COVID-19 Ethics Analysis: What is the Ethical Duty of Health Care Workers to Provide Care During COVID-19 Pandemic?

Provincial COVID-19 Task Force

March 28, 2020

Introduction

The COVID-19 pandemic presents a number of significant ethical issues regarding safety for healthcare worker (HCW). Some HCWs may be concerned that if they become infected themselves, they in turn may infect patients, their co-workers, as well as their own family members and children. These HCWs are at a difficult intersection: navigating these fears with their ethical sense of duty to patients and to society, and their sense of solidarity with fellow HCWs.

This discussion focuses on the HCWs ethical duty of care in circumstances where there is a risk of harm to their own person. As such, a key ethical question related to duty of care during COVID-19 is:

- **How should HCWs and organizations approach the ethical duty to care in the context of the COVID-19 pandemic?**

Since the degree of potential harm to HCWs can include serious morbidity and death, it is necessary to consider the degree to which HCW have an ethical duty to care and the circumstances under which that duty can be discharged. **The analysis does not, however, consider any legal or professional (i.e. regulatory and college) aspects.**

Facts & Relevant Information

HCWs are bound by an ethic of care which dictates that patients' well-being should be primary[1]. Simultaneously, HCWs are also bound by competing relational obligations such as parenting duties and other compulsory caregiving commitments. Tensions between these multiple realms of responsibility may be irreconcilable.

[1] Ruderman, C., Tracy, C. S., Bensimon, C. M., Bernstein, M., Hawryluck, L., Shaul, R. Z., & Upshur, R. E. (2006). On pandemics and the duty to care: whose duty? who cares?. *BMC Medical Ethics*, *7*(1), 5.

The ethical foundations of the duty to care are grounded in several ethical principles—primarily, the principle of beneficence to patients and to the public. The ethical obligation also stems from three features:

1. The ability of HCWs to provide effective care is greater than that of the general public and thus there is a greater obligation to provide this care.
2. HCWs freely choose to enter into their professions and thus inherently assume some degree of risk when they choose their profession.
3. HCWs are legitimized by society on the basis of a social contract that expects they are available in times of emergency, such as the COVID-19 pandemic.

Thus, while it is the case that an ethical duty to care exists, the degree to which it holds in the context of COVID-19, and the degree to which the duty extends to all healthcare activities, exists in relation to the facts about what is currently known about COVID-19. Accurate assessment of the facts, and assumptions, based on the best available information, are crucial in any analysis of the duties of HCWs.

The importance of grappling with the notion of discharging the duty of care illuminates the balance on which HCWs should weigh any immediate benefits to an individual patient *with their ability to care for patients in the future*[2].

Actual and assumed facts regarding the COVID-19 pandemic:

- COVID-19 is currently understood to be highly infective and easily transmittable from person to person through droplet and contact spread.
- The transmission of COVID-19 is primary through droplet spread[3]. Some healthcare activities and procedures may also generate aerosols composed of particles suspended in air (e.g. CPR before intubation)[4]. Appropriate PPE has been defined for both droplet and airborne risks. Appropriate PPE is considered an effective risk mitigating strategy when used properly. Thus, in

[2] See: Ruderman, C., Tracy, C. S., Bensimon, C. M., Bernstein, M., Hawryluck, L., Shaul, R. Z., & Upshur, R. E. (2006). On pandemics and the duty to care: whose duty? who cares?. *BMC Medical Ethics*, *7*(1), 5.

[3] See: Brewster, D., Chrimes, N., Do, T. et al. (2020). Consensus statement: Safe airway society principles of airway management and tracheal intubation specific to the COVID-19 adult patient group. *Medical Journal of Australia*. (Published online 15 March 2020. Available: https://www.mja.com.au/journal/2020/212/10/consensus-statement-safe-airway-society-principles-airway-management-and)

[4] Brewster, Chrimes, Do et al. (2020) noted the following AGPs: coughing/sneezing, NIV or PPV with inadequate seal, HFNP, delivery of nebulized medications via simple face mask, CPR prior to intubation, tracheal suction, tracheal extubation (see Table 1).

the absence of appropriate PPE, or in cases of improper PPE use, HCWs face heightened risks of harm to their person.

