

NURSES' ETHICAL CONSIDERATIONS IN A PANDEMIC OR OTHER EMERGENCY

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CNA, 2007, p. 1

“The nursing profession plays an integral role in all aspects of emergencies, including mitigation, preparedness, response and recovery” (CNA, 2007, p. 1). The following examples highlight some of the different challenges that nurses may experience in relation to a pandemic or other emergency.

- Shelley works in the emergency department in a large urban hospital. She is a single mother with two small children. During an influenza pandemic, she is torn by apparent conflicts among the financial need to work, her responsibilities to her employer and patients, and her worries that she will become infected and in turn infect her children.
- George is the nursing union representative on the joint worker-management health and safety committee in his community hospital. The committee is reviewing the hospital's draft pandemic plan. He wants to ensure that all nurses are given the best protection as well as sufficient information to protect their health and safety in the case of a pandemic.
- Adele works in a nursing home, and on the basis of her personal beliefs she has decided not to have the annual influenza vaccine offered by her employer. She doesn't know what she would do during a pandemic if she is required to take antiviral medication or be vaccinated.
- Lashmi works in a public health agency. She has been asked to set up a clinic in the community that will be used to triage sick people in the event of a large-scale emergency.
- Roseanna works in the out-patient clinic of her hospital. She fears that during a pandemic she will be redeployed to the medical floor, an area where she does not feel competent to practise.
- Antonio has just completed his fourth night shift in a row. He is asked by his nurse manager to stay and work an extra shift: the floor is short-staffed because many of his colleagues are sick.

INTRODUCTION

Since the SARS outbreak in 2003, and in anticipation of a pandemic influenza, nurses and other health-care professionals have been discussing and debating their responsibilities to their patients¹ during a major health emergency. A pandemic or disaster is an extraordinary occurrence that may take nurses beyond their normal nursing practice, and it raises specific issues about what nurses are obligated to do in providing care for patients. Nurses' ethical responsibilities as they go about their daily work can be challenging enough; determining ethical responsibility in an extraordinary situation such as a pandemic or other health emergency can be even more difficult. In addition, nurses must also grapple with other obligations, such as their responsibilities to their families and to themselves. In preparation for these exceptional situations, nurses, other health-care providers, employers, government officials and members of the public need to engage in collective problem-solving to ensure the

highest quality of care possible. Nurses, and indeed all health-care workers, perform an important function during pandemics and other emergencies in minimizing harm and providing care.

In this *Ethics in Practice* paper, the different roles, situations and ethical issues nurses can face during a pandemic or other emergency will be explored through various examples. The concept of *duty to provide care* will be examined, as well as the different obligations nurses have, as members of a self-regulating profession, to their patients, their employers, their families and themselves. The reciprocal duties of employers and society during a pandemic or other emergency will also be explored.

Although this paper does not attempt to provide all of the answers, it can assist nurses in considering their role in a pandemic or other emergency. It is one of a number of resources that the Canadian Nurses Association (CNA) has undertaken to support nurses in their ethical reflection.² It is also intended to encourage nurses to engage in discussion with colleagues, employers and families, with the goal of collaborating in a transparent and supportive manner on ways to meet collective responsibilities in an emergency.

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ETHICS AND THE DUTY TO PROVIDE CARE

The concept of *duty to provide care* was embedded in many health professional codes in the early part of the 20th century, but by the 1950s it had disappeared (Ruderman et al., 2006; Upshur et al., 2005). Several

1 Different terms for this responsibility are often used interchangeably in the literature (e.g., *duty of care*, *duty to care* and *duty to provide care*) (Sokol, 2006). Nevertheless, there are distinctions between these terms, and for accuracy the term *duty to provide care* is used in this paper as well as in the *Code of Ethics for Registered Nurses* (CNA, 2008).

2 Visit CNA's website at www.cna-aiic.ca to view other ethics resources.

legal and ethical experts attribute this change to the development of antibiotics and the belief that infectious diseases could be conquered (Wynia & Gostin, 2004; Ruderman et al., 2006, Upshur et al., 2005). Researchers at the Joint Centre for Bioethics at the University of Toronto have stated that one of the main lessons learned from the SARS outbreak in 2003 was that health-care workers lacked clarity about their duty to provide care during a communicable disease outbreak (Upshur et al., 2005). They therefore recommended that “professional colleges and associations should provide clear guidance in advance of a major communicable disease outbreak, such as pandemic flu. Existing mechanisms should be identified, or means developed, to inform college members as to the expectations and obligations regarding duty to provide care during a communicable disease outbreak” (Upshur et al., 2005, p. 21).

