

# Nursing violent patients: Vulnerability and the limits of the duty to provide care

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## Abstract

The duty to provide care is foundational to the nursing profession and the work of nurses. Unfortunately, violence against nurses at the hands of recipients of care is increasingly common. While employers, labor unions, and professional associations decry the phenomenon, the decision to withdraw care, even from someone who is violent or abusive, is never easy. The scant guidance that exists suggests that the duty to care continues until the risk of harm to the nurse is unreasonable, however, "reasonableness" remains undefined in the literature. In this paper, I suggest that reasonable risk, and the resulting strength of the duty to provide care in situations where violence is present, hinge on the vulnerability of both nurse and recipient of care. For the recipient, vulnerability increases with the level of dependency and incapacity. For the nurse, vulnerability is related to the risk and implications of injury. The complex interplay of contextual vulnerabilities determines whether the risk a nurse faces at the hands of a violent patient is reasonable or unreasonable. This examination will enhance our understanding of professional responsibilities and can help to clarify the strengths and limitations of the nurse's duty to care.

## KEYWORDS

duty to care, nursing ethics, violence against nurses, vulnerability, workplace violence

## 1 | INTRODUCTION

Workplace violence in health care has generated a significant body of literature (Ashton et al., 2018; Babiarczyk et al., 2020; Beattie et al., 2019, 2020; Ferri et al., 2020; van Leeuwen & Harte, 2011; Morphet et al., 2018; Wand & Coulson, 2006; Whittington, 2002; Wolf et al., 2014; Zuzelo, 2020). Despite this, and the recognition of the prevalence of workplace violence in foundational documents such as codes of ethics (ANA, 2015; CNA, 2017), little attention has been directed toward the ethical dilemmas that arise when health care providers encounter violence. While the duty to provide care<sup>1</sup> is a

basic standard of nursing practice, a nurse's ability to safely meet this standard is compromised in the face of violence and unreasonable risk. An important ethical question thereby arises: What constitutes a reasonable risk, and what makes a risk unreasonable? In this paper, I propose to clarify the limitations on a nurse's duty to provide care in situations of violence by examining the vulnerabilities and corresponding ethical responsibilities of both nurses and recipients of nursing care.<sup>2</sup> The perspective presented here sets the stage for further research examining nurses' ethical decision-making with respect to caring in the context of violence, and the resulting limitations on the duty to provide care.

<sup>1</sup>For the present purpose, I use the terms "duty to care" and "duty to provide care" interchangeably as a full discussion of the differences in meaning, while interesting, are beyond the present scope.

<sup>2</sup>Throughout this paper, I use the term "recipient of care," which is inclusive of the terms *patient*, *client*, and *resident*, as well as recognizing that at times families and communities are recipients of nursing care.

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## 2 | DUTY TO PROVIDE CARE

Much of the literature on duty to care in nursing relates to situations where there is a risk of personal harm to the nurse, as in the context of disasters and infectious disease (see for e.g., Benedetti et al., 2021; Hilliard, 2007; Malm et al., 2008; McConnell, 2020; McDougall et al., 2020; Pfrimmer, 2009; Reid, 2005). In these situations, fulfilling a duty to provide care can place nurses at increased risk of injury or infection, as well as a cascade of potential burdens and harms that may extend beyond the nurse, to members of their family and community.

The discussion in the literature and professional codes of nursing ethics support the notion that the duty to provide care is not unlimited (ANA, 2015; CNA, 2017). There is a level of risk that is unreasonable for a nurse to accept in the discharge of their professional duties. Risk exists on continua of likelihood and magnitude, from nonexistent through to certain death. While a nurse would be expected to provide care when there is little to no chance of personal harm, there is no such expectation in a situation where personal harm is all but guaranteed, as might be the case with the transmission of a highly infectious agent (Benedetti et al., 2021; Hilliard, 2007). Somewhere between “nonexistent” and “certain death,” there is a point at which the level of risk becomes unreasonable, and the nurse is essentially absolved of their duty to provide nursing interventions in that situation or at that time. The presence of mitigating factors such as the availability of personal protective equipment, vaccination, or natural immunity to the agent alters the tipping point, lowering the risk to an acceptable level.

Although the term “reasonable” is ethically and problematically imprecise, it can be more clearly defined by acknowledging the subjectivity of risk and the multitude of factors that affect an individual's vulnerability (Bensimon et al., 2007; Geppert, 2020; Malm et al., 2008; McConnell, 2020; McDougall et al., 2020; Reid, 2005; Water et al., 2017). For example, a nurse may feel a strong obligation to care for someone suffering from an infectious disease when the nurse has been vaccinated against it or has the appropriate personal protective equipment to prevent transmission. On the contrary, the duty to provide care may be reasonably limited in this same situation if the nurse is especially susceptible to the pathogen or has pre-existing health condition or an immunocompromised family member for whom infection would be a significant burden.