- Some HCWs engage more frequently in the provision of patient care that poses higher risks to their personal safety. The process of caring for severe COVID-19 patients and performing AGPs in this group presents an increased risk of infection to healthcare workers.
- Some HCWs may face increased personal risks in relation to COVID-19 (e.g. those who are older adults with comorbidities). HCWs with personal characteristics where COVID-19 is known to cause substantial harm (including death), face greater risks of harm.
- There are key sectors of the healthcare system (e.g. acute and critical care HCWs, specialty services), where losses of HCWs due to COVID-19 would substantially disrupt the ability of the healthcare system to respond to the COVID-19 outbreak. The impact of such disruptions would thus impair the ability of the healthcare system to care for all types of future patients, including those with COVID-19 infections.
- As is currently understood about the COVID-19 virus, the probability of spread is also very high if not contained. Thus, the risk of harm to the society is high and needs to be factored into any ethical response.

Limits to ethical duty to care

HCWs have an ethical duty to provide care, even when it involves potential exposure to some risk of harm[5]. However, when individual HCW face certain and significant harm to their person—such as may be the case in performing some healthcare activities without appropriate PPE—that duty may be discharged.

In the context of COVID-19, each individual HCW must bear the burden of justifying whether their duty to care is discharged. This justification must be clear and robust in order to avoid the dissolution of the generally high regard that society holds for HCWs and continuation of the trust and respect of such relationships. Thus HCWs must justify any discharge of their ethical duty to care in relation to:

a) their participation in a ***specific*** patient care activity (or activities) that pose intolerable and unmitigable risk of certain and significant harm; and,
b) their own unique personal circumstances.

For example, some HCWs may themselves fit within higher risk categories where COVID-19 is known to cause particular harms including death (e.g. those who are immune compromised, frail older adults) and thus may face both certain and significant harms if they engage in particular healthcare activities where the risks of harm cannot be mitigated (e.g. aerosol-generating procedures (AGPs) for a person with known COVID-19 without adequate PPE). In such a scenario,

[5] See: Damery, S., Draper, H., Wilson, S et al. (2010). Healthcare workers' perceptions of the duty to work during an influenza pandemic. *J Med Ethics, 36*: 12-18. doi:10.1136/jme.2009.032821

the HCW has no available strategy to effectively mitigate the exposure to COVID-19, they can defensibly discharge their duty to provide that ***particular activity*** of care.

Ethical Analysis

The ethical analysis and recommendations in this document follows the *BC COVID-19 Ethical Decision-Making Framework (EDMF): Interim Guidance (*See Appendix A).

This EDMF reflects the core ethical principles of public health ethics: respect; the harm principle; fairness; consistency; least coercive and restrictive means; working together; reciprocity; proportionality; flexibility; and procedural justice.

Values grounding an ethical duty to care and the circumstances under which that duty is discharged

- **Reciprocity**
  - If HCWs are asked to take increased risks, or face increased/disproportionate burdens, they should be supported in doing so, and the risks and burdens should be mitigated as far as possible. When these risks cannot be mitigated, the safety of HCW must be carefully considered and prioritized in order to preserve the future functioning of the healthcare system.
  - Giving clear guidance on the ethical duty to care—including the circumstances under which the duty to care is defensibly and justifiably discharged in the context of risks to personal safety—is predominantly supported by the principle of reciprocity and for the careful consideration of HCWs safety. This guidance is also supported by the harm principle (i.e. the right of society to protect itself from harm) as widespread and significant harms to HCWs (including deaths) threatens the functioning of the whole healthcare system and the care of future patients.

