



Nurses' role model duties for health and COVID-19 pandemic precautions

Nursing Ethics
2023, Vol. 30(2) 210–221
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DOI: 10.1177/09697330221128904
journals.sagepub.com/home/nej



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Abstract

Role modelling communicates a standard of behavior to another person. Silent role modelling occurs when this standard can be communicated without articulating reasons for the action; articulate role modelling occurs when it is necessary to articulate reasons in order to effectively role model the standard of behavior, and to avoid misinterpretation. Nurses are role models in virtue of the respect and admiration given to the nursing profession. As such, nurses have role model obligations. This paper examines nurses' role model obligations for healthy behaviors and pandemic precautions. Research often identifies nurses as role models for healthy behavior, despite the fact that nurses are typically no healthier than the general population. This paper argues that nurses do not have a duty to role model healthy behaviors. The ability to adopt healthy behaviors is affected by numerous personal and individual factors. For a nurse to share their struggles to adopt healthy behaviors as articulate 'imperfect' role models violates their right to privacy. By contrast, nurses do have a moral duty to role model pandemic precautions during the COVID-19 pandemic, such as correctly wearing appropriate masks, maintaining social distancing, avoiding gatherings of multiple households when pandemic precautions are not being taken, and staying up to date on vaccination. Nurses' duty to role model pandemic precautions does not involve sharing any personal information. Nurses have a duty to be silent role models when the risk of misinterpretation is low, and a duty to be articulate role models, who explicitly communicate reasons for the role modelled behavior, when necessary to ensure they are not misinterpreted. When articulate role modelling goes beyond the minimal role modelling duty, and imposes a comparative cost to the nurse, articulate role modelling is not obligatory, but supererogatory.

Keywords

role model, health promotion, nursing, COVID-19, supererogation, masking

Introduction

Nurses are role models in virtue of the respect and admiration given to the nursing profession. This article examines what role model obligations nurses have for healthy behaviors and pandemic precautions. It argues

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that nurses do not have role model obligations to promote healthy behavior; but do have moral obligations to role model all required and recommended precautions during the COVID-19 pandemic. Section two provides background on how nurses act as role models during the COVID-19 pandemic and how nurses are described as role models for healthy behavior in the academic literature. Section three analyzes the philosophical literature on role modelling, including the different types of role models and how role models are selected. Section four argues that nurses do not have a duty to role model healthy behavior because doing so violates nurses' right to privacy. Section five finds that nurses do have a duty to role model pandemic precautions, such as correctly wearing appropriate masks, maintaining social distance, avoiding gatherings of multiple households without proper precautions, and staying up to date on vaccination, and considers when role modelling is obligatory, and when it is supererogatory. Section six identifies implications for research, education, and for healthcare organizations to facilitate nurses' role model obligations.

Background

Throughout the COVID-19 pandemic, nurses performed work that society labelled 'heroic.' Nurses provided care in the early days of the pandemic despite not being provided with sufficient personal protective equipment.^{1,2} Nurses struggled to care for patients whose friends and families could not visit,³⁻⁵ and adapted their personal lives in a variety of ways to limit the risk to their own families while continuing to work.^{6,7} Nurses have done all of this while public figures spread dangerous misinformation about COVID-19, vaccinations, alternative 'treatments,' and the severity of the virus. Conspiracy theorists in several countries even sought to enter isolation units to 'prove' what was really going on.⁸

The COVID-19 pandemic has taken a heavy toll on individual nurses and the profession of nursing. Nurses have suffered from worsening mental health,^{9,10} post-traumatic stress disorder^{11,12} and burnout,¹³⁻¹⁶ and many have left nursing as a result. These are not new problems, but existing problems exacerbated by the pandemic and the decisions of hospitals and governments. Despite this, nurses have continued to use their role to push governments, communities, and individuals to take precautions to prevent the spread of COVID-19, such as correctly wearing appropriate masks in public places, maintaining social distancing, avoiding large gatherings, and getting vaccinated. Nurses have thus been role models for pandemic precautions during the COVID-19 pandemic.