In addition to infectious diseases, health care providers also encounter physical and psychological violence in the workplace with alarming frequency (Casey, 2019; Kibunja et al., 2021; Lee et al., 2020; Ramacciati et al., 2018; Royal College of Nursing, 2018; Shea et al., 2017). There is a dearth of research regarding the limits of a nurse's duty to provide care in the context of violence from recipients of care, although codes of ethics acknowledge that nurses should not have to tolerate abuse (ANA, 2015). Similarly, employers and unions tend to agree that nurses should not be subjected to violence at work (Manitoba Nurses Union, n.d.; Winnipeg Health Region, n.d). However, nurses regularly face violent situations that are not prevented by workplace health and safety regulations and

related policies (Ashton et al., 2018; Babiarczyk et al., 2020; Beattie et al., 2019; Ferri et al., 2020; Morphet et al., 2018; Wolf et al., 2014). These high-risk situations force nurses to make choices about whether and when to provide care, and cause dilemmas around the enforcement of policies that permit the refusal of care (Beattie et al., 2020).

Following the same thesis of “reasonableness” used in the context of infectious disease, a nurse who is larger in stature, trained in self-defense, and/or supported by a team of people may consider the risk of harm from a potentially violent situation to be reasonable. On the other hand, a nurse who is less prepared or lacks the required support may assess the level of risk to be unreasonable. The pandemic paradigm would suggest that the first nurse has a stronger duty to provide care than the second nurse. In other words, the second nurse's duty is limited by certain factors that predispose them to a greater risk of harm. Since these factors vary from person-to-person and with each unique situation, the level of reasonable risk must be weighed by the individual nurse in every situation.

The notion of “reasonableness” is frustratingly vague and insufficiently instructive to guide nurses' decisions about whether to (attempt to) provide care to a violent person. In the next section, I will examine the limitations of a nurse's duty to provide care in the context of violence, by defining “reasonableness” in terms of vulnerability. In addition, I will unpack the ways in which vulnerabilities intersect to strengthen or limit a nurse's duty to provide care.

## 3 | VULNERABILITY AND RESPONSIBILITY

There are intuitively and morally relevant differences between various workplace violence scenarios that alter the strength of a nurse's duty to provide care; that is, differences in perspective on the duty to provide care are determined by various contextual factors. For example, nurses will recognize that there is a stronger obligation to provide care when the recipient will die without the nurse's intervention, and a weaker obligation when there is an excessive level of risk for harm or injury to the nurse, or when the care is nonurgent (Benedetti et al., 2021). The reasonability of providing care is based on the varying level of risk for injury/harm to the recipient of care and the nurse.

I suggest that vulnerability is the pivotal element around which the ethical and practice-related implications of these contextual variations coalesce. The duty to provide care is directly impacted by the vulnerabilities and mitigating factors inherent in each instance. The risks to the recipient of care and the nurse vary in ways that make the decision to provide interventions either more or less reasonable. I propose that reasonableness can be determined by calculating the vulnerability of both the care provider and the recipient of care.

The element of trust is particularly salient in this calculation. The notion of vulnerability is central to decisions regarding the duty to provide care as it encompasses the ways in which the recipient of

care is dependent upon the nurse's actions and choices, and vice versa (Walker, 2007). The recipient of care is vulnerable in the sense that they require the assistance of a nurse to maintain or restore a level of wellness, and the recipient must trust that the nurse will intervene for their benefit. This makes the person susceptible to negative outcomes if they do not receive the required assistance. In addition, there is a reciprocal vulnerability on the part of the nurse in that they are dependent on the recipient of care to behave predictably and within the boundaries of expected interpersonal interactions. The nurse must trust they will not be injured by the recipient's actions. This notion will be unpacked further in the following section, starting with the recipient of care.