- **Respect**
  - Treat colleagues with kindness, care, and compassion
  - Communicate in an informed, thoughtful way
  - Each individual HCW must bear the burden of justifying whether their ethical duty to care is discharged

- **The Harm Principle (public safety):**
  - A society has a right to protect itself from harm, real or threatened. The government is justified in intervening and possibly impinging on the rights of individuals to protect the community from harm.

- **Duty to care**
  - Accepting the professional role as HCW in the context of a public healthcare system means accepting the responsibility to put the interests of patients and the public ahead of the HCWs personal interests to a reasonable extent. This duty would be overridden only when the risk of harm to a HCW's person is certain, significant, and cannot be adequately mitigated. The responsibility arises from multiple sources including:
    - the public investment in the education and training of HCWs, through subsidized and supported opportunities for professional education and training;
    - special status for governance and oversight of professional practice through healthcare professional organizations; and,
    - the relative power differential between patients and HCWs, where patients must trust HCWs to meet patient needs–creating a fiduciary responsibility on the part of the HCWs.

- **Fairness**
  - HCWs each consider the circumstances under which their ethical duty to care may be defensibly discharged in the context of threats to HCWs' personal safety in order to ensure they remain alive and remain able to care for future patients. This crucial consideration reflects the principle of fairness for future patient populations and for the healthcare system more broadly.

- **Proportionality**
  - Measures implemented, especially restrictive ones, should be proportionate to and commensurate with the level of threat and risk.
  - Where limits and restrictions are placed on patient care activities due to intolerable and unmitigable risks to HCWs' persons, these decisions should be communicated clearly and transparently. Especially restrictive limits should be proportionate to the risk HCWs actually face.

- **Least Coercive and Restrictive Means**
  - Any infringements on personal rights and freedoms must be carefully considered, and the least restrictive or coercive means must be sought.

- **Working together**
  - Cooperation is essential to this international threat – between individual citizens, health regions, provinces, and nations.

- **Procedural Justice**
  - There will be accountability to a fair and transparent process throughout the planning and implementation of managing COVID-19. Reflects the best available evidence, and ensures assumptions made are well grounded and defensible.

Recommendations

This section is organized for three groups: individual HCWs, organizational-level leaders, and system-level leaders.

Individual HCWs:

1. HCWs should acknowledge their ethical duty to provide care and understand that this duty remains even when it involves potential exposure to some risk of harm.
2. Each individual HCW should determine their obligation and willingness to provide care in contexts where they are exposed to risk of COVID-19 infection based on:
    a. The HCW's participation in a *specific* patient care activity (or activities) that pose risk; and,
    b. their own unique personal circumstances.
3. When a HCW faces certain and significant harm to their person, such as may be the case in the situations such as the absence of adequate PPE, they may consider their usual duty to provide care met; it would be reasonable to see any service that includes risk beyond this point as voluntary.
4. For HCWs who fit within higher risk categories where COVID-19 is known to cause particular harms including death, if the HCW has no available strategy to effectively mitigate the exposure to COVID-19, it would be reasonable for that provider not to provide that *particular activity* of care.
5. If an individual HCW is unwilling to accept the responsibility to provide care based on the balancing of their value commitments and weighing their personal circumstances, they should:
    a. Work with/support their supervisors or appropriate colleagues such that there can be a further effort towards meeting any of their unmet needs; and,
    b. Find alternatives to support patients and the system that allow them to balance their value commitments.

Organization-level leaders (e.g. Hospitals):

1. Organizations representing HCWs should give clear indication to what standard of care is expected of their members in the event of a pandemic[6]. As discharging the ethical duty to care is almost never an absolute discharge, organizations and HCWs should collaborate closely to examine activities that pose potential risks of harm. To the greatest extent possible, examinations of risk should consider all the available evidence and should be re-examined when new facts become available. In some circumstances, organizations may collectively endorse the discharge of a particular duty of care. These decisions must be communicated transparently and

[6] See: Ruderman, C., Tracy, C. S., Bensimon, C. M., Bernstein, M., Hawryluck, L., Shaul, R. Z., & Upshur, R. E. (2006). On pandemics and the duty to care: whose duty? who cares?. *BMC Medical Ethics*, *7*(1), 5.

openly in order to preserve trust in HCWs and in order to demonstrate respect for others.