The CNA *Code of Ethics for Registered Nurses* (2008, p. 9) addresses a nurse’s duty to provide care in pandemic or other emergency: “During a natural or human-made disaster, including a communicable disease outbreak, nurses have a duty to provide care using appropriate safety precautions.” The code also explains that “a duty to provide care refers to a nurse’s professional obligation to provide persons receiving care with safe, competent, compassionate and ethical care. However, there may be some circumstances in which it is acceptable for a nurse to withdraw from providing care or to refuse to provide care” (p. 46).

Duty to provide care can be a complex and controversial concept because it contains conflicting values, interests and contexts. Discussions about duty usually take place in relation to infectious diseases such as HIV/AIDS and SARS, the prospect of a pandemic influenza, or emergency situations resulting from floods, hurricanes, ice storms and disasters. The fundamental question that emerges from these discussions is: “When, if ever, do nurses have the right to refuse to care for patients?” Often, when this question is addressed, the approach is to polarize what has been called the “self-interest” of health professionals (i.e., concern for oneself and for one’s family) from the interest of patients in their care

(Reid, 2005). Consequently, one viewpoint is that nurses have the right to protect their own health and the health of their family (Ovadia et al., 2005; Singer et al., 2003; Torda, 2005). The opposite perspective is that care for patients is an integral part of nurses’ professional values, whatever the personal cost to the nurse. Many nurses may find themselves somewhere in between these opposing viewpoints, or terribly conflicted, depending on their work environment, the nature of the health emergency, their own health and their family responsibilities.

It is helpful to look at duty to provide care from the perspectives of the individual nurse, the employer, the nursing regulatory body and the state, since each entity will view it differently. The following fundamental questions may also help nurses in thinking about duty to provide care:

- Is there a limit on the obligation of nurses to provide care?
- Assuming there is a limit, what is the limit on the obligation to provide care?
- Who defines this limit? Is it the individual nurse, the employer, the regulatory body or the state?
- If the limit is defined by one of the above parties, what will be the perspectives and reactions of – and consequences for – the other parties?

THE INDIVIDUAL NURSE PERSPECTIVE

Ethical reflection and ethical decision-making is embedded in each nurse’s professional identity. Nurses must continually weigh obligations to self and family, patients and colleagues. In a disaster these calculations become more pertinent and complex.

Two concepts assist in clarifying duty to provide care: *beneficence* and *risk*. Beneficence is one of the foundational ethical principles that all nursing ethical codes acknowledge, either explicitly or implicitly. Beneficence “requires nurses to carry out their duties in ways that bring good to the client and minimize

harm and the potential of harm” (Storch, 2000, p. 35). Nurses would agree that they and other regulated health professionals have greater obligations than the average person to care for the sick and to alleviate suffering. In return, nurses and other health professionals are granted the special privilege and authority to regulate their professions within society.

If we agree with the statement that nurses accept some occupational risk by their choice of career, then what is the limit of the additional occupational risk to health and safety during a pandemic or other health emergency (Chaffee, 2006; Olsen, 2006)? Some may argue that this is a simple risk-benefit decision for a nurse: that is, one must look at the risks on one side and the benefits on the other. When the risk to the nurse providing care is low compared to the likely benefit to the patient, the nurse has a stronger duty to provide care than when the risk to the nurse is much higher than the possible benefit to the patient. An example of the latter situation would be where the patient will die with or without intervention but the nurse does not have adequate protective equipment and would therefore be exposed to a deadly pathogen. Sokol (2006, p. 1239) suggests that risk has to be assessed in relation to the usual level of risk and the usual area of work (or specialty) of the health-care worker. Nurses who work in high-risk areas (e.g., emergency) or have a high-risk specialization (e.g., infectious disease) would be considered to have accepted a higher level of risk and thus have a higher obligation to continue to provide care in a pandemic than those working in lower-risk settings.