The research on nurses as role models focuses on promoting healthy behavior through role modelling. Darch et al. finds that "Being a role model in health promoting behaviour involves being an exemplar, portraying a healthy image (being fit and healthy), and championing health and wellness."¹⁷ As many studies have noted, though, nurses are often no healthier than the general population.¹⁸⁻²⁰ Wills et al. argues that "Nurses who engage in unhealthy behaviours may be less willing to intervene and offer health promotion advice...and patients appear less likely to follow advice given by unhealthy nurses."²¹ However, Kelly et al. found that there is no "conclusive evidence that there is a relationship between nurses' personal health behaviour and their health promotion practice."²² Further complicating this picture, nurses sometimes use 'negative' or 'imperfect' role modelling, in which they share their own struggles with maintaining healthy behaviors with patients as a way to promote healthy behavior.^{17,22-24}

The Nursing Midwifery Council (NMC),^{17,21} the International Council of Nursing (ICN),^{17,21 22,25} and the American Nursing Association (ANA)^{18,25} are all frequently cited as the source of the expectation that nurses be role models for healthy behaviors. In their most recent codes of ethics, the ICN does not mention role modelling at all,²⁶ and the NMC states only that nurses should "act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to."²⁷ In the NMC's Standards of Proficiency for Registered Nurses, the expectation is only that nurses "act as a role model for others in providing high quality nursing interventions."²⁸ Provision five of the ANA's Code of Ethics focuses on the nurses' duties to self and others, "including the responsibility to promote health and safety."²⁹

Provision 5.2 states, in part, “Nurses should model the same health maintenance and health promotion measures that they teach and research.”²⁹ While this provision is in the context of a duty to self-care, the requirement that nurses *model* health maintenance and promotion seems to show a greater concern with nurses’ impact on others, than with nurses being healthy for their own sake. The “Healthy Nurse, Healthy Nation” initiative, sponsored in part by the ANA, is more direct, noting that “nurses are more likely to be overweight, have higher levels of stress, and get less sleep,” and urges nurses to improve their mental health, physical activity, nutrition, rest, quality of life, and safety, in order to serve as role models for others, and to promote healthy behaviors in the general population.³⁰

While these nursing organizations do not seem to align on whether or in what ways nurses should be role models, nurses often report seeing themselves as role models for healthy behaviors.^{18,19} A deeper analysis of role modelling and the duties of role models can clarify the scope of nurses’ responsibilities as role models for both healthy behaviors and pandemic precautions.

An analysis of role modelling

Role modelling is about communication – the role model seeks to communicate some standard of behavior or action to others through a demonstration of the action and an explanation of the reasons for the standard. Robert Audi describes role modeling as “doing something appropriate to a role, in circumstances to which it is appropriate, and perceptibly to someone who is a candidate for acquisition or reinforcement of the role in question.”³¹ The standard of behavior or action may be moral standard – for example, role modelling telling the truth when doing so contradicts one’s own interests – or it may be a professional standard, such as when a veteran wide receiver in American football role models correct route running for rookie teammates.

Edmund Erde distinguishes between articulating role models, who give reasons for their actions, and silent role models, who are “silent about their reasons for deciding how to act and might not even think about serving as a model.”³² A nurse is a silent role model when they demonstrate to a nursing student or new nurse the proper procedure for donning personal protective equipment (PPE) prior to entering a COVID-19 patient’s room, and an articulating role model when they also provide an explanation of the reasons for doing so. Good role models perform actions according to the correct standard and provide good reasons for the action. Nurses are good role models when they explain how the PPE will protect both the nursing student and the patient from infection, but poor role models if they simply say, “It’s hospital policy, so we have to do it.”

