify and problem-solve ethical issues in practice collaboratively with colleagues, patients, families, organizations, communities, and health care systems. With diverse needs and dynamic issues emerging, nurses require ongoing opportunities to dialogue with one another, collaborate with interdisciplinary team members and organizations, and advise the public on how to work toward a 'new normal' within and beyond the COVID-19 pandemic. The entire world is depending on nurses. In the spirit of solidarity we recognize that "we are all in this together!"

REFERENCES

1. Adams JG, Walls RM. Supporting the health care workforce during the COVID-19 global epidemic. JAMA 2020;323(15):1439-40.
2. Morley G, Grady C, Mccarthy J, Ulrich CM. Covid-19: Ethical challenges for nurses. Hastings Center Report 2020;35-39. https://doi.org/10.1002/hast.1110
3. Michalsen A, Vergano M, Quintel M, Sadovnikoff N, Truog RD. Epilogue: Critical care during a pandemic–A shift from deontology to utilitarianism? In Compelling Ethical Challenges in Critical Care and Emergency Medicine 2020 (pp. 157-166). Springer, Cham.
4. Nguyen LH, Drew DA, Graham MS, Joshi AD, Guo CG, Ma W, Mehta RS, Warner ET, Sikavi DR, Lo CH, Kwon S. Risk of COVID-19 among front-line health-care workers and the general community: a prospective cohort study. The Lancet Pub Health 2020;5(9):E475-83.
5. Vahidy F, Sostman HD, Bernard D, Boom ML, Drews AL, Christensen PA, Finkelstein J, Kash BA, Phillips RA, Schwartz RL. Prevalence of SARS-CoV-2 infection among asymptomatic healthcare workers in greater Houston: a cross-sectional analysis of surveillance data from a large healthcare system. JAMA Network Open 2020;3(7):e2016451.
6. CBC News. More than 600 nurses have died around the world from COVID-19, association says. 3 June 2020. https://www.cbc.ca/news/health/icn-nurses-covid-deaths-1.5596300
7. Huang L, Lin G, Tang L, Yu L, Zhou Z. Special attention to nurses' protection during the COVID-19 epidemic. Critical Care 2020;24:120-3.
8. Shakya DR, Mishra DR, Gyawali R, Rimal SP, Lama S, Yadav AK, Nepal S, Pokharel B, Sapkota N. COVID-19 pandemic and BPKIHS: our situation, endeavors and future direction. Journal of BP Koirala Institute of Health Sciences 2020;3(1):39-49.
9. Monforte-Royo C, Fuster P. Coronials: Nurses who graduated during the COVID-19 pandemic. Will they be better nurses? Nurse Education Today 2020;94:104536.
10. World Health Organization (WHO). State of the world's nursing 2020: Investing in education, jobs and leadership. Geneva: WHO 2020. https://www.who.int/publications-detail/nursing-report-2020

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