Does 'duty of care' have borders?

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Keywords: duty of care, COVID-19, legal-professional-moral obligations

Prof Nurs Today 2022;26(2):6-8

The COVID-19 pandemic has made us 'wonder' about so many things in life. Countries' borders were closed to limit the spread of COVID-19 to and from neighbouring countries; our personal borders in terms of space were forcibly retracted with only our usual housemates/family that lived with us, if we were not living on our own. That is now for those of us who were not frontline workers – they were thrown in at the deep end, fighting a foe that nobody understood at the beginning, and being overwhelmed with patients that they could not distance themselves from.

And yet, within months, we managed to reach out virtually over the closed personal/provincial/country borders to other parts of the country and the world, to colleagues, students, school children, even doing virtual shopping. Life carried on in a different dimension that became our new normal – we learned that we can successfully work, host meetings, and teach on virtual platforms without charging around like crazies to get to our destinations to do so. We attended very successful virtual conferences locally and internationally which offered us the extended benefit of access to conference materials for a while after conference ended. So, many positives originated as a result of the pandemic that would not have occurred had we not been forced to shrink our boundaries.

Duty of care

What made me 'wonder' during the various stages of lockdown regulations, is whether our duty of care has boundaries? Duty of care is the responsibility and moral obligation of every one of us in society to ensure the safety of others.[1] As healthcare workers we have a legal duty, which is our responsibility to care for patients classified as a vulnerable population, to protect them from harm which could result from our omissions or actions. Based on their professional education, healthcare practitioners are no ordinary citizens as they possess specialised skills which place their expected standard of care at a higher level. They therefore must be 'reasonably able to foresee' where potential problems can arise, and act accordingly. There is a professional standard of care that governs our performance as nurses requiring us to be competent nurses or midwives in whichever situation we practise. This refers to our professional duty of care which includes setting standards for education and practice, and this is managed by the SA Nursing Council.[2,3]

Most healthcare practitioners chose their professions because they 'wanted to help people' or 'make a difference'. But as we enter clinical practice, especially in the early days, we realise we do not necessarily know how to do so, and even if we do our best, accidents can happen, and sometimes we cannot save our patients.

The COVID-19 pandemic made us relive this feeling all over again – in spite of our experience and expertise, we found ourselves in the same situation. But our collective experience, expertise and knowledge assisted us as a nation to find ways to deal with the challenges brought about by the pandemic.

Obligations of the duty of care

The pandemic brought about many demands impacting on the duty of care. In addition to the unknown phenomenon of a virus that spread like wildfire, there were increased demands for patient care with rising numbers of ill patients with COVID-19; resource constraints and poor provision of personal protective equipment (PPE) to protect workers; inadequate skills mix with not enough nurses competent in intensive care and the care of ventilated patients; nurses taking on tasks that they were not competent to perform, or even outside their scope of practice; redeployment to unfamiliar areas. These were compounded by nurses falling ill and some dying which not only further compromised staffing ratios but was immensely traumatic for colleagues unable to save the life of a colleague.

Following earlier pandemics, the World Health Organization (WHO)[4] outlined three categories of obligations of healthcare

providers during a pandemic, namely legal, professional and moral. The *legal obligations* of nurses working in the health services are contained in a service contract indicating that the nurses are employed to use their skills and expertise to deliver services on behalf of the employer. This arrangement implies a relationship between the healthcare practitioner and the patient. However, this does not mean that the nurses have to work in unsafe conditions and this obligation of the employer to provide a safe working environment is clearly stated in the Occupational Health and Safety Act, 1993 (as amended)[5] and its regulations. These determinations, and the Bill of Rights in the Constitution of the RSA,[6] is clear about the right to a safe working environment. This right was often not adhered to, mainly with regard to poor provision of PPE and shortage of staff. While healthcare workers have the right to withdraw their labour in unsafe conditions, a limited incidence of this was seen during the pandemic. The second part of our legal obligation is to work within the legal framework of the country and the nursing profession; however, this also became difficult as many of us had to participate in activities that we were not equipped for.

The *professional obligations* require healthcare practitioners to provide care to all persons admitted to the health service, which often means taking risks, as was seen during the pandemic, especially when practitioners were not sure at all what they were confronted with. As professionals we have to provide the best care possible under the circumstances, but it also requires the community to do their bit, as seen with the request to not purchase N95 masks so that they would be available for healthcare workers. It also refers to the call by healthcare workers for the population to get vaccinated – a process that has been slow in taking off in our country.

The *moral obligations* include beneficence, nonmaleficence and all the other ethical principles that we know so well which inform nurses' obligation to provide safe care. This is where the difficulty arises – when moral obligations and the right of nurses to protect their own health in a situation of high risk come into play. Balancing these obligations and rights requires the assessment of each situation and minimising the restrictions that the one imposes on the other. But that is a debate for another time. In an interesting commentary by American physicians about the right to decline to treat patients who refuse to be vaccinated for the coronavirus there remain differing opinions.