The process of role modelling aligns with Albert Bandura’s social learning theory. Wouter Sanderse notes that Bandura found “that a considerable amount of learning takes place through a process in which children learn behaviours, attitudes, values and beliefs by observing others and the consequences of others’ actions.”³³ Further, Bandura found it important that reasons be given for the actions and behaviors one models. Sanderse explains, “According to Bandura, this more cognitive kind of modelling works particularly well in situations when it is difficult to learn by observation only, for example in cases when teachers’ thoughts are not adequately reflected in their actions.”³³

Erde finds similar drawbacks to silent role-modeling: “First, without an account of a behavior there are too many variable interpretations of it available, and no one could automatically tell which features of the case motivate or direct the role-model.”³² If a nurse is silent about the reasons for donning PPE prior to entering a patient’s room, the nursing student is left to interpret the nurse’s behavior – was it because the patient had COVID-19 or some other condition? Was it related to a specific treatment the patient was receiving? Without communicating the reasons for donning PPE, the nursing student “is not in a position to know when she has *the same* (type of) case or is doing the same thing that her model did” when the nursing student acts on their own in the future.²⁴ Another problem with silent role modelling is that “tacit modelling fails to subject each view to the test of public review, both of its logic and of its values.”³² In this scenario, the nursing student is not in a position to judge the reasonableness of the nurse’s actions if the nurse does not communicate the

reasons for taking it. This makes it difficult for the nursing student to determine whether the nurse is in fact a good role model.

In practice, role modelling is about relationships. A good role model is one who understands when to explain the reasons for performing an action, when to question the learner about the reasons, and when the reasons for the action are evident even when remaining silent. A role model who always explains the reasons for frequently performed actions may become tedious and easy to ignore, while a role model who never explains the reasons may have their actions misinterpreted. Summing up the literature on how nurses perceive role models for healthy behavior, Darch et al. find that role models are “caring, non-judgmental, trustworthy, inspiring, self-aware and self-caring.”¹⁷ A role model must establish a good relationship with the learner in order for either silent or articulate role modelling to be effective. Thus, someone who performs the right actions, regardless of whether they explain the reasons behind those actions, is not an effective role model if they are not viewed as caring, trustworthy, or inspiring by others.

In a healthcare setting, a nursing student or a less-experienced nurse may select a role model based on these characteristics, in addition to seeing that the role model has, and at least sometimes articulates, accurate reasons for their behaviors. Outside a healthcare setting, nurses may be seen as role models for the general public. Linda Zagzebski argues that moral exemplars are “persons who are *most imitable*, and they are most imitable because they are most admirable. We identify admirable persons by the emotion of admiration.”³⁴ Zagzebski argues that moral exemplars are identified in the same way that people identify other substances. One does not need to know, for example, that water is H₂O or that the melting point of gold is 1,064 degrees Celsius, in order to identify an object as water or gold. Similarly, “Good persons are persons *like that*, just as gold is stuff *like that*. Picking out exemplars can fix the reference of the term ‘good person’ without the use of descriptive concepts. It is not necessary for ordinary people engaged in moral practice to know the nature of good persons.”³⁴ Nurses have been ranked first in a survey about professions with high honesty and ethics for 20 consecutive years in a Gallup poll of people in the United States.³⁵ Similarly, a Maru public opinion poll of people in the United States from 2021 found nurses to be the second most respected profession, trailing only firefighters.³⁶ Thus, acquaintances, friends, family, and the public generally may select individual nurses, or nurses in general, as role models because they are admired for belonging to a profession that is widely respected and seen as honest and ethical. They may do this even if they do not know what the proper features of a role model are, or any particular nurse who possesses them.