Others might argue that if a nurse doesn't know the level of risk, the duty to provide care may be less. This lack of knowledge was certainly the case at the beginning of the SARS outbreak. The infectious agent, the case-fatality rate and the correct infection control procedures were unknown. However, if the level of risk is known and the best protective equipment and procedures are available, should the duty to provide care be higher? To many nurses, this kind of risk-benefit calculation is hypothetical or superficial and leaves out the context, the relationship the nurse has with the patient, and the

responsibility of the nurse to his or her family (Chaffee, 2006). It also begs the question of what responsibility do employers have to ensure that systems are in place to assist the nurse in making an informed decision.

RESPONSIBILITIES TO FAMILY

Nurses and other health-care workers have indicated that during a pandemic or other emergency they would feel pulled between obligations to their patients and obligations to their family (Balicer et al., 2006; Chaffee, 2006; Ehrenstein, Hanses & Salzberger, 2006; French et al., 2002; Qureshi et al., 2005). This conflict is certainly at the heart of the example of Shelley, the emergency department nurse who is a single parent with two small children. She feels divided between her obligations to her patients and her responsibilities to her children, which may increase during a pandemic if day-care centres and schools close. Nurses caring for elderly or chronically ill relatives may have a similar dilemma.

The Joint Centre for Bioethics (Thompson et al., 2006; Upshur et al., 2005), the Public Health Agency of Canada (PHAC, 2006) and many health-care organizations recognize in their pandemic plans the need to address the obligations of health-care workers to families, and consequently the need for employers to provide support.

The *Ontario Health Plan for an Influenza Pandemic* (Ministry of Health and Long-Term Care [MOHLTC], 2007, p.8A-23) has a one-page questionnaire that nurses can use to ask themselves about their readiness to participate in a pandemic in relation to their personal circumstances. Among the 11 questions are the following:

- Do I require family support because of dependent child or children, spouse or parent(s)?
- Do I have plans to care for family members who may become ill during a pandemic?
- Does my family have a personal home pandemic plan?

- Have I discussed my participation [in a pandemic] with family members?
- Does my employer offer any family support?

Reflecting on these questions may help nurses work out issues of concern with their family and employer before an emergency so that they are able to carry out their professional responsibilities when an emergency occurs.

OBLIGATIONS TO SELF

Apart from the obligations nurses have to their patients and families, what about their obligations to themselves and their ability to provide safe, compassionate, competent and ethical care? One of the examples in the introduction is that of Antonio, who is asked by his nurse manager to stay on and work another shift because illness has left the floor short-staffed. Antonio is tired, and he wonders whether he can safely perform on another shift. He is torn between his need to go home and rest after working long hours and his responsibilities to his patients, his colleagues and his organization. However, in considering his responsibility to his patients, Antonio must also carefully consider his fitness to practise and his ability to provide safe care.

The CNA *Code of Ethics* states that “nurses maintain their fitness to practise. If they are aware that they do not have the necessary physical, mental or emotional capacity to practise safely and competently, they withdraw from the provision of care after consulting with their employer or, if they are self-employed, arranging that someone else attend to their clients’ health-care needs. Nurses then take the necessary steps to regain their fitness to practise” (CNA, 2008, p. 18).

Provincial and territorial nursing regulatory bodies also have statements that address this situation. For example, the College of Registered Nurses of British Columbia (CRNBC) has published *Overtime and Fatigue: To Stay or Not to Stay* (2001), and *Duty to Provide Care* (2007), which discusses a nurse’s

obligation to provide care, withdrawal from providing care and refusal to provide care, as well as the issues of abandonment and negligence. The College of Nurses of Ontario also has a useful document, *Refusing Assignments and Discontinuing Nursing Services* (2005). Other resources addressing this situation may be available: nurses can check with the regulatory body in their jurisdiction.

However, a pandemic or other health emergency may be a sustained situation, beyond what most nurses have experienced. For example, it is anticipated that an influenza pandemic would come in waves of 6-8 weeks and could last up to 18 months to 2 years in total (Toronto Academic Health Sciences Network [TAHSN], 2006). Health human resources is a major consideration for all pandemic planners because there will be an overwhelming increase in the number of people requiring care at the same time that many health-care professionals will become ill. Therefore, this is not simply the case of an isolated double shift. Many pandemic plans discuss the need for health-care professionals to pace themselves during a pandemic and to do their utmost to keep themselves healthy. The experiences of nurses during the SARS outbreak and disasters such as Hurricane Katrina have renewed the emphasis on the duty of nurses to preserve their own health. During the SARS crisis, nurses and other health-care workers were lauded for going “above and beyond the call of duty” (Godkin & Markwell, 2003). However, an alternative viewpoint is that “one’s obligations to oneself are no less moral in character than one’s obligation to others” (Reid, 2005, p. 357). It is therefore inevitable that nurses’ individual rights and values might sometimes conflict with patients’ right to receive care: “Nurses most often experience ethical dilemmas in meeting their obligations to provide care when they are faced with an unreasonable burden, personal danger, or concerns about individual competence and conscientious objection...” (CRNBC, 2007, p. 1). While “a [patient’s] right to safe, effective and competent care is of paramount importance” (p. 1), there may be some instances where nurses “are not

