

The ethics of refusing to care for patients during the coronavirus pandemic: A Chinese perspective

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Abstract

As a result of the coronavirus (COVID-19) pandemic, health professionals are faced with situations they have not previously encountered and are being forced to make difficult ethical decisions. As the first group to experience challenges of caring for patients with coronavirus, Chinese nurses endure heartbreak and face stressful moral dilemmas. In this opinion piece, we examine three related critical questions: Whether society has the right to require health professionals to risk their lives caring for patients; whether health professionals have the right to refuse to care for patients during the coronavirus pandemic; and what obligations there are to protect health professionals? Value of care, community expectations, legal obligations, professional and codes of practice may compel health professionals to put themselves at risks in emergency situations. The bioethical principles of autonomy, justice, beneficence and non-maleficence, as well as public health ethics, guide nurses to justify their decisions as to whether they are entitled to refuse to treat COVID-19 patients during the pandemic. We hope that the open discussion would support the international society in addressing similar ethical challenges in their respective situations during this public health crisis.

KEYWORDS

China, COVID-19, ethics, health professionals, nursing, pandemic, refuse, value of care

1 | INTRODUCTION

As the first group to witness patients suffer and die during the pandemic, Chinese health professionals have endured heartbreak and faced impossibly stressful moral dilemmas (Thomson, 2020).

I am only performing my responsibility

Being a lifesaver as a nurse

Often, I had to stand at the front line without any protection

No choice of life or death

Do not have any great thoughts

Please do not give me a wreath

Do not give me any applause

And not ..., martyr, or any merit

Coming over to Wuhan, not for ...receiving praise

Just want to go back home safely after the epidemic

Even if it is just a skinny body left

I want to bring myself back to my children and my parents

Ask yourself:

Who is willing to hold your peer's urn

Making the way to home

A poem written by a nurse sent from another province to work in a field hospital in Wuhan (Rou, 2020). The Chinese people were deeply moved by this poem. The nurse's simple words struck a chord among many health professionals, which is worthy of reflection: Do we, as a society, have the right to require the health professionals to devote their lives to the care of patients when they may also have obligations to their own family?

Coronavirus disease (COVID-19) caused by the virus named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was characterized as a pandemic by the World Health Organization (WHO) on 11 March 2020 (WHO, 2020a). There are now over 16 million cases worldwide across 188 countries/regions and 648, 966 deaths as at 27 July (Center of Systems Science & Engineering at Johns Hopkins University, 2020) with numbers expected to grow. The characteristics of this public health crisis include a novel pathogen; uncertain transmission routes; deficiencies in testing for the virus; no effective treatment; a shortage of protective equipment; and the exponential speed of its spread (Livingston, Desai, & Berkwits, 2020; Omer, Malani, & del Rio, 2020). These characteristics have meant that health professionals, including nurses, face real dangers and have to confront new and difficult moral questions in a crisis situation (Thorne, 2020).

There is a significant element of distress and anxiety in the face of COVID-9 among the general public as well as health professionals (Montemurro, 2020) with some evidence that both experience vicarious traumatization (Li et al., 2020). Dealing with the unprecedented uncertainties and challenges means that health professionals are likely to confront ethical dilemmas and conflicts for which they are ill-equipped. 'Perception, rather than reality, has been seen to control the resolution of ethical dilemmas' (Freedman, 1988, p.20), and the perception, based on widespread coverage of the COVID-19 pandemic, is that it is risky to take care of a patient who has COVID-19. In this paper, we examine three interrelated questions: Whether society has the right to require health professionals to risk their lives caring for patients; whether health professionals have the right to refuse to care for patients during the coronavirus pandemic; and what obligations are there to protect health professionals? We discuss these ethical issues starting from the perspective of Chinese health professionals before situating them in a global perspective.

2 | BACKGROUND

Chinese health professionals were the first to face the challenge of caring for patients with coronavirus when little was known about the nature of the virus and demand for health services outstripped their ability to respond. At the outbreak of COVID-19, 346 health care teams consisting of 42,600 health care workers from across China went to Wuhan to support the local health care services (Beijing News, 2020; Rou, 2020). Initially, the situation in Wuhan was challenging: dead bodies could not be moved from wards on time because of lack of personnel and equipment, and patients had to wait for treatment for hours and even days in a state of panic (Thomas, 2020).