2. Organizational leaders have an obligation to consider and recognize the power differentials and vulnerabilities that impact staff differently across the range of personnel who make up the healthcare workforce. The ethical duty to care that arises out of the special characteristics of health professions may justify greater expectations for certain HCWs.

3. Provide health authorities with the following guidance:

    a. HCWs have an ethical duty to provide care, even when it involves potential exposure to some risk of harm.

    b. However, when an individual HCW faces certain and significant harm to their person, such as may be the case in the absence of PPE, that duty may be discharged. This ethical duty is discharged *only* when the risk of harm to a HCW's person is certain, significant, and cannot be adequately mitigated.

    c. Willingness to work despite personal risk to themselves is a largely contextual and personal decision (e.g. caregiving duties for family members, unique personal health needs). Leaders should proactively and transparently explore this context by strategizing their workforce and seeking to identify those who face both the least and greatest risk from COVID-19.

    d. Health authorities should re-deploy HCWs who are available and willing to work despite personal risk to areas of greater need, or to relieve higher risk individuals from exposure (See: Ethics SBAR Staffing models - in draft 21 Mar 2020). Should HCWs willingness to assume the risk of harm relate to any type of service (e.g. childcare, pet care) or incentive (e.g. additional compensation), ensure all HCWs are offered options equally.

    e. Any individual HCW who decides to continue to work, despite personal risks to themselves, should do so in a fully informed manner, and should not be pressured or coerced to do so.

        i. The notion of discharging ethical duty of care—particularly in the context of risks to HCWs' personal safety—is important. Such importance illuminates the balance on which HCWs should consider immediate benefits to an individual patient with t*heir ability to care for patients in the future.* As such, organizational and system-level leaders should consider whether there are particular care activities and/or specific services that will be temporarily suspended in the context of COVID-19 on the basis that they pose too great of a risk to HCWs broadly and thus may threaten their ability to provide care in the future.

4. Respect for privacy and confidentiality is essential. As such, personal health or social information that may be disclosed during discussions between leaders and staff members must be confidential. Any form of public shaming or pressure should be avoided.

5. Governments and the healthcare sector should develop human resource strategies for communicable disease outbreaks that cover the diverse occupational roles, that are transparent in how individuals are assigned to roles in the management of an outbreak, and that are equally with respect to the distribution of risk among individuals and occupational categories[7].

System-level Leaders (e.g. Health Authorities, Provincial Governments):

1. Specific criteria should be developed to establish what constitutes an acceptable reason for duty to be discharged. These criteria should be consistently and transparently applied and special attention paid to the harms to consistency if exceptions are allowed.
    a. There should be provincial consistency in the application of these recommendations and criteria to uphold the values of *consistency* and *working together*.

2. The risks to HCWs may extend beyond physical threats to their personal safety. Threats may also include psychological, mental, and emotional harms[8]. Senior decision-makers will have to make difficult decisions about staff assignment. To do so they need to have support of the highest levels of administration, including the Ministry of Health. Ethics consultation services are available to assist with this decision making, as required.

3. Disability insurance and death benefits must be available to staff and their families adversely affected while performing their duties recognize the need for additional benefits and protections for those HCW who are more vulnerable in the healthcare system.

4. All decisions related to duty to care should be communicated openly and transparently.

[7] See: Upshur, R., Faith, K., Gibson, J., Thompson, A., Tracy, C., Wilson, K., Singer, P. (2005). Stand on Guard for Thee. Ethical Considerations in Preparedness Planning for Pandemic Influenza. A report of the University of Toronto's Joint Centre for Bioethics, Pandemic Influenza Working Group.

