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Maureen Muldoon
University of Windsor

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Humanities and Social Sciences, University of Windsor

Abstract: This paper argues that Personal Support Workers (PSWs), the staff people who care for residents in long-term care facilities and nursing homes and who have been severely affected by the COVID-19 pandemic, need to negotiate a new social contract with government based on equitable terms to recognize the essential nature of their work, thereby helping to ensure public accountability and trust.

Keywords: COVID-19 pandemic, health care professions, long-term care facilities, Ontario, personal support workers (PSWs), social contract

During the COVID-19 pandemic, essential workers have carried out a range of services that people rely on for their daily lives. Residents in long-term care facilities and nursing homes have been severely affected by this novel virus, with high rates of infection and death.[1] Personal support workers (PSWs) care for residents in long-term care facilities and provide home-based care to elderly and disabled people who need help with the activities of daily living. In pre-pandemic times and today, the work of PSWs is characterized by difficult working conditions, such as heavy workloads and low pay. Many PSWs are employed on a part-time basis. To make ends meet, some PSWs work in more than one facility. During the pandemic, personal protective equipment to keep PSWs and their clients/patients safe from the virus were in short supply.
PSWs can be identified as part of the precarious work force in Canada.[2] However, the need for the type of work done by PSWs in long-term care facilities is acknowledged as indispensable.[3] In the media, PSWs and other health care workers have been called "heroes."[4] The motives for doing this work vary, such as the need for income, adherence to an employment contract, or because of a personal commitment to serve and care for their clients. Throughout the pandemic, PSWs have dutifully provided quality care to their clients, even when their jobs have put them at risk. Why should they do so?

This paper explores the basis for PSWs to adhere to ethical standards in their occupational roles. It examines the lack of agreement as to what is required for an occupation to be acknowledged as a profession. Then, the ethical requirements embedded in the implied social contract of established health care professions, such as for physicians and nurses, are discussed. The value of establishing a social contract, even if implied, is considered in terms of the implications for PSWs.

Personal Support Work: Occupation or Profession?

In a 2018 Government of Ontario publication regarding the Personal Support Registry, it is stated that the purpose of the Registry is to provide recognition, provide credibility, build public trust in the profession, and to allow for the evolution of this profession.[5] The Registry document uses the term "profession" for this occupational group, even though PSWs are unregulated. Does

it matter if PSWs do not have government or public recognition as a regulated profession? This raises the question of whether the ethical requirements of the medical and nursing professions are dependent on having government endorsement of their regulated status. While this issue does not have a definitive answer, it is helpful to examine various views on the ethics of traditionally recognized professions as a way to understand the ethical basis of the occupation of the PSW.

There are numerous occupations that identify themselves as "professionals." The terms "profession" and "professional" are used loosely. Some groups identified as professional are regulated, and others are not. There is no universally accepted set of characteristics that make an occupation a profession.[6] However, sociologists and philosophers have a range of perspectives on the characteristics of a profession and the role of professions in society.[7]

Barker proposes that a historical review of the etymology for the term "professional" can be a helpful way to understand what it means to be a professional and why professionals are required to act ethically. The term "profession" is taken from the Latin, *professionem*. Barker notes that this means a public declaration, but in the medieval university it was used to refer to the taking of religious vows.[8] By the 14th century, *professionem* referred to the taking of a solemn declaration, promise, or vow. The "profession" came to mean the vocation that the candidate entered after taking the oath.[9] "In the 16th century," Barker states "it comes to mean an occupation in which learned knowledge is applied to the affairs of others, as especially in medicine, law, divinity and university teaching."[10] The oath required the professionals to profess their dedication and commitment to the ideals of the profession and the everyday realities involved in their roles. Barker identifies two distinctive features of medieval professions: 1) high-level knowledge gained in the university and 2) the requirements to professionals-to-be to commit to "a distinctive ideal of service" that imposed a set of ethical demands that ordinary citizens did not have to follow.[11]

Barker is careful not to create the misunderstanding that it is only professionals who have ethical obligations. He acknowledges that there are occupations such as firefighting, an occupation that he does not consider a profession, which require courage and, at times, high moral demands.[12] The basis of firefighters' duties arise from their employment contract, not from a professional designation. Firefighters negotiate the terms of their contract, including terms of work and remuneration. It is generally accepted that they will act with self-interest in these negotiations. Barker notes that pursuing the socially desirable goals of their occupational ideals is optional outside of the terms of their contract. It is admirable for firefighters to increase their knowledge of firefighting or to promote high standards of fire safety outside of work hours, but they are not required to do so.