Faced with the kind of dilemmas posed by the coronavirus pandemic, decision-makers and health professionals, including nurses, need to base decisions in an ethical framework according to a set of agreed values. These should balance the rights and duties of individuals, communities and populations with regard to protecting and maintaining health (Schröder-Bäck, Duncan, Sherlaw, Brall, & Czabanowska, 2014). We pose a series of questions based on the

experience of Chinese nurses and discuss these through the lens of ethics.

3 | DOES SOCIETY HAVE THE RIGHT TO REQUIRE HEALTH PROFESSIONALS TO RISK THEIR LIVES CARING FOR PATIENTS WITH COVID-19?

Early in the pandemic, health professionals working at the frontline caring for suspected and diagnosed patients with COVID-19 were faced with tough ethical decisions about whose safety to prioritize—their patients and that of the whole community, or their own. To explore this, we have drawn on the concepts of duty of care and how this is shaped by community expectations and culture, codes of conduct, law and regulations, and biomedical as well as public health ethics.

3.1 | Duty of care

From a professional perspective, duty of care refers to obligations to act towards others in regard to a particular standard (Royal College of Nursing (RCN), 2019). The Royal College of Nursing (RCN) in the UK goes on to state that there is both a legal and professional duty of care: the law imposes a duty of care where it is 'reasonably foreseeable' that the health practitioner might cause harm to patients through their actions or omissions. The professional duty of care pertains to adherence to professional codes of practice (RCN, 2019; Wright, Peterson, & Gifford, 2020). Registered nurses are required to be accountable for the safety of themselves, their patients and the public (American Nurse Association (ANA), 2015; Royal College of Nursing (RCN), 2020; Wright et al., 2020).

Prioritizing which of these concerns is paramount, especially in the context of a disaster, such as a pandemic, when existing resources are overwhelmed may create dilemmas. For example, if health professionals do not have access to the required personal protective equipment they may put themselves or their patients at risk but refusal to provide care will also risk patients' lives. That this can be a balancing act with responsibility to one party (e.g. the health service), possibly in conflict with the responsibility to clients, is acknowledged by an Australian health service (New South Wales Health, 2004).

3.2 | Community expectations, culture and political ideology

Historically, nursing, and perhaps to a lesser extent medicine, has seen as a 'calling,' in which nurses and doctors are expected to sacrifice themselves for their patients (Freedman, 1988; Kao & Jager, 2018).

During the COVID-19 pandemic, Chinese media and government emphasized the idea of sacrifice. The ideal of sacrificing

oneself for a higher, national goal is deeply embedded in Chinese culture: 'sacrificing one's family for all, and putting the country before oneself has always been a spiritual hallmark of the Chinese nation [and is] ingrained in our genes'. (Ministry of Foreign Affairs of PRC, 2020).

In China, the dual effects of traditional culture, media publicity and propaganda, has bypassed questions of ethics and duty of care in emotional appeals to health professionals to 'give up family for everyone, for the country', where the risk of sacrifice is the greatest (Xu, 2020). The media praised the health professionals working at the front line at high risk of infection and depicted them as heroes, 'soldiers in white' (Beijing News, 2020). Health professionals were encouraged to have the spirit to continue to work even if they were ill: 'do not leave the front-line while being slightly injured' (We-yuan-rong-mei, 2020; Zi-gong-chen-shi, 2020). A particularly pertinent example of this propaganda is a video, released by Chinese state media, of a heavily pregnant Chinese nurse treating people with coronavirus with the intent to portray her as a self-sacrificing hero (BBC News, 2020). Instead, there was a backlash across China with people responding that the woman was being used as a tool and that it was 'sick' (BBC News, 2020).