[8] See: Upshur, R., Faith, K., Gibson, J., Thompson, A., Tracy, C., Wilson, K., Singer, P. (2005). Stand on Guard for Thee. Ethical Considerations in Preparedness Planning for Pandemic Influenza. A report of the University of Toronto's Joint Centre for Bioethics, Pandemic Influenza Working Group.

References

Ruderman, C., Tracy, C. S., Bensimon, C. M., Bernstein, M., Hawryluck, L., Shaul, R. Z., & Upshur, R. E. (2006). On pandemics and the duty to care: whose duty? who cares?. *BMC Medical Ethics*, *7*(1), 5.

Joint Centre for Bioethics Pandemic Ethics Working Group. (2008). The duty to care in a pandemic. *The American Journal of Bioethics*, *8*(8), 31-33.

Rolls, S., & Thompson, C. (2007). Nurses' obligations in a pandemic or disaster. *Nursing New Zealand (Wellington, NZ: 1995)*, *13*(10), 27.

Devnani, M. (2012). Factors associated with the willingness of health care personnel to work during an influenza public health emergency: an integrative review. *Prehospital and disaster medicine*, *27*(6), 551-566.

Upshur, R., Faith, K., Gibson, J., Thompson, A., Tracy, C., Wilson, K., Singer, P. (2005). Stand on Guard for Thee. Ethical Considerations in Preparedness Planning for Pandemic Influenza. A report of the University of Toronto's Joint Centre for Bioethics, Pandemic Influenza Working Group.

Contributors

- Jillian Boerstler, Providence Health Care
- Bethan Everett, Vancouver Coastal Health
- Jennifer Gibson, Providence Health Care
- Julia Gill, Vancouver Coastal Health
- Bashir Jiwani, Fraser Health
- Jeff Kerrie, Vancouver Island Health
- David Migneault, Vancouver Coastal Health
- Kirsten Thomson, Northern Health
- Alice Virani, Provincial Health Services Authority

Appendix A: British Columbia COVID-19 Ethical Decision-Making Framework

COVID-19 Ethical Decision-Making Framework

Provincial COVID-19 Task Force

March 28, 2020

Table of Contents

Introduction

During a public health event, unknown and sometimes unpredictable variables may influence unfolding events throughout the duration of the episode. The BC health system's stated aim is to stay within the principles and values of the *COVID-19 Ethical Decision-Making Framework Interim Guidance* to foster transparent leadership, sound ethical Decision-Making (policy, direction, and resource allocation), and partnership across stakeholders geared towards providing consistent public information.

Public health ethics involves a systematic process to clarify, prioritize, and justify possible courses of public health action based on ethical principles, values and beliefs of stakeholders, and scientific and other information. While clinical ethics focuses on the health and interests of the individual patient, public health ethics considers the health and interests of a population, informing public health actions and decisions.

Similarly, public health ethics, especially with respect to pandemics or outbreaks, has a different focus than traditional clinical ethics. The two central dilemmas in public health ethics are:

> 1) To what degree is it justifiable for a state to intervene on privacy and personal liberties of individuals in the name of the greater good of the broader population?
>
> 2) If there are inadequate resources to adequately respond to each individual patient's medical needs, how should resource allocation decisions be made to best serve the greater population?

A disease outbreak, such as COVID-19, can lead to an extreme public health crisis where the health and safety of the population is at risk. In recognition of this risk, it is crucial to weigh the respecting of individual rights and freedoms while attempting to satisfy the needs of and protecting the broader public.

The needs of the community may outweigh the needs of individuals in such crises; personal rights and freedoms must sometimes be constrained. Any infringements on personal rights and freedoms must be carefully considered, and the least restrictive or coercive means must be sought.

In a pandemic, there are resource constraints, such as anticipated in a COVID-19 outbreak, allocation responses will aim to maximize effective use of scarce resources, such as critical supplies (like Personal Protective Equipment), and human resources.

This ethical decision-making framework, and underlying principles and values provides an interim process to support healthcare organizations and teams to make these challenging decisions in a COVID-19 outbreak.