The scope of the nurse as a role model falls under what Earl Spurgin refers to as particularism, in which “one’s role-model status applies only to one’s particular field. Such status entails that one’s role model obligations extend only to the virtues associated with one’s field.”³⁷ This role-model status is voluntary insofar as becoming a nurse is voluntary. When an individual joins the nursing profession, they are likely to be admired by the general public, and hence seen as a role model for behaviors related to their role as nurses. By contrast, generalism “extends role-model obligations further into the lives of role models.”³⁷ This type of role model communicates a much broader array of values than role models in the particular sense. For example, someone may admire a famous singer for their lyric-writing and vocal skills and seek to imitate not just their singing, but their entire lifestyle – the clothes they wear, their mannerisms and language, and to seek out the things the singer values. Nurses are role models in the narrower, particularism sense – their behaviors related to health and wellness may be imitated, but one does not, for example, see the general public seeking to imitate the fashion of nurses by wearing scrubs in their daily life.

Nurses are not obligated to role model healthy behavior

The research on nurses as role models often focuses on healthy behaviors, especially those related to diet, exercise, and smoking. However, research consistently finds that nurses are no healthier than the general population.^{18–20} This should not be surprising. Nurses are subject to the same pressures and barriers to

adopting healthy behaviors as the general population, which can include lack of access to affordable, healthy foods; lack of knowledge, time or energy to prepare healthy foods; lack of access to spaces in which to exercise; lack of time or energy to exercise; stress from work, from caring for friends or family, or from experiences of racism; and health conditions or disabilities that make obtaining or preparing healthy foods and exercising difficult. Nurses have also cited stressful work environments, shift work with long hours, and lack of organizational support as barriers to nurses' health.²³ None of these factors are observable by patients or the general public; yet nurses who appear overweight are presumed not to be good role models, regardless of what factors influence their appearance. Further, even when nurses are observed performing healthy or unhealthy actions, there is no way to connect these actions with their overall health. Observing an overweight nurse eating a donut, for example, does not necessarily demonstrate unhealthy behavior, given that this may be the first donut the nurse has eaten in a month, the 12th donut they have eaten in the last 2 days, or the only thing they had time to grab from the breakroom because poor staffing and high patient loads meant that they did not take a lunch or full break, or were mandated into working a double shift.

Consider, then, a nurse who offers education about the type of diet and exercise regimen that would improve the health of a diabetic patient. In order for this to be role modelling, rather than simply teaching, the nurse must demonstrate how to eat a healthy diet. As Audi points out, "role modeling is not possible simply by stating the relevant standards of action – say, by presenting them in a peptalk."³¹ But at the bedside, nurses cannot role model a proper diet – they cannot, for example, have lunch at the patient's bedside so the patient can watch them eating a nice, healthy salad, or invite the patient to join them after work for yoga or a jog. At most, nurses can relay their own stories about how they incorporate healthy foods into their diets and make time for exercise, or how they have struggled to do so thereby empathizing with the patient's own struggles.^{17,22–24} For example, nurses might describe how they have struggled to budget money to afford healthy foods, what community resources, such as food pantries, they have used, or ways they tried to balance commitments to family and friends in order to find the time and energy to exercise.

But sharing these details of nurses' personal lives goes far beyond what the duty to role model can require. Spurgin argues that the value of privacy limits the obligations of role models: public figures "do not automatically choose to share their lives with fans, students, or whomever their roles touch. They automatically choose, instead, to share things such as their talents, skills, and knowledge with those others."³⁷ Even though nurses take on a duty to role model when they become nurses, they are not automatically obligated to share the details of their personal lives with patients, family, friends, or the general public. But nurses' health behaviors, and the factors that influence them cannot be demonstrated without doing so. Thus, the only way for nurses to effectively role model healthy behaviors, or the struggles that they have experienced in trying to maintain healthy behaviors, is to share their own personal, private lives with patients or the general public.

Spurgin argues that privacy is important for a variety of reasons, including the ability to demarcate one's relationships and control with whom one is intimate, and to develop one's own identity in a private space where one is free from fear of judgment.³⁷ The value of privacy, then, is central to human identity and flourishing. If nurses as role models are obligated to share their personal lives with patients or the general public, including what they eat, how they spend their time away from work, how stressful relationships, work environments, or experiences of racism impact their ability to eat a healthy diet and exercise, and what genetic, social, or economic factors influence their appearance, then they lose the ability to control with whom they are intimate. The duty to role model does not justify this intrusion into nurses' private lives.