Exhausted health professionals had mixed reactions to media accolades. As narrated in the heartfelt poem, presented at the beginning of this paper, nurses wanted to return to their homes and families and not sacrifice themselves and be praised as martyrs (Rou, 2020). Media depictions of health professionals as heroes are not confined to China: this has been happening across the globe as COVID-19 affects other countries, for example in Italy people sang from their balconies and during the lockdown in the UK people gathered on their doorsteps to clap health workers. A registered nurse from a Massachusetts-based hospital notes that 'praise and applause from hospital leadership does not alleviate the dangers nurses face' (Vaidya, 2020). It is also not new: during the SARS outbreak, a doctor in Taiwan stated that it was too heavy a burden to be called a hero 'I just do what I should do'. (Hsin & Macer, 2004, p.210). Albert Camus in his classic and prescient novel 'The Plague' written in 1948 put it thus:

There's no question of heroism in all this. It's a matter of common decency. That's an idea which may make some people smile, but the only means of fighting a plague is common decency. (p. 57)

During the COVID-19 pandemic, a head of an infection control department in China told the media: 'I require all health care workers who are communist party members to replace all those who have been working over the past days. In this critical period, there is no negotiation, and all communist party members should work at the front-line'. This demand was widely supported by Chinese local and national official media (Xinhuanet, 2020). Communist ideology is taught in school and is a required subject at university level. The communist ideology combines the traditional Chinese cultural message that sacrifices should be honoured if one dies for the people into the political

imperative that one should eliminate all difficulties and serve the people without fear of sacrifice (Xinhuanet, 2020). This contrasts with the situation in the west: police and army are obliged by their service to put their lives at risk and professionals in health are relied on to follow their codes of professional conduct and ethics; vocation is drawn on as a concept to reinforce this expectation of service.

As health professionals, we should ensure there is an adequate workforce and that workforce is adequately protected without having to resort to demands to work based on political grounds. Political ideology can be an uneasy fit with medical ethics and professional judgement. While it is admirable that the communist party members act as a role model, if their own health status prohibits them from working or they lack the required clinical knowledge, they should not be working at the front line without sufficient preparation. Health professionals' autonomy and right to make their own choices should be respected.

3.3 | Codes of ethics, law and regulations

Codes of ethics are based on the ethical principles derived from the broader ethical considerations and adapted to the scope of practice and role of each health professional in order to clarify roles and responsibilities to ensure ethical practice. The established nursing ethical standards provide a guide for nurses in ethical analysis and decision-making (ANA, 2015). However, health professional codes of practice and ethical statements may be prescriptive (Freedman, 1988), for example, stating that nurses are required to care for patients regardless of diagnosis. In the context of the human immunodeficiency virus (HIV), the American Nurses Association suggested that nurses must care where the value of the care outweighs the potential risk to the nurse (Freedman, 1988), but the ethical code of the American Nursing Association indicates that nurses have the obligation and responsibility to take care of their own health while taking care of patients (ANA, 2015). In practice, it is not easy to assess the value of care and risk.

During an emergency, if Chinese nurses do not assume their professional responsibility to save lives, they could violate the first principle of the Chinese Nurses Association code of ethics, which indicates that 'Nurses' responsibilities are ... to follow the nursing mission by protecting lives, relieving pain, promoting health, and preventing disease'. (Zhang, 2014). A provision of the Chinese Nurses' Regulation states that nurses must participate in health care during a natural disaster, public health event and other emergencies that seriously threaten the life and health of the public (State Council of PRC, 2008). Accordingly, the health authority will give a warning and order correction if a nurse fails to meet the obligations mentioned above when asked to do so. In serious circumstances, the nurse's certificate for practice shall be suspended for more than six months but less than one year; it may also be subject to revocation (State Council of PRC, 2008).

Faced with a public health crisis, politicians, hospital leaders and the media should not expect the health professionals to be martyrs

for society on moral grounds or political grounds. It is not enough to say that the health professional has a duty of care, other ethical principles apply.

