INTRODUCTION

Nurses in America have protested the treatment (or lack thereof) for their own who are stricken with Ebola and the lack of preparedness in the U.S. for this disease (Demoro, 2014; National Nurse, 2014), which is the new AIDS or Avian Flu of the 21st century. The West and U.S. are now forced to confront the killer that they had previously responded slowly to and mismanaged (Ebola: a failure of international collective action, 2014). We have seen media-fueled over-reaction and stigmatization directed toward American nurses and doctors struck with the disease, as was the case in the AIDS era. Unnecessary quarantining of health care professionals believed to be possibly infected with the virus highlights the need for education – of the public, public health and government systems as well as health care providers. Recent articles in *The National Nurse* (2014) highlight the controversy and the push to stop blaming the nurse victims. Nurses may be understandably afraid of getting infected by this highly lethal disease of which much is still unknown, and consider refusal to care for Ebola patients.

An issue that warrants addressing is whether nurses have a duty to treat (DTT). What does society owe nurses and what do nurses owe society? Literature review does not provide many arguments for or against DTT. It seems--as with most ethical issues--to be multifaceted and with few precedents. There are logical limits to DTT expectations, including when the nurse's life is truly endangered. But what constitutes significant risk? In the 1980's during the HIV-AIDS epidemic in the U.S., and only ten years ago during the Avian flu epidemic in Toronto, many nurses refused to care for patients (Sokol, 2006). There are unknowns regarding the transmission of Ebola. And even when risks are known, it is difficult to educate away fear and prejudice. I experienced much resistance as a staff educator in the 1990's teaching about AIDS and infection control, in spite of the fact that the chance of contracting HIV with a needle stick is 0.4% or less

ETHICAL FRAMEWORKS

Nurses in other states are left to make those decisions independently, hopefully in consultation with their profession's code of ethics, which are general and vague; it is up to nurses to use their own judgment. Two themes that emerge related to DTT are social contract and moral obligation, as well as risk-benefit considerations. Codes of ethics for nurses mandate a duty to treat if the risk is low, but they are not legally binding (Brewer, 2010; Malm et al., 2008).

Beauchamp and Childress' (2012) *Four Principles* of biomedical ethics are basic guidelines that leave room for individual choices in decision-making in such cases

Respect for autonomy: respecting decision-making abilities of autonomous persons and enabling them to make informed choices.

not causing harm; the healthcare professional should not harm the patient beyond what may be inherent in treatment.

Justice: applying fairness concepts to the distribution of benefits, risks and costs; treating everyone equitably.

the balancing of benefits against the risks and costs of treatment; the healthcare professional should perform care so that the patient benefits.

Beneficence appears to be the most logical ethical principle with which to argue a DTT. Yet, nurses are left to weigh the 480dh

exclusions have been offered such as pregnancy. However, nurses have expressed a sense of unfairness that people without families were expected to care for the infectious patients while others were

Beauchamp, T.L. & Childress, J.F. (2012). *Principles of Biomedical Ethics*, (7th Edn). New York: Oxford University Press.

Bensimon, C., Tracy, C., Bernstein, M., Shaul, R.,& Upshur, R.