Nurses should of course provide education to patients and attempt to encourage them to adopt healthy lifestyles. But the duty of health promotion does not entail a duty to role model healthy behaviors. This is clear when one considers the impossibility of demonstrating healthy behaviors without sharing stories with patients that violates nurses' right to privacy. Nurses may choose to do so, but are not obligated by any role modelling duties to share aspects of their private lives that may touch on their personal circumstances or ability to adopt and maintain healthy behaviors. Kelly et al. notes "a range of themes to describe how nurses who engage in

unhealthy behaviours view their role in encouraging behaviour change, including hypocrisy, guilt, cognitive dissonance, and anxiety about being challenged,” as well as “feeling subjected to others’ disapproval.”²² The conclusion that nurses do not have role model duties for healthy behaviors may alleviate the concern some nurses report about not ‘practicing what one preaches.’

Nurses’ obligation to role model pandemic precautions

Role modelling pandemic precautions differs from role modelling healthy behaviors in two important ways. First, many pandemic precautions are immediately observable. One can determine, at a glance, whether someone is correctly wearing an appropriate mask, or maintaining social distancing. Second, pandemic precautions are immediately effective after a single choice. One’s choice to don a mask provides immediate protection against being infected, or infecting others with COVID-19. Role modelling this pandemic precaution, then, does not require repeated observations of the nurse, or a deeper understanding of the nurse’s personal life or situation. By contrast, eating a healthy salad for lunch does not immediately make one healthy or give one a healthy appearance, nor does it indicate whether a person has, more generally, adopted healthy behaviors. In order to understand the action of eating a healthy salad as role modelling, one must understand how that salad fits into a person’s overall life and health. As argued earlier, this interferes with the role model’s right to privacy. By contrast, role modelling pandemic precautions, such as masking and social distancing, produces immediate results without the need for such intrusions into the role model’s private life.

The selection of role models is based in part on appearance. To create an appearance or body image that is seen as healthy may require months or years of struggle, and is influenced by many factors outside of an individual’s control. By contrast, one can correctly put on an appropriate mask in a few seconds. There may be social barriers to pandemic precautions in places where these precautions are widely ignored or have become politicized. Wearing a mask may expose one to stares or criticism, and strain relationships. But these difficulties, while real, are a matter of public opinion, which is precisely what good role modelling can change.

Another significant difficulty is the changing nature of the pandemic, as case levels and hospitalizations ebb and flow with each wave, and as different variants of COVID-19 make certain precautions more or less important. Part of the duty of being a role model during a pandemic is to stay abreast of what the science and best practice indicates. Nurses are perceived to be role models precisely because the general public expects that they will know and understand best practice, and nurses’ role modelling can be effective in communicating to others what best practice is at any given point during a pandemic. This includes following both recommended and required pandemic precautions. For example, public health bodies, such as the Center for Disease Control (CDC), may only be able to recommend that masks be worn in indoor, public settings or on public transportation. Nurses have a duty to role model these recommended behaviors, even though they are not required.

As silent role models, nurses communicate proper behavior during the COVID-19 pandemic by understanding and following evidence-based recommendations and requirements from organizations like the CDC, and doing so for the right reasons. While everyone has a moral obligation to wear appropriate masks correctly to prevent transmission of COVID-19, nurses have a duty to role model this behavior. Thus, nurses who wear an appropriate mask correctly prior to entering a public, indoor setting, fulfill both a general moral obligation and a role model obligation that is specific to nurses. The nurse may be recognized as a nurse, and hence as someone whose pandemic precautions are worthy of imitation, because they are wearing scrubs on public transportation on the way to work, or because they are well-known in their community as a nurse. Articulating role models are those who communicate the reasons for the behavior they are exhibiting. This does not mean that a nurse who gets on a bus wearing an appropriate mask needs to announce their reasons for doing so. As noted above, part of being a good role model is knowing when it is appropriate to provide reasons

for one's behavior, and when remaining silent can still effectively communicate the standard of behavior the role model is demonstrating.