Occupations and professions differ in their reasons for acting ethically, according to Barker. Whereas employees in an occupation must adhere to the terms of their employment contract, members of a profession have agreed to impose ethical requirements on themselves that include an ethical ideal of service to society. Professionals are supposed to curb their self-interested impulses regarding the use of their specialized skills. As a result, professionals are "to promote high standards of performance, to make their services better available to society, and to serve other ends connected with the distinctive type of good which their profession can do for others."[13] For

instance, a physician cannot promote medicines that have no proven value, because the social good of medicine is to heal and restore people's health. A person in the occupation of business owner can sell products that may not have any proven benefit with the understanding of *caveat emptor*, meaning "buyer beware."

The dominant view held until the late 1960s by sociological theorists was that professions were distinguished from other occupational groups based on certain defining characteristics. Two variations of this taxonomic approach were the functionalist approach and the trait approach.[14] For functionalists, professionals serve an important function in society, contributing their expert knowledge and commitment to serving the public. Trait theorists created lists of traits that were identified with a profession. Occupational groups could be assessed as more or less professional based on their traits. There were variations on the required traits for what was defined as a profession, but common traits included specialized expert knowledge, work autonomy, a code of ethics, and some type of licensing or certification.

Saks notes that the critics of this ahistorical and uncritical taxonomic approach identify that the parallels among the professions are acknowledged rather than their differences. Occupations that do not have profession-making traits can be stigmatized. The expert knowledge requirement as a trait for a professional designation has been challenged by the recognition that many occupations have their own specialized body of expert knowledge, such as auto mechanics. Saks argues for a neo-Weberian approach to understanding professions. He explains that "professions are normally defined at root by neo-Weberian scholars in terms of exclusionary closure in the marketplace sanctioned by the state."[15] This approach assumes that professions exist within a world that operates with power structures and economic interests. "Professionalization thus construed," Saks explains, "is centered on attaining a particular form of legal regulation with registers creating bodies of insiders and excluding outsiders."[16] He notes that membership in a profession leads to the chance of a better quality of life in terms of higher incomes and access to social goods. Saks states that this neo-Weberian approach is helpful, because it acknowledges that professionalization is a socio-political process that involves power and economic interest in the market at the macro level."[17]

The early attempt of PSWs to get regulatory status in Ontario in 2006 failed.[18] The first attempt at establishing a Registry in 2012 was unsuccessful. The 2018 Registry indicates that the Registry may be a step in the evolution of the PSW occupation into a profession at some future time. The Ontario Personal Support Workers Association (OPSWA) serves as the professional association for PSWs with voluntary membership. It advocates on behalf of PSWs and describes the roles and responsibilities of the PSW. Estok notes that PSWs are a "shadow work force" that has a negative effect on the financial infrastructure of the province.[19] The "shadow work force" is made up of PSWs who work individually with their clients, receiving cash payments for completing additional hours of care. Estok claims that this "shadow health force" is not accountable to any professional body and may not contribute to tax revenues. PSWs can work independently and privately. There is no regulatory body that determines who can work as a PSW, what standards of practice they must follow, what code of ethics is operative, or the amount and

form of payment they should receive. In view of Saks' perspective, PSWs do not have an exclusionary monopoly on calling themselves PSWs. The OPSWA casts a wide net for those who can become members. Estok argues that eliminating the "shadow work force" through the regulation of PSWs will serve the economic interests of the province. Codes of ethics and other ethical requirements associated with professions do not factor into Saks' approach.

Is a regulatory body and code of ethics necessary for ethical practice?

In 2018, the Michener Institute in Toronto made a third attempt to establish a Registry for PSWs.[20] Izenberg and Taylor note that a code of ethics, a set of roles and responsibilities, and a complaints process were posted on the Registry website. The posting of this occupational information was similar to the kinds of information found on various regulatory college websites and suggested that registered PSWs could be held accountable to these professional standards. However, the Registry for the PSWs was not a regulatory body. It was unclear what authority the Registry had to deal with a PSW who did not adhere to the code of ethics or carry out her roles and responsibilities.

Why should unregulated, not-yet professional PSWs be bound by the code of ethics posted on the Registry website? The code of ethics was not developed by an association that represents PSWs. Professional codes of ethics are usually put forth either by the regulatory body or the association that represents the members. Codes of ethics usually arise out of a common understanding of what constitutes ethical practice by an association's membership. The extent to which PSWs participated in the creation of the code of ethics or can claim ownership of it is unspecified.[21]

Why should personal support workers act ethically in their occupational roles?