This framework aims to ensure ethically defensible decision-making to:

1. Serve as a transparent guide for ethical decision-making before, during, and after the pandemic
2. Encourage integration of shared values into health care practices, treatment and funding

decisions
3. Contribute to improved health outcomes and service delivery, and maximize human and financial resources
4. Increase public awareness of and confidence in policy making decision processes
5. Increase public awareness and preparedness for a communicable disease pandemic

This framework does not provide detailed instructions for responding to ethical dilemmas on a case-by-case basis. Instead, it identifies the ethical principles and values that should guide ethical decision-making, strategies, and processes. Health authorities are encouraged to use this provincial framework, and consult with their local Ethics Service, to inform communicable disease pandemic planning and response activities, as well as any applicable health authority framework.

Ethical Principles & Values

In developing these ethical guidelines for Decision-Making, these principles and values are drawn from previous pandemic ethical frameworks and literature in BC and Canada. COVID-19 is a potential public health crisis, and therefore broader community-focused public health ethics form a critical component of the overall guidelines.

The ethical principles and values presented below are not ranked because, as per the Ethical Decision-Making Process below, they will need to be specified and prioritized in the context of the specific ethical issues they are used to address. In some circumstances, value-trade-offs will have to be made when it is not possible to uphold all values. In these situations, it will be important to justify these trade-offs and prioritizations.

The key ethical principles and values that underpin this framework are:

- **Respect:** To whatever extent possible, individual autonomy, individual liberties, and cultural safety must be respected. This means respect for privacy and confidentiality, and an obligation on behalf of leaders and care providers to be truthful and honest to individuals affected.
- **The Harm Principle:** A society has a right to protect itself from harm, real or threatened. The government is justified in intervening and possibly impinging on the rights of individuals to protect the community from harm.
- **Fairness:** Everyone matters equally but not everyone may be treated the same. There are three competing forces in fair delivery of care and services that must be balanced. Persons ought to have equal access to health care resources (*equality*), however:
    - Those who most need and can derive the greatest benefit from resources ought to be offered resources preferentially (*equity*), and
    - Resources ought to be distributed such that the maximum benefits to the greatest number will be achieved (utility, and *efficiency*) and
    - Resource allocation decisions must be made with *consistency* in application across populations and among individuals regardless of their human condition (e.g. race, age,

disability, ethnicity, ability to pay, socioeconomic status, pre-existing health conditions, social worth, perceived obstacles to treatment, past use of resources).

- **Least Coercive and Restrictive Means**: Any infringements on personal rights and freedoms must be carefully considered, and the least restrictive or coercive means must be sought.
- **Working together:** Cooperation is essential to this international threat – between individual citizens, health regions, provinces, and nations.
- **Reciprocity:** If people are asked to take increased risks, or face increased/disproportionate burdens during a pandemic influenza, they should be supported in doing so, and the risks and burdens should be minimized as far as possible.
- **Proportionality:** Measures implemented, especially restrictive ones, should be proportionate to and commensurate with the level of threat and risk.
- **Flexibility:** any plan must be iterative and adapted to new knowledge that arises.
- **Procedural Justice**: There will be accountability to a fair and transparent process throughout the planning and implementation of managing COVID-19.
    - *Openness and transparency:* Any planning, any policy, and any actions deriving from such policies, must be transparent and open to stakeholder input as well as available to public inspection. All plans and all decisions must be made with an appeal to reasons that are mutually agreed upon and work toward collaboratively derived goals.
    - *Inclusiveness:* This means that those making decisions should:
        - Involve people to the greatest extent possible in aspects of planning that affect them.
        - Decision makers should take into account all relevant views expressed.
        - Work to make sure that particular groups are not excluded from becoming involved. Some people may find it harder to access communications or services than others, and decision-makers should consider how they can express their views and have a fair opportunity to get their needs for treatment or care met.
        - Take into account any disproportionate impact of the decision on particular groups of people.
    - *Accountability:* This means that those responsible for making decisions may have to justify the decisions that they do or do not make.
    - *Reasonableness:* This means that decisions should be:
        - Rational
        - Not arbitrary or based on emotional reactivity
        - Based on appropriate evidence, available at the time
        - The result of an appropriate process, taking into account how quickly a decision has to be made and the circumstances in which a decision is made
        - Practical - have a reasonable chance of being feasible to implement and to achieve their stated goals

Ethical Decision-Making Process

The following is a simplified ethical Decision-Making process:

1. Define the Issue
    - What is the issue or problem? This question begins the very important process of reaching consensus about what the issue actually is.