### 3.1 | Vulnerability of recipient of care

The level of dependency of the recipient is particularly significant to the nurse, as it confers their responsibility to provide the care that is needed (Goodin, 1985, as cited in Walker, 2007). There is a continuum of dependency, ranging from self-sufficiency to complete reliance on another for life-sustaining measures. In the middle of this continuum, the nurse's level of responsibility is affected by variables such as the likelihood and degree of harm that is expected to result from absent or delayed care. A person who is reliant on another for the necessities of life, including nutrition, hydration, or ventilation, is acutely vulnerable to the actions and choices of the other. At this level of dependency, the recipient dies if the responsibility is not fulfilled. Conversely, the dependency of a person who needs help to transfer from their bed to a chair, to get dressed, or to change hearing aid batteries is notably less urgent, and therefore they are less vulnerable to withholding or delay of care. It stands to reason that the nurse's duty to provide care strengthens with the (increasing) level of vulnerability produced by the recipient's dependency. There is a much stronger obligation to uphold the duty to provide care in situations where the absence of care would lead to an outcome of death rather than a simple inconvenience (Beattie et al., 2020; Benedetti et al., 2021).

In situations where a recipient of care is violent, the nurse's duty to provide care will be dictated by the recipient's level of dependency. For example, it would be difficult to justify a refusal to provide care to someone who is at imminent risk of dying from an injury sustained during a psychotic episode, even if the person is throwing punches or furniture. In this case, the vulnerability conferred by their emergent medical condition establishes a strong responsibility for the immediate provision of life-saving medical assistance. There would be less urgency to intervene if the injury were not life-threatening, making it possible to allow time for the behavior to de-escalate before offering care.

Several other characteristics can also affect vulnerability. For example, children and people with cognitive impairment or developmental disabilities tend to be classified as vulnerable persons, as they are often dependent on others to provide the necessities of life. However, the more capable a person is of performing self-care, the less dependent and the less vulnerable they are to the actions and choices of an external caregiver. As a result, the duty to provide care is affected by the individual's ability to understand the implications of their actions and

choices. For example, people with greater cognitive capacity tend to be held to higher standards of social conduct. People who commit crimes while experiencing mental illness or cognitive impairment are not accountable in the same way as people who commit these actions while in a rational state of mind. A young child who speaks a harsh truth is more likely to be excused than an adult who utters the same words because we accept that children may not have internalized the social norms that govern interpersonal behavior, or developed a sense of empathy. People are generally quicker to forgive a person who is incapable of understanding that a violent act will cause harm than someone who knows the consequences but chooses to do it anyway.

Nurses are governed by specific legislation that codifies their obligations to children, people in care, and people with cognitive and developmental disabilities (The Child and Family Services Act, 1985; The Protection for Persons in Care Act, 2000; The Vulnerable Persons Living with a Mental Disability Act, 1993). The duty to care is stronger for vulnerable persons because they are incapable of protecting, providing, or speaking for themselves. Therefore, cognitive capacity must be factored into decisions about when and whether to intervene when a recipient of care becomes violent. In general, the more capable someone is, the less tolerant others tend to be of any violent outbursts. Although there have been calls to prosecute people committing acts of violence against health care providers (van Leeuwen & Harte, 2011), it seems unlikely that someone who is incapable of appreciating the consequences of their actions will benefit from the involvement of the criminal justice system.

The implications of vulnerability on a nurse's duty to provide care are directly related to the recipient's level of dependency, as well as on their cognitive capacity. As discussed previously, the duty to provide care is strongest when the recipient is highly dependent on care for survival or significant health outcomes, and/or when they are less capable of anticipating or appreciating the outcomes of their actions. As a result, vulnerability varies in ways that are ethically important to decisions related to the duty to provide care.

For example, a person with advanced dementia is dependent on care providers for sustenance and safety, making them highly vulnerable to the care provider's actions and choices. A nurse may be obligated to provide care in spite of risks when an individual is experiencing transient delirium or lacks awareness of the harm caused by reactive behaviors. Alternatively, if a person becomes violent in an emergency department simply because they are tired of waiting to be assessed for a nonurgent condition, they are choosing to act out despite being capable of appreciating the implications of their behavior. In such a situation, it might be justifiable to remove that person from the department, and refuse to provide care at all, as long as the level of dependency does not reach a threshold where it confers a duty to provide care.

Consider a final example where someone insists they will only accept care from providers of a particular race, age, or sex.<sup>3</sup>

<sup>3</sup>This is not to suggest that a request for a provider of a certain gender is always discriminatory. For example, it would be a reasonable accommodation in a situation where religious or cultural belief systems dictate that females must receive care from a female provider or have a chaperone present if care is provided by a male.

While this does not constitute physical violence, it is a form of discrimination, and can even reach the level of verbal abuse, depending on the viciousness with which the person refuses to cooperate or engage with any care provider that does not fit their accepted demographic. In cases where the recipient appears capable of understanding the implications of their actions, the strength of the duty to provide care depends on the physical vulnerability of the recipient. If they are bed-bound and receiving life-sustaining interventions, it is far more difficult to justify a reduction in care than if the care requirements were less urgent, such as assistance with activities of daily living.