Does a posted code of ethics on a Registry website impose a set of ethical requirements on occupational workers when registration is voluntary?[22] The main function of a code of ethics is to provide clarity of ethical standards to the stakeholders.[23] These stakeholders include the personal support workers, government, the employers, the clients/patients, and their families. Codes of ethics serve many purposes. They can be a source of inspiration and guidance, serve as an educational resource, or be a tool for deterrence and discipline.[24] Whether this code of ethics that was posted on the Registry would have served any of these functions was not determined. The college curriculum for PSWs who have undertaken that educational route includes an introduction to ethical issues in their work. However, an important question is whether a posted code of ethics by the Registry and knowledge of ethical issues in their work are compelling enough for PSWs to act ethically.

Personal moral commitments based on religious or cultural worldviews may influence how PSWs carry out their duties. They may choose to act in responsible, altruistic, and caring ways in their PSW role based on a variety of motivations. Philosophers have offered many responses to such questions including the following: what does it mean to be a moral person; does this personal

morality extend into the workplace; can it be assumed that occupational ethics are the same as professional ethics, and are personal ethics and workplace ethics related? Often discussions of occupational ethics borrow heavily from what has been written about professional ethics. The lack of a clear delineation between professional and occupational spheres of work result in most occupations identifying themselves as professions with a code of ethics.

Some hold that personal morality needs to be separate from professional ethics, thereby enabling professional distance and limiting conflicts of interest. Martin argues against this view, which he labels "the consensus paradigm." This commonly accepted paradigm consists entirely of the moral requirements attached to a profession and imposed on all its members, including codes of ethics and practice guidelines.[25] Even though this paradigm has positive value in that it creates shared standards to restrain greed, fosters public trust, and limits misguided personal ideals, it is problematic, because it neglects the personal moral commitments of the professional. Martin claims that it is necessary to acknowledge how personal moral commitments and ideals serve to motivate, sustain, and guide professionals in their work.[26] Without doing so, the proper demarcation of personal and public life cannot be maintained. Martin holds that a professional person needs overall or global integrity. This means considering all aspects of the professional's life rather than just professional roles and responsibilities. Overall integrity includes commitments to the professional's family and to the community as well as to himself or herself. Martin states that overall integrity "is the coherence of character and conduct as formed around a core of reasonable and authentic commitments to moral values." Martin claims that it is impossible to fragment personal integrity into the spheres of profession, family, or citizenship. Nonprofessional commitments need to be integrated with professional commitments.[27] He recognizes that professions have distinct ethical requirements, such as the need for client confidentiality. The ethical commitments of PSWs and others in occupations and professions may be motivated by personal integrity.

Tarlier relates how personal moral knowledge is transformed into disciplinary ethical knowledge through a disciplinary consensus.[28] She sets out an ethical framework of nursing based on the personal and public morals that make up what she calls the "responsive nurse-patient relationship." Tarlier holds that the concept of caring, which has often been claimed as the basis for ethical nursing practice, is insufficient. According to her, "The foundation of ethical nursing knowledge is the personal moral sense that resides within the individual and that nurses hold in common with others."[29] This personal moral knowledge is then transformed into disciplinary ethical knowledge specific to the nursing practice work of PSWs that involves a responsive relationship with their vulnerable clients.

Pellegrino claims that medicine has an internal morality.[30] Symons presents a detailed examination of Pellegrino's perspective and that of his critics.[31] For Pellegrino, the role of the physician as healer is to seek the good of the patient and to restore the patient to physical or psychological health. The physician-patient clinical encounter is the basis of this internal morality. He acknowledges the vulnerability of the patient. For Pellegrino, this medical morality is fixed and unaffected by social and cultural contexts.[32] There is no external morality that can be imposed

on the physician, and the basic nature of the physician-patient relationship does not change over time depending on circumstances.