Consider, then, a nurse who is invited to attend a large, indoor gathering of family and friends during a period of high transmission of COVID-19 in the community. A nurse who declines the invitation may act as a silent role model, showing through their behavior that these types of gatherings violate moral duties not to infect others with COVID-19 and not to strain healthcare workers with additional hospitalizations. A nurse who declines the invitation, and gives public health reasons to the host for doing so, is an articulate role model. A nurse who articulates their reasons for not attending ensures that the host, and anyone with whom the host shares this information, knows the public health rationale for not attending. A silent role model is more easily misinterpreted – perhaps the nurse didn't attend because they don't like the host or some of the other guests, or perhaps they were too stressed out from working during the pandemic to feel like attending a party.

If silent role modelling is likely to be misinterpreted, the nurse in this scenario has a minimal duty to articulate the public health reasons for not attending, or to offer suggestions on how to make the event safer. But this may also strain the nurse's relationship with the host, or with others who decide to attend the event with no precautions in place. Many people have found it difficult to maintain relationships during the COVID-19 pandemic.³⁸ Nurses who have worked through the COVID-19 pandemic may find it difficult to maintain relationships with family and friends who believe or spread misinformation, or who refuse to take pandemic precautions. Are nurses nevertheless obligated to act as articulate role models, even when doing so will further strain or damage important relationships?

Spurgin argues that role model obligations can be limited by a person's need for privacy, which enables one to "demarcate one's relationships" and "control with whom one is or is not intimate."³⁷ Articulate role modelling may require, or lead to, nurses sharing experiences with COVID-19 pandemic that has been stressful or even traumatizing with family and friends – the very people with whom one ought to be able to count on for support – but who nevertheless ignore or discount the harms nurses have experienced. Privacy, which the nurse maintains by being a silent role model, thus enables the nurse to control with whom they are intimate. Given that articulate role modelling may alienate nurses from important relationships and infringe on their need for privacy, it seems that articulate role modelling may, in certain circumstances, not be obligatory, but supererogatory.

J.O. Urmson³⁹ argues that supererogatory actions are actions which are good, but not morally obligatory. To illustrate this, Urmson describes a live grenade falling into a room with five soldiers, one of whom jumps on the grenade to save the others' lives. This act was not morally obligatory – the other soldiers did not fail in their moral duty by not jumping on the grenade. But the act is clearly morally good – thus, it is supererogatory.

While the concept of supererogation is debated,⁴⁰ Urmson's example illustrates that supererogatory actions typically come at a cost or harm to the person performing them. Claire Benn⁴¹ argues that what is important is not the absolute cost – the life of the soldier in Urmson's example, or the nurse's strained relationships with family and friends in the previous example – but the comparative cost. Benn explains, "The notion of cost...represents a comparative reduction in those things that are valuable or make life go well...Some costs might be subjectively determined, while some are clearly more objective."⁴¹ Supererogatory acts carry a cost greater than that imposed by one's minimal moral duties.

In some cases, nurses' minimal role model duties may require articulate role modelling. For example, a nurse who takes on the role of a preceptor for a nursing student or a new nurse has a minimal duty not only to role model correct procedures for donning PPE prior to entering a COVID-19 patient's room, but also to articulate the reasons for doing so. Articulating reasons, at least some time throughout the preceptorship, is a minimal duty of role modelling because role modeling cannot be effectively carried out silently. The time it takes to articulate reasons may impose a cost on the nurse. But this is just part of the cost of fulfilling the nurse's minimal duties to effectively role model. Thus, articulate role modelling in this case is not supererogatory.