### 3.2 | Vulnerability of the nurse

It is not only the vulnerability of the recipient that must be considered in assessing a duty to provide care. It is generally supported in the literature that health care professionals will uphold their duty to provide care in situations of high risk unless the risk of harm exceeds what is deemed “reasonable” (Bensimon et al., 2007; Geppert, 2020; Malm et al., 2008; McConnell, 2020; McDougall et al., 2020; Reid, 2005; Water et al., 2017). The notion of “reasonableness” is affected by various factors such as the likelihood the nurse will be injured during an altercation, and the implications of this potential injury, which may include permanent or temporary disability that could impair the nurse's ability to work, support their family, and engage in other responsibilities.

The notion of vulnerability differs between people and scenarios due to the interplay of innumerable personal characteristics and circumstances. For example, a person of smaller stature or who is less physically fit may be more prone to injury than someone who is physically larger or trained in self-defense. Similarly, there may be significant implications of a workplace injury for a single parent with no alternative income or family to assist with childcare. On the other hand, a nurse who is precariously employed may feel obligated to provide care in spite of higher levels of risk when the prospect of withdrawing their services means they do not get paid.

Workplace violence will never be eliminated, but the risks can be mitigated. Nurses must evaluate the level of risk that is reasonable and in line with their duty to provide care, based on their own circumstances and personal vulnerabilities with respect to family and other responsibilities. Nurses must also take some responsibility for minimizing their own vulnerabilities and preventing violent incidents. Strategies such as situational awareness, training and education, communication between providers, reporting of incidents, and awareness of triggers for violence may help (Babiarczyk et al., 2020; Beattie et al., 2019; Casey, 2019; Ferri et al., 2020; Mophet et al., 2018; Wand & Coulson, 2006; Zhang et al., 2021). Although some responsibility technically falls on the recipient of care, they often lack the capacity to be aware of the possible outcomes of their behaviors and/or the ability to consciously treat others with respect, it is important to recognize that many acts of violence are perpetrated by people who lack self-awareness and self-control. It is also critical to understand that the recipient is not always accountable to the nurse,

even if the nurse is vulnerable to the recipient's actions. A person with limited cognitive capacity is not expected to bear the same kind of responsibility as someone with full capacity and therefore is not held accountable in the same way.

There is also a certain amount of responsibility borne by the employer to reduce risks and facilitate nurses' ability to fulfill their duty to provide care (Pfrimmer, 2009; Upshur & Nelson, 2008). For example, employers need to ensure nurses have access to appropriate personal protective equipment to guard against infectious diseases. Similarly, employers can mitigate the risks of violence toward nurses through a variety of institutional factors, including adequate staffing, safe visit plans, working alone protocols, and team-based interventions. In situations where the recipient of care is deemed not accountable for their actions, the responsibility for protecting the nurse may shift even more strongly to their employing institution.

The same personal and institutional/employer factors would apply to situations where the violence is emotional or psychological rather than physical; for example when a nurse is subject to racist, sexist, or homophobic insults from a recipient of care. The harms caused by any type of assault, including verbal, are known to be traumatic and can significantly affect nurses' physical and mental health (Paradies et al., 2015). Although the Canadian Human Rights Act (1985) prohibits discrimination, it does not protect individual nurses from the moral injury sustained when recipients of care refuse to abide by it. Even more problematic, there is an almost inevitable risk of moral injury—either by being subject to discrimination or by being complicit in permitting it to continue (Litz et al., 2009), regardless of whether the nurse identifies with the groups rejected by the recipient of care, or with those deemed “acceptable” to that person.

With these kinds of psychological violence, the limits on the duty to provide care are not as clear as they might be with physical violence because the potential impacts on the nurse are harder to assess, although no less significant. The vulnerability of the nurse would be determined based on personal factors including their social identity, the likelihood of experiencing verbal abuse, and characteristics of their personality or life experiences that would impact the extent of the harm. When an individual fails (or refuses) to be accountable for the harms they cause, the nurse's employer can take on some of the residual responsibility by implementing strategies to mitigate or remediate these harms. Prevention of psychological harm presents a greater challenge to employers than physical violence where perpetrators can be overpowered or disarmed. Employers cannot prevent verbal abuse simply by having more staff on hand during the provision of care. Effective strategies to mitigate psychological violence in the workplace are limited; zero-tolerance policies are often used as a last resort because they are difficult to enact and enforce (Beattie et al., 2019, 2020), and hiring based on the characteristics that the recipient accepts or rejects is in direct contravention of the Human Rights Code (Canadian Human Rights Act, 1985). Although the employer can and ought to mitigate risks for all types of workplace violence, it is ultimately the nurse's responsibility to decide whether to provide care and to have appropriate justification for their decision.