Kenny, one of Pellegrino's sundry critics, notes many of the same concerns identified by MacDougall and Langley. Kenny observes that the way medicine is practiced in the 21st century is different than when Pellegrino was writing about the internal morality of medicine.[33] She notes that physicians now practice in teams in a complex health delivery system rather than in isolated physician-patient encounters. PSWs hold both the caregiver-client relationship and are members of client's the health care team.[34] PSWs may not be healers in the sense that Pellegrino understood physicians' role in the physician-patient relationship; however, PSWs may develop long term relationships with their clients/patients and their families, and they provide care as designated by a regulated health professional.[35] The relationship that physicians and nurses have with their patients is characterized as a fiduciary trust, which means that they are to act in the patient's best interest. The maintaining of this trust by the physician or nurse with the patient is both a legal and ethical requirement. The clients of PSWs may live at home, in a long-term care facility, or in a hospital. In addition to their regular care duties, they may have other care responsibilities as determined by a regulated health professional. The work of the PSW usually involves the care of vulnerable clients. These clients may vary in age and disability. PSWs may have a role in the care of a child, an adult with a disability, or an older person with dementia. Care given to the client may be carried out when the PSW is alone with the client in the client's home or in a room in a health care facility. Fiduciary trust is essential in this PSW-client relationship because of the vulnerability of the client. It is recognized in law.[36] It would be a difficult challenge to argue that internal morality should be applied to the work of the PSW in the way that Pellegrino has for physicians. But it is possible to "rethink" the internal morality of the health care professional-client relationship, including PSWs, as seeking the good of the patient/client.

The social contract as a basis for ethical practice

Beginning in the latter half of the 20th century, the concept of the social contract has been used to describe the relationship between health care professionals and society.[37] Cox acknowledges that health care workers have a clear but limited duty to treat patients during the COVID-19 pandemic. She states that this duty can be grounded in a broad social contract associated with certain reciprocal duties between society and health care workers.[38] The requirement for a distinctive commitment to serve patients and the promotion of the public good as well as a set of ethical demands are echoed in this implicit social contract for physicians. It is derived from political science and is not exclusive to the profession of medicine.

A similar social contract has also been described for nursing and other health professionals.[39] Cruess and Creuss explain that professionalism is the way that society organizes the delivery of complex services that are needed by its members.[40] The social contract is neither explicitly defined nor does it spell out the responsibilities of each party. The arrangement of the social contract with medicine works mostly in an implicit way based on what society expects from the profession and what the profession expects in return. Societal expectations include the services

of a healer, guaranteed competence, altruistic service, transparency, accountability, morality, integrity, and the promotion of the public good. Medical professions expect autonomy, trust, status and rewards, self-regulation, and a functioning health care system. It is necessary for both parties to meet the respective terms of the contract in order to ensure the delivery of quality health care services.

Barker suggests that an implicit social contract has developed between society and the professions over time. Members of a profession agree to constrain their self-interest and promote the ideals of their profession. They offer a social good to society. In return, society (the state) allows the profession to act as a monopoly over entrance into the profession and to formulate and administer their code of ethics. In this bargain, society gets a profession with expert knowledge and a commitment to service while professionals get status, remuneration, and some protection from political intrusion.[41]

Even though there may be evidence of a social contract between physicians and society, MacDougall and Langley point to many existential challenges to the practice of medicine and the public's perception of physicians.[42] These challenges suggest that if there was a social contract in the past, it is now a weakened social contract. The current CMA Code of Ethics provides an explicit outline of what is expected of a medical professional and a statement of ethical principles.[43] During the first wave of the pandemic, all health care workers were called heroes. Health care workers dutifully cared for those infected with COVID-19.[44] However, the discussion in the media did not focus on whether to treat patients for COVID-19 but rather on whether there was a duty to treat if personal protective equipment was unavailable. Health care workers expected the government and their facilities to provide sufficient supplies so that they could do their work.[45] In retrospect, sociological research will have to establish if there is evidence for a reinvigorated social contract between health care professionals and the public.

It appears that the Government of Ontario expects PSWs to practice with the same societal expectations as other health care professionals.[46] They are expected to carry out their occupational roles in an ethical manner and to be willing to promote the public good. However, unlike other regulated health care professionals, PSWs lack a regulatory body and have limited autonomy, limited social status, and generally low pay. The terms of this social contract need to be explicitly spelled out by both the Government and the PSWs as a matter of fairness.

Code of ethics or ethics by employment contract?

There is an expectation by clients/patients and their families, employers, society, and government that PSWs will act ethically in their occupational role, even though their occupation is unregulated. Employment contracts can also provide direction for occupational and professional behaviour. Employers participated in the creation of the PSW code of ethics. Contracts with an employer can include a requirement to adhere to a code of ethics. It may be the code of ethics for the employer's workplace, the Registry's code, or both. In such cases, the requirement to follow the code of ethics is not self-imposed by the PSW. However, ethical organizational cultures are created by a number of factors such as the tone set by ethical leaders and education programs for

ethical behaviour. PSWs work in many different types of employment settings, from term care facilities to private homes. Ongoing ethics education specific to PSW work poses many challenges. These challenges include PSW instructors with knowledge of the ethics specific to PSW work and the cost and the time involved in this education for precarious workers.