There are four basic principles of biomedical ethics according to Beauchamp and Childress (2001): autonomy, justice, beneficence and non-maleficence. Autonomy is about the protection of individual choice, rights and freedoms against the control of organizations (Thompson, Melia, Boyd, & Horsburgh, 2006). Justice in the context of medical ethics means that there should be fairness in medical decisions and involves fair distribution of scarce resources, competing needs, rights and obligations, and potential conflicts with established legislation (Beauchamp & Childress, 2001). Beneficence is the principle that requires care to be provided with the intent of doing good—that all professionals have the foundational moral imperative of doing the right thing (Kinsinger, 2019). Non-maleficence refers to the principle that care harms neither the patient nor others in society.

The four above-stated ethical principles mainly guide health professionals in making their decisions to protect individual patients' best interests in clinical medicine. However, complying with public health emergency requests a move away from a person-centred care approach to a population health approach (McKenna, 2020). Ensuring the health population often entails imposing limitations on rights and preference of individuals, which may impose burdens on health professionals. We fully agree 'the straightforward application of the principles of autonomy, beneficence, non-maleficence and justice in public health practice is problematic' (Upshur, 2002, p.101). The principle of 'do no harm' should also be applied to any decisions made about deploying health professionals in dangerous situations.

One of the lessons to be drawn from the severe acute respiratory syndrome (SARS) epidemic in 2003, arguably, is for us to pay greater attention to the duty of care owed to health professionals (Singer, Benatar, & Bernstein, 2003). Health care professionals sacrificed time, income or health should be compensated (Upshur, 2002). Strategies should focus on protection and compensation, such as guarantees for health professionals' safety; adequate rest; attention to the welfare of themselves and their families; psychological support; financial compensation; and affirmation. An example of this is the initiative of the COVID-19 working team in Chinese central government in February 2020 that included ten strategies for protecting health professionals (State Council of PRC, 2020). These included increasing salary, a monetary bonus, opportunities for promotion and the provision of psychological and social support for health professionals who were working with COVID-19 patients.

Recently, the CNA Code of Ethics highlighted the duty of employers and governments to protect and support nurses during disasters, outbreaks and pandemics (Wright et al., 2020). As was advocated by Hsin and Macer (2004): a well-developed society should have sufficient space to apply humanism to everyone in any kind of situation, including a public health crisis. Then, the second question follows:

4 | DO HEALTH PROFESSIONALS HAVE THE RIGHT TO REFUSE TO TAKE CARE OF PATIENTS DURING THE CORONAVIRUS PANDEMIC?

Caring for patients is a foundational value and moral commitment in nursing (Watson, 2009) and the same is true of other health professionals. For nurses, their ethical behaviour is theoretically grounded in the responsibility to care for the patient (Georges & Grypdonck, 2002) as well as a professional obligation (ANA, 2015). Caring for others is also a major reason people join the helping professions and a value that guides their actions. When unable to practice in a way that upholds their ethical values, they are vulnerable to moral distress (Davis, 2006) and we witnessed the tears of Chinese doctors and nurses who went to Wuhan to support the local medical personnel but were unable to save many of their patients.

Health professionals have a responsibility to take care of their own safety and health, and this may come into conflict with their moral duty to care (McKenna, 2020). If health professionals either individually or as a group refuse to take care of patients during an emergency, such as a pandemic, they are highly likely to face widespread condemnation both from the public and from other health professionals.

Health professionals across the world working at the front line of the COVID-19 pandemic are realistically anxious about their own health and that of their family because, until the development of a vaccine for COVID-19, health professionals face the threat of becoming infected and even dying. Health care workers in China made many sacrifices to protect their own family's welfare: many chose to stay in hotels due to the fear of transmitting the infection to their loved ones. Across the globe, nurses have also faced prejudice with laypeople concerned about them bringing infectious disease to the community and they have faced eviction and hostility (Nguyen, 2020).

Most nurses and health professionals will care for patients with infectious diseases, but during the SARS, MERS and Ebola viruses, a minority of nurses refused: they escaped from working at the front line, either by taking sick leave or by resigning due to fear of infection, or worries about the safety of family members (Venkat et al., 2015). Although we do not have definitive evidence of this occurring in China during the coronavirus, health professionals were heard voicing their fears and considering this as an option (Liu et al., 2020).