2. Clarify the Facts as much as Possible
    - What are the established facts of the issue? (i.e. The Who, What, When, Where, Why, and How?)
    - What we do not know?
    - What are the relevant factors?

3. Identify Stakeholders and their Perspectives
    - Who is affected by this decision?
    - How does each stakeholder see this issue and what is motivating their perspective?

4. Identify and Analyze the Principles and Values
    - What are the principles and values pertaining to this decision?
    - Determine principle and value conflicts: What values are being affirmed? What values are being negated?
    - Identify and prioritize the principles and values that will be upheld

5. Identify Alternative Courses of Action in Light of the Values
    - What are all of the options (including doing nothing)?
    - What are the pros and cons of each option (including intended and unintended consequences) - as measured against the prioritized values?

6. Make a Decision
    - Which option best fulfills the principles and values identified?
    - Are there contingency plans in case the decision does not have the intended outcomes, or creates possible conflicts?

7. Implement the Decision
    - Who will implement the decision? How and when will the decision be communicated to all stakeholders?
    - What process and criteria for measuring will be used to evaluate the decision and outcome?

8. Review and Document the Decision
    - Who will be responsible for documenting, following-up and maintaining the decision?
    - How will the decision be effectively communicated to all relevant stakeholders?

Checklist of Values for Evaluating Options and Articulating a Decision

This is a tool for analyzing a draft solution against key values in the context of a pandemic, and for improving the solution to better live up to these values. The prioritized values are drawn from previous public health ethics work done in BC, from the Ebola and Pandemic Flu contexts.

Step 1: Name the question or COVID-19 related issue you are trying to address.

Question/issue _____?

Step 2: Review the list of values and build a solution that tries to live up those values.

Solution_____

Step 3: Review the proposed solution against the listed values below. Complete the 'YES', 'NO', 'ONLY IF' and 'N/A' columns.

Step 4: Check to see whether the solution meets higher-ranking values over lower-ranking values.

a. If it does, go to Step 5.
b. If it does not, revise the solution to ensure the higher-ranking values are met and then go to Step 5.

Step 5: Check to see whether the solution lives up to all of the core values.

a. If it does, congratulations, and move forward!
b. If it does not, revise the solution to ensure as many of the core values are met as possible, then go to Step 6.

Step 6: If any of the core values remain unmet, articulate which of these are unmet and why it is important to move forward even though we cannot live up to our core values in this case.

Step 7: Articulate your final decision and rationale and then implement your decision.

Priority	Value Theme	Does the proposed solution…	YES	NO	Only if…	N/A
1	**Public safety**	Minimize the net harm to the public, (including through the spread of disease, disruption to essential activities and services, etc.)				
1	**Care Provider Safety, Well-Being and**	Minimize risk to the affected health care providers of other harms to their health and wellbeing, including managing moral distress				