The implicit social contract was relevant in the late 20th century but is becoming less so with societal changes. It was originally a means to get professionals to act ethically and promote the benefits the public receives from the use of their expertise. In return, the professional received social status, high remuneration, and other benefits. PSWs are expected to use their knowledge, skills, and labour for the good of their clients/patients as a way to promote the public good. However, PSWs were provided with a code of ethics that was not self-imposed, basic remuneration, and precarious working conditions. What is needed is a social contract explicitly negotiated by both the government and PSWs. A new social contract based on equitable terms will recognize the essential work done by PSWs and ensure public accountability and trust. If the basis for ethical practice for PSWs is their employment contract, then that should be made explicit to both PSWs and the public.

Notes

[1] Laura Stone and Tu Thanh Ha, "Ontario, Quebec Revamp Staffing at Nursing Homes Amid 'Wildfire' COVID-19 Outbreak," *The Globe and Mail,* April 14, 2020, https://www.theglobeandmail.com/canada/article-ontario-quebec-revamp-staffing-at-nursing-homes-amid-wildfire-covid/

[2] Katherine Zagrodney and Mike Saks, "Personal Support Workers in Canada: The New Precariat? *Healthcare Policy* 13, no. 2 (2017): 31-39, doi:10.12927/hcpol.2017.25324.

[3] The Government of Ontario requested the help of the Canadian Armed Forces to assist in the care of residents and to help prevent the spread of COVID-19. This resulted in the Armed Forces issuing a scathing report about the living conditions for residents in some Toronto long-term care facilities. Nick Boisvert, "Ontario Long-Term Care Homes in Scathing Report Could Face Charges, says Ford," *CBC News*, May 26, 2020. https://www.cbc.ca/news/canada/toronto/ontario-military-ltc-report-1.5585131

[4] Caitríona L. Cox, "'Healthcare Heroes': Problems with Media Focus on Heroism from Healthcare Workers During the COVID-19 Pandemic, *Journal of Medical Ethics* 46 (2020): 510-513.

[5] In 2006, the Health Professions Regulatory Advisory Council (HPRAC) decided not to grant self-regulation to PSWs. The decision was justified on several grounds. The HPRAC stated that PSWs should not become a self-regulated health profession, because there was ambiguity around their scope of practice, PSWs did not have standardized knowledge, and there was a lack of

consensus among key stakeholders. (HPRAC 2006). In 2012, a PSW Registry was established by the Government of Ontario. Its purpose was to determine the number of PSWs in the province and their work locations. The Government's intent was to offer some assurance to the public that PSWs were trained, competent workers who could be identified on the Registry. In 2016, this Registry was shut down because it could not adequately track all PSWs.

[6] Tracey L. Adams, "Profession: A Useful Concept for Sociological Analysis?" *Canadian Review of Sociology* 47, no. 1 (January 26, 2010): 49–70.

[7] A good introduction to the sociological literature on the professions can be found in Sareh Pouryousefi,
A Normative Model of Professionalization: Implications for Business Ethics (PhD dissertation, University of Toronto, 2013); https://tspace.library.utoronto.ca/handle/1807/70133. For a philosophical discussion, see: Stephen F. Barker, "What is a Profession?" *Professional Ethics, A Multidisciplinary Journal* 1, no. 1/2 (Spring/Summer 1992): 73-99.

[8] Barker, "What is," 84.

[9] Barker, "What is," 86.

[10] Barker, "What is," 84.

[11] Barker, "What is," 87.

[12] Barker, "What is," 88.

[13] Barker, "What is," 89.

[14] Mike Saks, "Defining a Profession: The Role of Knowledge and Expertise," *Professions and Professionalism* 2, no. 1 (June 2012): 1. doi:10.7577/pp.v2i1.151.

[15] Saks, "Defining," 4.

[16] Saks, "Defining," 4.

[17] Saks, "Defining," 5.

[18] The Michener Registry website indicated that it was no longer accepting applications for registration as that project ended on March 31, 2020. See Estok, "The Benefits of Self-Regulation: (Educational Standards)" *Policies and Papers OPSWA,* (October 2019). https://ontariopswassociation.com/policies-and-papers/

[19] Estok, "Benefits," 4.