Similarly, a nurse may fulfill their minimal duty as a role model for family and friends when they get vaccinated and communicate their vaccination status to others, either in conversation or on social media. Here, silent role modelling is insufficient, since it is impossible to communicate one's vaccination status silently. Thus, even if communicating their vaccination status to others puts a strain on relationships with anti-vaxxer friends or family, this is still morally required as a minimal duty of the nurse as a role model. Nurses may fulfill their minimal duty by, for example, posting a picture of their vaccinated arm on social media along with some important reasons for getting vaccinated, or by sharing their vaccination status and reasons in conversation. If this strains relationships between the nurse and the nurse's anti-vaxxer friends or family, then this cost is part of the minimal duty of articulate role modelling. Note that the minimal role modelling duty, which in this case requires articulation, does not impede on the nurse's right to privacy. While the *effect* of articulation may alienate anti-vaxxer friends or family, the articulation itself does not require the nurse to share deeply personal information, thereby taking away the nurse's choice about with whom to be intimate.

By contrast, consider the nurse who declines an invitation to a large, indoor gathering during a period of high transmission of COVID-19. Role modelling is about relationships, and so the nurse must judge whether silent or articulate role modelling is necessary to communicate the importance of not holding such events, or designing them around pandemic precautions. The nurse's minimal role modelling duty is to ensure that the host understands the public health reasons for taking pandemic precautions. If the nurse has already articulated these reasons to the host, it may not be necessary to do so again, and silent role modelling fulfills the nurse's role modelling duty. If the nurse decides, despite the additional strain this may put on the relationship, to articulate the reasons for taking pandemic precautions one more time, then the nurse goes beyond their minimal duties, and their articulate role modelling is supererogatory. It is supererogatory because the cost of articulating reasons for refusing the invitation go beyond what was necessary to fulfill the nurse's minimal duties of role modeling. This means that while it may be morally better for the nurse to articulate reasons, the nurse's role modelling obligation can be fulfilled silently.

Nurses' duty to role model pandemic precautions extends to social media. Knowing that others might draw lessons about the safety of certain activities during the COVID-19 pandemic based on what nurses post on social media requires nurses to be careful about role modelling pandemic precautions. Suppose, for example, a nurse posts pictures of a gathering they attended with family and friends. The pictures may not reveal whether the event was held in a stuffy, enclosed space, a well-ventilated space with air filters, or outside at an open-air pavilion; they will not show whether attendees were required to be up to date on vaccination or provide a negative test result. If the nurse decides to attend an event at which pandemic precautions are taken, then the nurse has a minimal duty to articulate those precautions when posting pictures about the event in order to avoid providing misinformation, and to avoid misinterpretations that may result from silent role modelling. The nurse's role modelling duties cannot be fulfilled silently. Thus, even if articulating reasons comes at a social cost, nurses' minimal role modelling duty requires articulation, and articulation is not supererogatory.

To determine nurses' minimal role modelling duties, one must first determine what is necessary to communicate the desired standard of behavior or action. In some cases, this standard can only be communicated by articulate role modelling, while in others, silent role modelling is sufficient. In cases where silent role modelling is sufficient to communicate the standard, then articulate role modelling, when it imposes an additional cost, is supererogatory.

If everyone has a moral obligation to take pandemic precautions, such as correctly wearing appropriate masks to prevent transmission of COVID-19, then what differences does it make that a nurse also has a role model obligation to do so, especially if they act as a silent role model? Randolph Feezell⁴² puts the objection this way: "If someone has a moral reason to do *x*...it seems superfluous or redundant to say she has an additional moral reason to do *x*" because they are a role model. Feezell considers that such additional moral reasons may be "stronger or provider strong moral motivations in certain circumstances."⁴² However, Feezell

argues that “it is not clear what the practical difference amounts to... This appears to be a distinction without a moral difference.”