In February 2020 for a period of five days, Hong Kong's Hospital Authority Employees Alliance staged a planned protest. Some nurses called in sick to register their disapproval of the government's response to the virus (Chan, 2020). They also requested that the government provide adequate personal protective equipment. This resulted in a public debate with many harshly condemned the health professionals refuse to treat and care for patients with COVID-19 and stated that they did not fulfil

their humanitarian duty to save lives during an emergency (Global Times, 2020).

The experience of recent history shaped the nurses' actions. In 2003, about 20% (about 1,000) of Hong Kong's health professionals were infected by the SARS virus and among those who died about one-third were doctors and nurses (Liu, 2020b). In Wuhan, for the first four weeks of January 2020 40 (29%) of the 138 patients with COVID-19 who were treated in Zhongnan Hospital were health care workers infected due to insufficient equipment and strategies, or not following proper self-protection procedures in the early stages of the epidemic. By 11 February 2020, 1,716 health care workers in China were diagnosed with COVID-19, which was 3.8% of all cases in China, and at least six have died (Ma, 2020). International Council of Nurses (ICN, 2020) declared more than 600 nurses die from COVID-19 worldwide and calls on all countries to record more detailed data on infections and deaths of health care workers on 6 May 2020 (Liu, 2020a), and there is lack of updated statistics in Chinese official report yet.

The primary principle of biomedical ethics as proposed by Beauchamp and Childress (2001) is that decisions should consider the balance of beneficence, risks and costs of actions. It is arguable that authorities requiring health professionals to work at the front line with insufficient PPE may have the intent to do good to patients, but the decision is not in line with beneficence or non-maleficence for health professionals. The government has the responsibility to develop a plan of emergency preparation for epidemics, which includes measures to protect staff. Health professionals' safety cannot be guaranteed without adequate personal protective equipment (PPE), and they can become the source of infection themselves and endanger lives. In short, compromising the safety of health professionals in the short term with also has longer-term ill effects on patients, the public and society.

4.1 | Circumstances in which it is acceptable for health professionals to withdraw from care provisions or to refuse to provide care for patients with COVID-19

1. Clinician's health condition. For example, health professionals who may be suffering from an infectious disease that they could potentially pass on to patients and colleagues. Health professionals have an obligation to report whether they are suffering from, or potentially suffering from, an infectious disease so that they do not put themselves, their colleagues or patients at risk. It was sad knowing two Italian nurses with coronavirus kills themselves (Steinbuch, 2020). It is important to encourage health professionals to seek psychological counselling when they are extremely stressful.
2. If a health professional has an underlying condition which weakens their immunity, then this would preclude them from working with patients diagnosed with COVID-19 and hospital

management has the responsibility to facilitate this. Sadly, many retired doctors heeded a call to return to work, despite knowing that their age put them at risk of being infected and many have died (Weaver, 2020).

3. When the care is outside the health professional's scope of competence or training (RCN, 2020). Unlike other overseas countries who brought student health care workers into clinical settings before their training was complete in order to bolster the workforce, student involvement in COVID-19 pandemic is forbidden in China. Some Chinese students have objected to this decision, as they feel ethically compelled to fulfil their duty to care for COVID-19 patients. The restriction was largely justified during Ebola outbreaks: it aims to protect the public health by minimizing the population directly engaged with COVID-19 at clinical front lines, and it ensures trainee well-being as recommended by American College of Emergency Physicians, the Emergency Nurse Association and the Society for Academic Emergency Medicine (Venkat et al., 2015).
4. Where there is conscientious objection (RCN, 2020). The Australian Nursing & Midwifery Federation (ANMF, 2017) has made clear that 'fear, personal convenience or preference, are not sufficient basis for conscientious objection'. Fear, personal preference and convenience cannot be cited by nurses as reasons to avoid treating COVID-19 patients. Chinese health professionals have made remarkable contributions in challenging work environments while being fully aware of the dangers of their tasks (Wen-Xue-City, 2020; Zhu, 2020). The same is true of their colleagues around the globe.
5. Where there is physical violence (RCN, 2020). Regrettably, this has included, in the coronavirus pandemic, health professionals being deliberately coughed or spat on.
6. Where there are health and safety hazards, for example a lack of appropriate equipment (RCN, 2020). For example, under the Canadian provincial and territorial occupational health and safety legislation, employers have a responsibility to provide a safe work environment. While health professionals are forced to decide between the risk of providing patient care and the need to protect their own (or their family's) health and safety, the CNA Code of Ethics highlights the reciprocal duty of employers and governments to protect and support nurses during disasters, outbreaks and pandemics (Wright et al., 2020).