obligated to place [themselves] in situations where care delivery would entail unreasonable danger to [their] personal safety” (p. 2).

Individual nurses must therefore think about the ethical dilemma of when to provide care, and collaborate with nursing organizations and employers to ensure a safe workplace well in anticipation of a crisis (CNA, 2008; CNRBC, 2007). A public health emergency will require that nurses, other health-care workers, employers and government officials support one another so that care can be provided and nurses do not experience burnout.

OBLIGATIONS OF EMPLOYERS

Under provincial and territorial occupational health and safety legislation, employers have a responsibility to provide a safe work environment. George, as the nursing union representative on the joint health and safety committee, is working to ensure that all health-care workers in his hospital will be given the protective equipment and prophylaxis (antiviral medication and vaccine, once it is available) needed during a pandemic, and that the hospital will commit the required resources and be transparent about decisions both before and during a pandemic. “It is incumbent upon the particular health care institution to provide adequate safeguards such as risk-reducing equipment, enforce protective procedures that minimize risks, educate staff concerning risks, and engage in research to identify actual and potential risks which impact nursing care” (ANA, 2006, p. 5).

The CNA *Code of Ethics* (2008, p. 47) highlights the reciprocal duty of employers to protect and support nurses:

...Nurses have a right to receive truthful and complete information so that they can fulfill their duty to provide care. They must also be supported in meeting their own health needs. Nurses’ employers have a reciprocal duty to protect and support them

as well as to provide necessary and sufficient protective equipment and supplies that will “maximally minimize risk” to nurses and other health-care providers (Human Resource Recommendations, SARS Human Resources Working Group, Ontario Hospital Association, as recorded in Godkin & Markwell, 2003).

Research and government studies reporting on the SARS crisis unequivocally acknowledged that “loss of trust, low morale, fear and misinformation” (Upshur et al., 2005, p. 4) was the overwhelming experience for health-care workers during the outbreak (MOHLTC, 2006; Singer et al., 2003, Thompson et al., 2006; Upshur et al., 2005). Consequently, it has been recommended that the ethical principles of transparency and reciprocity be more prominently embedded in pandemic planning at several levels (Upshur, 2006).

Transparency relates to the method and the context in which decisions are made (Gostin, Bayer & Fairchild, 2003; Kotalik, 2005; Upshur, 2002). Information about decisions and the reasons they are made should be provided to health-care workers in an open and truthful manner. The University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group developed an ethical framework to guide planning and decision-making for a pandemic (Thompson et al., 2006; Upshur et al., 2005) that includes five characteristics of an ethical decision-making process: accountability, inclusiveness, openness and transparency, reasonableness and responsiveness (Thompson et al., 2006, Table 1).

Having nurses such as George on planning committees is one way for employers to uphold these values. George’s participation as a union representative in anticipation of a disaster takes into consideration the code’s recommendation to nurses to “work together with nurses and others in positions of leadership to develop emergency response practice guidelines, using available resources and guidelines from governments, professional associations and regulatory bodies” (CNA, 2008, p. 48).

“The value of reciprocity requires healthcare organizations to support and protect healthcare workers, to help them cope with very stressful situations, to acknowledge their work in dangerous conditions, and to have workable plans for emergency situations” (Singer et al., 2003, p. 1343). The interpretation of this statement will vary among jurisdictions and health-care agencies but can include the following in the pre-emergency phase: communication of information about the type of threat, how it is transmitted and outbreak management strategies; preparedness planning and dissemination with ample input from all employees; and clarity regarding legal, ethical and professional obligations. During the emergency, reciprocity can include provision for the personal safety for employees and perhaps their family members (e.g., protective equipment and prophylaxis), frequent and transparent communication, strategies for reducing staff distress and provision of employee assistance. Employers have a responsibility to address employee concerns about fulfilling family responsibilities.