There does, though, seem to be both moral and practical differences. Nurses may indeed find extra moral motivation from the awareness that others may draw lessons about the importance of pandemic precautions from their actions. Harriet Zuckerman⁴³ argues that role modelling is a two-way relationship, and that while role models influence people who seek to imitate them, role models are also influenced themselves by being chosen as a role model. When one’s status as a role model is due to membership in a profession, one may feel like they are representing that entire profession through their actions. Someone who does not wear a mask entering a store or on public transportation fails to fulfill a general moral obligation; but a nurse who does not do so, fails to fulfill an obligation specific to them *as a nurse*. Throughout the pandemic, nurses have pleaded with the general public to take the pandemic seriously. When fellow nurses fail to meet their role model obligations *as nurses*, they may further undermine morale and feelings of solidarity among nurses. Further, the failure to fulfill role model obligations to take pandemic precautions may have additional practical implications that failing to meet a general moral obligation to take pandemic precautions does not. For example, nursing educators may consider the need to provide better instruction on the importance of pandemic precautions, and nursing organizations may consider the need for stronger or clearer standards, or even for sanctions for those who violate these standards. The fact that role model obligations for pandemic precautions is specific to nurses gives organizations that a reason to act that may otherwise be lacking.

Implications

Nurses do not have role model obligations for healthy behaviors, such as those related to diet and exercise. One implication for researchers is that studies focused on nurses’ health should not be framed around nurses as role models. Such studies may have value in showing how workplaces can better promote the health of their employees, but they have no bearing on nurses’ duties as role models.

Nurses do have role model obligations for pandemic precautions. Role model obligations for pandemic precautions may be performed silently, without articulating reasons, when the risk of being misinterpreted is low. When silent role modelling creates the risk of misinterpretation or prevents evaluation of the reasons for actions, nurses have a minimal duty to articulate reasons. Since role modelling involves relationships between nurses and others, nurses must judge when silent or articulate role modelling is necessary, and what costs each imposes. When silent role modelling can effectively communicate the standard of behavior, and articulate role modelling imposes a cost greater than silent role modelling, articulate role modelling is supererogatory.

Nurses fail to fulfill their role model obligations by acting publicly in ways that diminish the importance of pandemic precautions or by silent role modelling where this can be easily misinterpreted. Nursing organizations, including nursing schools, should take a more active role by educating nurses on how to be good role models for pandemic precautions, whether in-person or on social media.

Fatigue and providing direct patient care inhibit nurses’ engagement with pandemic precautions outside of the workplace.²⁵ Hospitals have failed to protect nurses from fatigue and burnout, both prior to and during the COVID-19 pandemic. For example, Mary Turner, the President of the Minnesota Nurses Association, argued in April 2020, before COVID-19 began surging in Minnesota, that rather than furloughing nurses when elective procedures were cancelled and seeking emergency licenses for out-of-state travel or agency nurses, hospitals should have been training medical-surgical and procedure nurses to work with COVID-19 patients.⁴⁴ This could have relieved pressure on nurses who were overworked during the Delta and Omicron surges. Instead, hospitals struggled to maintain sufficient nursing staff during these periods, and relied on higher paid travel or agency nurses,⁴⁵ which in turn created backlash from employees and contributed to additional turnover.⁴⁶ Before healthcare organizations can play a meaningful role in enabling nurses to be role models for pandemic precautions, they must first gain the trust of their workforce. One way to reduce nurses’

fatigue would be to support legislation to mandate staffing ratios. Supporting legislation, rather than making vague promises, would acknowledge that healthcare organizations have not taken nurses' concerns about fatigue seriously in the past, and would create meaningful ways to hold healthcare organizations accountable in the future.

Nursing departments and faculty should prepare nursing students to be good role models by being good role models for pandemic precautions themselves. Nursing faculty should thus push administrators to require pandemic precautions on campus. Nursing faculty can role model strong leadership by not backing down when campus administrators focus more on enrollment or the politics of funding from state legislators than public health. Regardless of campus-wide decisions, nursing departments should require their own faculty and students to take pandemic precautions in all nursing classes and events.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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