Priority	Value Theme	Does the proposed solution…	YES	NO	Only if…	N/A
1	Sustainability (Reciprocity)	Minimize risk to affected health care providers of being exposed to COVID-19				
1		Expose as few people as possible to patients with COVID-19 symptoms				
1	Justified Decision-Making	Align with and have the support of decisions provincially and federally				
1		Reflect the best available evidence and ensure assumptions made are well grounded and defensible				
1		Live up to the established core values for COVID-19 planning and management, consistent with other decisions we have made				
1	Proportionate Restriction	Minimize restriction or coercion as much as possible, commensurate with the level of risk to broader wellbeing				
1	Fair Accountability, Respect for patients and families	Enable messages sent from the province/health authority to be clear and consistent and provide reasons why the decision has been made				
1	Equity, Respect for patients and families	Lead to engaging patients suspected to have COVID-19 and their families in a way that is respectful and mindful of power dynamics and life circumstances				
1	Patient Wellbeing	Respect the privacy of the patient and their family				
1		Minimize the turnaround time for diagnosis				
1	Trust	Enable greater trust of the province/health region by the public				
1		Enable greater trust between system and staff				
2	Consistency	Align with the broad approach within the health authority, across the province and other health authorities?				
2	Duty to Care	Assist our care teams to understand their responsibility (duty) to provide care and live up to this even when it involves exposure to some risk of harm				
2	Equity	Ensure all patients who present with COVID-19 symptoms receive a consistent level of care, regardless of where they present				
2	Integrity	Enable clarity about what interventions will and will not be offered and the rationale for these decisions				
2	Justified Decision-Making	include transparency about the approach taken to all those affected by it				
2	Patient Wellbeing	Ensure patients with COVID-19 symptoms are given the best care (not necessarily treatment) possible				
2		Prevent patients from coming to preventable harm while waiting for a diagnosis of their illness				
2		Ensure non- COVID-19 related patients continue to receive appropriate and timely care				
3	Patient Wellbeing	Ensure decisions about care are made based on the values and beliefs of patients				
3	Respect for colleagues	Enable care providers to treat each other with kindness, care and compassion				

Priority	Value Theme	Does the proposed solution…	YES	NO	Only if…	N/A
		Enable care providers to communicate in an informed, thoughtful way				
3	**Respect for patients and families**	Ensure that where someone is impacted by a decision, they are given the reasons for the decision and have opportunities for responding and, where appropriate, appealing the decision through the appropriate channels				

References

British Columbia. Ministry of Health (2012). British Columbia's Pandemic Influenza Response Plan: An ethical framework for Decision-Making: Supporting British Columbia's pandemic influenza planning and response. Retrieved from: https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/bc-pandemic-influenza-ethics-framework-2012.pdf

British Columbia. Ministry of Health. Office of the Provincial Health Officer. (2015). Ebola Virus Disease Ethical Decision-Making Framework. Retrieved from: https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/ebola-virus-disease-ethical-decision-making-framework.pdf

British Columbia. (2017). Responding to British Columbia's overdose public health emergency – An ethics framework. Retrieved from: https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/overdose-public-health-emergency-ethics-framework-march-2017.pdf

Centers for Disease Control (CDC), https://www.cdc.gov/os/integrity/phethics/index.htm (accessed March 17, 2020).

Jiwani, B. (2015). Ethically justified decisions. *Healthcare Management Forum*, *28*(2), 86–89. https://doi.org/10.1177/0840470414562663

Jiwani, Bashir. (2013). Ethics-based decision process: An evidence and values-based process for working through specific issues. Retrieved from: http://incorporatingethics.ca/wp-content/uploads/2016/11/Fraser-Health-Ethics-Based-Decision-Process-fancy.pdf

Upshur, R., Faith, K., Gibson, J., Thompson, A., Tracy, C., Wilson, K., Singer, P. (2005) Stand on Guard for Thee. Ethical Considerations in Preparedness Planning for Pandemic Influenza. A report of the University of Toronto's Joint Centre for Bioethics, Pandemic Influenza Working Group. Retrieved from: http://www.jcb.utoronto.ca/people/documents/upshur_stand_guard.pdf

Alberta Health Services, "Alberta's Ethical Framework for Responding to Pandemic Influenza", 2016 https://open.alberta.ca/dataset/5ae20e2c-4d4a-4251-bf05-dcdf32d0cd97/resource/5621dbe3-4b27-4c37-9073-58d762312d6f/download/apip-pandemic-ethics-framework-2016.pdf