Impact on nursing management

So, to get back to the original question – does duty of care have boundaries? Speaking to nursing managers in one-on-one conversations, it is clear that managers tend to suffer the same consequences as the rest of the nursing staff, in addition to the obligation to ensure that services continue to be offered. Globally it is seen that boundaries have indeed been placed on the duty of care.

In the commentary referred to earlier, a doctor informed his patients that he will not see them any longer if they have not been vaccinated against COVID-19 as he cannot deal with seeing them fall ill and die.[7] This was not regarded as a good reason, his colleagues said. In Massachusetts, a hospital has developed a Crisis Standards of Care Model to prioritise limited resources based on major and severe chronic medical conditions with 46.55% and 50% mortality at one and five years.[8] In Mexico, the way was cleared in 2021 for hospitals to ration care if necessary due to a shortage of nurses.[9] In South Africa, it will not be that easy to institute boundaries on the duty to care[10] – the Constitution states that we all have the right of access to healthcare services. Section 36 of the Bill of Rights[6] on the other hand, refers to the limitation of rights *provided* that the limitations are reasonable and justifiable – this would be, for example, where the health and safety of the larger community become a priority. Here we have seen employers and universities which have made a decision obliging employees and students to be vaccinated, determining additional measures for those who are not vaccinated to provide proof that they do not have COVID-19. We have not seen hospitals yet refusing to treat patients diagnosed with COVID-19, but based on comments by healthcare practitioners, it is clear that the patients admitted in 2022 seem to be mainly those who are not vaccinated and who also tend to be sicker than those who are.

None of this addresses the moral plight of the nurse manager. This person reports to the employer on the one hand and must also oversee the staff and the nursing care provided in the institution. There are even more challenges for managers: should certain essential but not-quite-urgent services continue; how to prioritise triage of patients; how to explain to families how an oxygen outlet is allocated in the units; how to deal with the dilemma that staff have when asking if they should come to work with mild symptoms and risk infecting others, or stay at home knowing the team is taking strain?[11] What should be done in the event that there is only one bed available, but not enough staff to care for another ventilated patient? Does the nursing service manager allow the patient to be admitted knowing that the nursing staff is inadequate? Or if admission is declined – what then about the patient if the next facility is far away or full?

Managers observe all this while trying to do damage control under difficult circumstances. The moral anguish experienced by healthcare workers, including nursing management, during the pandemic, and its unrelenting challenges have been well described in many journals and discussions. The basic moral uncertainty of what the right thing is to do, migrated to the current moral dilemmas experienced when ethical values clash – for example, in situations where there are too few ventilators with moral conflict arising when agreement cannot be reached on what to do next – ultimately leading to moral suffering on a daily basis when patients and also colleagues cannot be saved, and additionally with concerns arising for the safety of our families and loved ones. A small number of practitioners have spoken up in moral outrage about the violation of the rights of patients to quality and safe care, and at the same

time the right of healthcare workers to be protected, for example, amongst other things, by being provided with adequate PPE.[12] One wonders how much of this has fallen on deaf ears!

What do we do?

This discussion clearly raises more questions than answers. Nurses, in particular, are considered a vulnerable group, who can fall prey to acute stress disorder and subsequent psychological distress.[13] In many instances, staff has said that the "thank you" from patients and their loved ones, and particularly from the employer and management, have made a difference to the morale of staff. This includes the groups of people singing outside hospitals when nursing shifts change and handing out gift packs to nurses as they come off duty. The need for staff debriefing has become imperative, and in many institutions, nursing management has managed to incorporate this to a certain extent – this should be easily accessible to staff.

However, there is a great need for practitioners to also consider a measure of self-care. Coping self-efficacy has been found to ameliorate the effect of psychological distress on the traumatic situations which nurses experience.[13] A nurse, Sarah Jividen,[14] has outlined 10 tips for nurses to promote their mental health, as summarised in the accompanying block.

Tips for mental health

1. Take a break from COVID-19 – avoid reading news and social media. Engage in some mindless activity.
2. Communicate with family and friends using virtual communication tools.
3. Get outdoors and take a walk.
4. Watch funny movies and maintain a sense of humour – laughing can be good to release stress and anxiety.
5. Do yoga and meditation with free online videos and music. The arrival of *Jerusalema* and the dancing videos has brought much relief to nurses.
6. Listen to music, whatever you prefer – and dance your heart out!
7. Eat healthily – this provides energy and boosts the immune system.
8. Be grateful for the little things in life – every day – hearing a bird sing, the sun shining outside the ICU.
9. Ask for help and speak to someone who understands your struggle – do not try to be a superhero.
10. Remind yourself and others that we will get through this.

Conclusion

South Africa has not imposed boundaries on the duty of care and it seems unlikely to happen any time soon. This remains a time filled with ethical dilemmas that should be dealt with as they arise. The need for moral support and access to debriefing opportunities are essential components for staff and management alike. And remember to say thank you as often as you can.

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