## 4 | DISCUSSION

Although there are limits to a nurse's duty to provide care, the individual nurse is rarely, if ever, justified in simply walking away from a situation. As a result, nurses feel a sense of responsibility even when it is not safe to provide the required care intervention and feel they must do *something*. As Reid (2005) points out, "...the risk refused by one individual is left to be absorbed by someone else..." (p. 351). Regardless of the potential danger to the nurse, there is an inherent level of vulnerability and corresponding responsibility.

For example, a nurse working overnight at a small rural emergency department encounters a patient brandishing a knife. The nurse determines that the risk of approaching the patient to provide care is unreasonable. The nurse also assesses the patient has a high degree of vulnerability and that their care needs still require prompt intervention. The nurse's responsibility turns to either finding someone who can accept the risk (e.g., another nurse, or security or law enforcement), or monitoring the patient's condition and intervening only when the risk drops below the threshold of reasonableness (i.e., if the patient were to lose consciousness or de-escalate). The nurse's duty to demonstrate respect and protect the dignity of the person (and others) remains a priority even when direct care cannot safely be provided.

The decisions that nurses need to make when faced with physical or emotional violence are fundamentally complex. There are ethical challenges to consider even when the withdrawal of direct care is justified. When there is no other care provider or when the threat of violence does not abate, the nurse is still accountable for protecting those who are vulnerable to their decisions and actions, including the violent person and others in the nurse's direct or indirect care. When the nurse is unable to safely address priority care needs, the person's secondary needs, including safety (of the person and others in the vicinity), comfort, or privacy becomes a priority. Interventions aimed at secondary needs should respect the humanity of the person. At a minimum, the nurse's duty to provide care requires they remain vigilant to any opportunity to safely address the person's vulnerabilities. The vulnerabilities of nurses and their recipients of care are individualized and context-dependent. Regardless, nurses have a duty to provide whatever care is possible in ways that maintain the person's dignity while also minimizing the risk of harm to the nurse and to others in the area, thereby addressing, as appropriate and possible, the nurse's own and other's vulnerability. Nurses can never simply abandon their patients. Participants in the study by Beattie et al. (2020) aptly describe this morally distressing position as being "stuck" between nontolerance of violence and the duty to provide care (p. E19).

Violence in health care settings will continue to raise ethical questions and challenges for nurses. For instance, how can the welfare of nurses and patients be protected when aggression makes it unsafe to provide necessary nursing interventions? What risks are reasonable or unreasonable, and how does a nurse decide? When withdrawal of care is justified, how can the nurse manage any guilt or moral distress that occurs? There is a great deal of work to be done to clarify the values, expectations, and factors that affect the responsibilities of individual nurses, the nursing profession, the institutions

that employ nurses, and society in general. It is critical that we deepen our understanding of these groups' respective roles in preventing, managing, and responding to violence against health care providers. I suggest that much of this study hinges on the interplay of vulnerabilities in any given situation.

## 5 | CONCLUSION

Workplace violence, especially against health care providers, is a complex phenomenon fraught with ethical challenges. When a situation exceeds the limits of a nurse's duty to provide care, the nurse may need to shift their obligations to meet the patient's ongoing needs. The discussion in this paper sought to tease out some of the morally relevant distinctions that affect a nurse's duty to provide care.

Vulnerability is a central quality that determines whether the risk a nurse faces at the hands of a violent patient is reasonable or unreasonable. The vulnerabilities of the recipient of care are determined based on their dependency on care as well as their capacity to appreciate the impacts of their actions. These vulnerabilities impact the strength of the provider's duty to provide care in the face of personal risk. The personal characteristics and circumstances of the nurse determine their own vulnerability, and there is a complex interplay between the nurse's own vulnerabilities and those of the recipient of care. The nurse's duty to provide care can also be affected by strategies implemented by the employer to mitigate risks to a level the nurse deems reasonable. A thorough examination of the vulnerabilities of both the nurse and the recipient of care enhances our understanding of nurses' professional responsibilities and may serve to guide nurses in conceptualizing and fulfilling their duty to care.

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## DATA AVAILABILITY STATEMENT

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