Shelter for family members, pet care and provision of basic needs such as food, water and rest have also been found to enhance nurses’ ability and willingness to provide care in a disaster (French, Sole & Byers, 2002). After the emergency, reciprocity includes mental health debriefing and the provision of disability insurance and death benefits (Chaffee, 2006; Godkin & Markwell, 2003; Kotalik, 2005; Singer et al., 2003; TAHSN, 2006).

RECIPROCITY BETWEEN HEALTH PROFESSIONALS AND SOCIETY

Reciprocity requires that society supports those who face a disproportionate burden in protecting the public good and takes steps to minimise their impact as far as possible. In an influenza epidemic, measures to protect the public good are likely to impose a disproportionate burden on health care workers, patients, and their families. (Thompson et al., 2006, Table 2)

The *Canadian Pandemic Influenza Plan for the Health Sector* (PHAC, 2006) states that health-care workers will be the first group to receive the pandemic influenza vaccine as soon as it is available. The principle of reciprocity between the public and health-care workers is implicit in this priority setting. That is, in exchange for priority in receiving prophylaxis, health-care workers are expected by the rest of society to provide care during a pandemic. Ruderman, Tracy, Bensimon, Bernstein et al. expand on three reasons from Clark (2005) why health-care professionals provide care during an outbreak: “(1) The ability of physicians and health care professionals to provide care is greater than that of the public, thus increasing the obligation to provide care; ... (2) By freely choosing a profession devoted to care of the ill, health care professionals have assumed risk; ... (3) The profession is legitimated by social contract and therefore its members should be available in times of emergency.... Society has granted and permits professions to be self-regulating on the understanding that [health-care professionals will respond in an infectious disease emergency]” (2006, p. 3).

Thus, the example of Adele, the nurse working in a long-term care facility who does not think she will take the antiviral medication or be vaccinated during a pandemic, is ethically challenging. During regular influenza season, health-care professionals working with elderly people are encouraged to take the annual influenza vaccine to protect their own health and that of their patients. This immunization is not mandatory in any province; however, during an influenza outbreak in a health-care facility, public health units have the mandate to withdraw from the workplace health-care workers who are not immunized. This is an example of the public health ethics notion of balancing the rights of the individual with the protection of the public’s health (CNA, 2006). At the moment, there is no clear legal decision or directives about the right of health-care workers to refuse antiviral medication or vaccination during an influenza pandemic. Pandemic planners, public health

agencies and health-care organizations all anticipate that health-care workers would take the prophylaxis offered, with the expectation that health-care workers will provide care.

A controversial issue is the possibility of emergency legislation compelling health-care workers to work during a crisis. The following is taken from Annex H: Resource Management Guidelines for Health Care Facilities during an Influenza Pandemic of the Public Health Agency's *Canadian Pandemic Influenza Plan for the Health Sector* (2006, p. 12-13):

3.2.2 Review Emergency Legislation Pertaining to Health Care Workers

Emergency Preparedness Legislation makes many provisions for the management of workers during a crisis. This includes the recruitment of professional and other paid staff as well as volunteers, managing human resources and protection of people who volunteer...

The following provisions of legislation are particularly applicable to human resource issues including:

- authority regarding licensing and scope of practice issues, and the ability of government to make unilateral changes during a crisis;
- safety and protection of workers, (one of the primary responsibilities);
- fair compensation;
- insurance, both site insurance, workers compensation and other forms of insurance;
- training;
- provision of clothing and equipment;
- protection of the jobs of workers who take leave to assist during the crisis.

Compelling Workers

Under Emergency Legislation, provinces/territories may have the authority to designate "Essential Services" and workers and have the ability to compel people's time or property with due compensation as a *last resort*.

This issue has been raised both because of the existing shortage of health care workers and concerns that health care workers and others may refuse to work during a pandemic due to changed job responsibilities, fear of infection, family responsibilities or other reasons. However, the [Resource Management] Subgroup notes the extreme difficulty of enacting or enforcing such legislation and would strongly encourage the jurisdictions to review all other methods of obtaining health care workers, in advance of a pandemic.