The refusal to care on the basis of health and safety hazards has created the majority of dilemmas health care professionals have faced in this pandemic (Medoza & Kruesi, 2020). Health professionals should be able to raise concerns about safety without detriment to themselves. In the turmoil of COVID-19, whistleblowers daring to speak up and tell the truth have been targeted (Zhu, 2020). Tragically, three Russian doctors were reported to have mysteriously 'fallen' out of a window after raising concerns about lack of PPE and being forced to work despite a positive COVID-19 test (CNN, 2020). This then leads to our third question:

5 | WHAT OBLIGATIONS ARE THERE TO PROTECT HEALTH PROFESSIONALS?

Commentators on the current coronavirus crisis have frequently likened requiring health professionals to care for patients with coronavirus without adequate supplies of personal protective equipment to sending soldiers into war with no guns (Hushion, 2020). On 27 February 2020, the WHO Director-General called on all countries to prioritize the protection of health professionals during the COVID-19 outbreak (WHO, 2020b) because across the globe clinicians and frontline workers have not been given the equipment they need to stay safe and many have died as a result.

In most countries, the law requires every employee and the employer to protect their own safety and the safety of others. Health professionals are entitled to a safe place of work as was laid out by the British Medical Association (BMA, 2020) and RCN (2020) which both noted that health professionals have employment rights to ensure their protection and employers must provide a safe system of work, which includes provision of appropriate PPE. The British Medical Association (BMA) concerned about the British government's inability to provide adequate protection and subsequent 'watering down' of PPE recommendations advised doctors that they should not face a disciplinary process or detriment if they are confronted with serious and imminent danger in their workplace and they refuse to work. They advised that there are limits to the risks they can be expected to face:

You are under no obligation to provide high-risk services without appropriate safety and protection. You can refuse to treat patients if your PPE is inadequate, you are at high risk of infection and there is no other way of delivering the care.

(BMA 2020, p.1)

Similarly in April 2020, the UK Royal College of Nursing (RCN) issued guidelines for nurses if they are considering refusing to treat due to a lack of adequate PPE during the pandemic (RCN, 2020). The guidance provides the decision route and potential legal consequences for nurses deciding whether the PPE provided is appropriate for nurses and what to do if it is not. All staff, registered or not, if they are considering refusing to treat due to lack of adequate PPE, they must be empowered by RCN and the employment law protections to speak up and promote the safest way forward (RCN, 2020).

Nurses in the United States are taking legal action against the New York State Department of Health because they were supplied with 'grossly inadequate and negligent protections' and were instead forced to work in 'unsafe working conditions' (Mahbubani, 2020). The CNA Code of Ethics highlights that nurses have a right to receive truthful and complete information so they have a clear understanding about the obligations and expectations around their role, and be able to fulfil their duty to provide care (Wright et al., 2020).

On 6 April 2020, the United Nations Educational, Scientific and Cultural Organization (UNESCO), International Bioethics Committee (IBC) and World Commission on the Ethics of Scientific Knowledge

and Technology (COMEST) highlight an urgent recognition all over the world that 'our right to health can be guaranteed only by our duty to health both on an individual and collective levels' (UNESCO, IBC, & COMEST, 2020, p. 2).

6 | CONCLUSION

Consideration of the COVID-19 pandemic and its various ramifications continues and with it continued ethical dilemmas for health professionals, health service managers and decision-makers at government level. The paper has highlighted the pandemic ethical issues relating to cultural, political and social contexts and competing values and perspectives.

We sincerely hope that this open discussion starting from a Chinese perspective will highlight the need for a collaborative global approach to the pandemic and the ethical dilemmas it raises. As the nurse so eloquently put it in her poem, we 'just want to go back home safely after the epidemic'.

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