[20] In 2006, the Health Professions Regulatory Advisory Council (HPRAC) decided not to grant self-regulation to PSW. The decision was justified on several grounds. They stated that PSWs

should not become a self-regulated health profession, because there was ambiguity around their scope of practice, PSWs did not have standardized knowledge, and there was a lack of consensus among key stakeholders (HPRAC 2006). However, they are considered as essential workers who care for the vulnerable people in society. In 2012, a PSW Registry was established by the Government of Ontario. Its purpose was to determine the number of PSWs in the province, their work locations, and the nature of their training. The Government's intent was to offer some assurance to the public that PSWs were trained, competent workers who could be identified on the Registry. In 2016, this Registry was shut down because it could not adequately track all PSWs.

This Registry currently collects data from PSWs who work for a "registered employer." It records the names of PSWs who have completed a community or career college program in 2016 or later. By 2019, Registration was mandatory. The Registry verifies PSWs' credentials. Dafna Izenberg and Maureen Taylor, "Who are Ontario's PSWs?" *Healthy Debates* (March 1, 2018). https://healthydebate.ca/2018/03/topic/psws-ontario

[21] The Ontario Personal Support Worker Association has a Code of Ethics. However, membership in the association is voluntary. "Code of Ethics," OPSWA, accessed August 3, 2020. https://ontariopswassociation.com/code-of-ethics/#:~:text=Working%20with%20Integrity%20and%20Respect,encourage%20dishonesty%20or%20illegal%20conduct

[22] Ontario Personal Support Workers Association, Memberships, accessed August 21, 2020. https://www.psw-on.ca/assets/documents/policies/registration-and-renewal-policy.pdf
The Registry explains that the code of ethics was developed through literature reviews and consultations with comparable professional registries, relevant regulated colleges, PSW employers, and PSWs from different health sectors. The link to this information regarding the code of ethics posted by the Registry is no longer available. See Avtar On, *All You Need to Know About the New PSW Registry of Ontario,* accessed on August 11, 2020 and accessed on December 28, 2020. https://personalsupportworkerhq.com/psw-registry

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[25] Mike Martin, *Meaningful Work: Rethinking Professional Ethics* (Oxford University Press, Oxford, 2000), 4.

[26] Martin, *Meaningful Work*, 4.

[27] Martin, *Meaningful Work*, 203.

[28] Denise S. Tarlier, "Beyond Caring: The Moral and Ethical Bases of Responsive Nurse-Patient Relationships," *Nursing Philosophy* 5 no. 3 (October 2004): 232, doi:10.1111/j.1466-769X.2004.00182.x. PMID: 15385033.

[29] Tarlier, "Beyond Caring," 230.

[30] Edmund D. Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions," *The Journal of Medicine and Philosophy* 26, no. 6 (January 1, 2001):559-79. doi: 10.1076/jmep.26.6.559.2998. PMID: 11735050.

[31] Xavier Symons, "Pellegrino, MacIntyre, and the Internal Morality of Clinical Medicine," *Theoretical Medicine and Bioethics* 40, no.3 (2019): 243-251. doi:10.1007/s11017-019-09487-8

[32] Symons, "Pellegrino," 246.

[33] Nuala Kenny, Nuala, "Medicine's Malaise: The Pellegrino Prescription," *American Journal of Bioethics* 6, no.2, (2006): 78–80.

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[35]Marg McKee, "Personal support workers and ethical issues in front-line care," Presentation to Centre for Health Care Ethics, School of Social Work, Lakehead University (April 2018). https://www.lakeheadu.ca/sites/default/files/uploads/30/Events/2018/PSWs%20and%20Ethical%20Issues%20in%20Front-line%20Care%20-%20presentation%20M%20McKee.pdf

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See also: Gwendolyn L. Adrian, "Do Personal Support Workers & Caregivers Owe Fiduciary Duties to the Individuals They Take Care of?" LinkedIn, November 29, 2017. https://www.linkedin.com/pulse/do-personal-support-workers-caregivers-owe-fiduciary-duties-adrian/

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[41] Barker, "What is," 93.

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[44] Bruce Arthur, "'I didn't sign up to die on my job': Fear and Anger Among Ontario Nurses Battling COVID-19 Pandemic," *Toronto Star,* March 30, 2020. https://www.thestar.com/opinion/star-columnists/2020/03/30/i-didnt-sign-up-to-die-on-my-job-fear-and-anger-among-ontario-nurses-battling-covid-19-pandemic.html

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