OBLIGATION TO ANTICIPATE AND PREPARE

The main lesson learned from the SARS outbreak and all other recent emergencies is the importance of planning ahead and being prepared. Certainly, pandemic planning and generic emergency preparedness is well underway in Canada. However, each nurse must ponder some of these issues for himself or herself: "Deciding whether to report to work in a disaster is not always easy. But being prepared, individually and through institutional policy, is the primary ethical demand disasters make of health care professionals" (Olsen, 2006, p. 57). To anticipate, deliberate and prepare is part of the "social contract" or duty of health professionals to provide care (ICN, 2006). The CNA *Code of Ethics* (2008) presents a number of helpful ethical models for reflection and decision-making in its appendices. Multiple accountabilities are shared among professional associations, unions, regulatory colleges, employers, governments and all key stakeholders. All parties need to work together in a transparent and collaborative manner to analyze the issues and make appropriate policy decisions for everyday situations and in preparation for pandemics and other emergencies.

GUIDANCE FROM THE CNA CODE OF ETHICS

A. In anticipation of the need for nursing care in a disaster or disease outbreak, nurses:

- work together with nurses and others in positions of leadership to develop emergency response practice guidelines, using available resources and guidelines from governments, professional associations and regulatory bodies;
- learn about and provide input into the guidelines the region, province or country has established regarding which persons are to receive priority in care (e.g., priority based upon greatest need, priority based upon probability of a good outcome, and so on);
- learn how support will be provided for those providing care and carrying the physical and moral burden of care;
- request and receive regular updates about appropriate safety measures nurses might take to protect and prevent themselves from becoming victim to a disaster or disease;
- assist in developing a fair way to settle conflicts or disputes regarding work exemptions or exemptions from the prophylaxis or vaccination of staff; and
- help develop ways that appeals or complaints can be handled.

B. When in the midst of a disaster or disease outbreak, nurses' ethical obligations are to:

- refer to regulations and guidelines provided by government, regulatory bodies, employers and professional associations;
- help make the fairest decisions possible about the allocation of resources;
- help set priorities in as transparent a manner as possible;
- provide safe, compassionate, competent and ethical care (in disasters, as much as circumstances permit);
- help determine if, when and how nurses may have to decline or withdraw from care; and
- advocate for the least restrictive measures possible when a person's individual rights must be restricted.

– CNA, 2008, pp. 48-49

CONCLUSION

Nurses value the ability to provide safe, compassionate, competent and ethical care. Current legal frameworks, collective agreements, standards of practice and ethical codes provide a foundation for nurses in their ethical deliberations concerning their work during a pandemic or disaster. Individually, nurses need to reflect upon and think through their ethical responsibilities, including their competing duties and personal and professional values, before an emergency occurs.

The examples at the beginning of this paper point to differing priorities in decision-making. Shelley must weigh her family's financial and physical well-being and her responsibility to her patients. In his role as a nursing union representative for a community hospital, George has to advocate for the safety of nurses. Adele must examine her own values surrounding vaccinations and determine whether she can fulfill her professional duties. Roseanna and Antonio both need to examine the limits of their competence so that they are aware of how to perform safely in the event of being posted to another floor or being asked to work an extra shift. Before setting up a clinic, Lashmi needs to work with her employer and various stakeholders to plan for a disaster. But ethical responsibilities do not apply only to individual nurses. Employers, public health officials, and representatives from professional associations, regulatory bodies and government must also collaborate and make decisions both in anticipation of and during an emergency in a "reasonable, open, transparent, inclusive, responsive and accountable" manner (Upshur et al., 2005) so that the public is protected as much as possible from harm and so that nurses may practise in the best interests of the public.

CNA's website (www.cna-aiic.ca) provides valuable information and links on pandemics and other emergencies:

Documents

- *Code of Ethics for Registered Nurses* (2008)
- Position Statement: Emergency Preparedness and Response

Information

- Emergencies, Disease Outbreaks and Disasters – What Every Nurse Should Know: *This webpage includes helpful links to government websites and other resources*

Links to:

- NurseOne: The Canadian Nurses Portal – *includes emergency and surveillance links*
- Provincial and territorial nursing regulatory bodies

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For more information mail, fax or e-mail:

Canadian Nurses Association

50 Driveway

Ottawa, ON Canada K2P 1E2

Telephone: 1-800-361-8404

or 613-237-2133

Fax: 613-237-3520

E-mail: info@cna-aiic.ca

Website: www.cna-aiic.ca

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