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Research Paper

When Duty Calls in Multiple Directions: Assessing Conflicting Responsibilities of Healthcare Workers Facing Contagious Diseases

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ABSTRACT

Healthcare professionals who supervise patients with contagious diseases frequently encounter ethical dilemmas that arise from their obligations to their families, personal safety, and their obligations to patients. Using a structured framework that has been derived from empirical research, this study evaluates these competing responsibilities. A 28-item tool was administered to a diverse group of healthcare workers, enabling a comprehensive understanding of the experience and management of conflicting obligations. Key psychological and institutional dimensions that influence ethical decision-making and personal well-being in the healthcare context are resilient accountability, perceived occupational health risk, adaptive self-regulation, work-life balance support, and ethical governance and compliance. This research makes a valuable contribution to the development of support systems for healthcare professionals, the formulation of ethical policies, and the development of mental health intervention strategies.

Keywords: *Contagious Diseases, Healthcare Workers, Ethical Dilemmas, Risk Perception, Competing Obligations, Ethical Conflict*

Healthcare professionals stand at the frontlines of society's defense against contagious diseases, and their role becomes even more critical during public health emergencies. Diseases such as Tuberculosis (TB), Hepatitis, AIDS, and COVID-19 have not only strained healthcare systems but have also amplified ethical and psychological challenges for those who provide care. In these high-stakes contexts, the commitment to duty is weighed against personal safety and familial responsibilities, producing what has come to be recognized as "competing obligations."

The obligation to provide care is a foundational principle of medical ethics, rooted in beneficence and the Hippocratic Oath. Yet, this principle is not absolute. As Beauchamp and Childress (1994) argue, the duty to care must be balanced against other ethical principles such as autonomy, justice, and non-maleficence. During disease outbreaks, particularly when safety protocols are insufficient, the ability to provide care without compromising one's own well-being becomes ethically complicated. Healthcare professionals are expected

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to act with resilience and courage, but they are also individuals with families, health vulnerabilities, and legitimate concerns.

This moral tension was made strikingly evident during the COVID-19 pandemic, which exposed serious gaps in institutional preparedness and support. Studies, such as those by Adams and Walls (2020), documented widespread concerns among healthcare workers regarding inadequate PPE, psychological strain, and fears of transmitting the virus to loved ones. Research by Bensimon et al. (2007) further supports that nearly a quarter of medical professionals surveyed believed it was ethically permissible to withdraw from duties under high-risk circumstances-citing family protection as a principal concern.

In low-resource settings such as India, where the healthcare infrastructure is frequently overstretched, these conflicts are even more pronounced. Healthcare workers in both metropolitan and rural environments must navigate difficult choices with limited guidance, unclear institutional policies, and societal expectations. Such environments create the perfect storm for ethical dilemmas, burnout, and moral injury. These challenges underscore the need for tools that can systematically assess and quantify the psychological and ethical tensions experienced by frontline professionals.

The significance of this framework is not merely academic. As emphasized by Kirkpatrick et al. (2024), policy interventions that fail to account for the ethical and emotional landscape of healthcare professionals risk jeopardizing the very sustainability of health systems. The Competing Obligation Scale (COS) (Hasme and Khan, 2025) serves as both a diagnostic and strategic tool-offering insights into areas that require immediate support, such as mental health resources, ethical governance, and institutional transparency. It enables researchers, administrators, and policymakers to develop better-targeted interventions that ensure healthcare professionals are not left to bear invisible burdens alone.

In this context, the present study aims to systematically examine these competing responsibilities. By deploying the COS among a representative sample of healthcare professionals in West Bengal, the study explores the psychological, ethical, and institutional dynamics that influence professional decision-making in contagious disease scenarios. The findings are intended to inform both academic discourse and practical frameworks for resilience-building, policy formation, and ethical governance within the healthcare sector.

LITERATURE REVIEW

Risk perception is a multidimensional concept central to healthcare workers' decision-making processes during contagious disease outbreaks. As noted by Rohrmann (2008, 2013), risk perception is shaped not only by objective probabilities but also by emotional responses, cultural beliefs, and previous experiences. Healthcare professionals often make critical choices in environments of uncertainty, where the perceived risk to themselves and their families can outweigh clinical obligations.

Slovic (1987), Weyman and Kelly (1999) emphasized that laypersons and professionals alike rely on heuristics and social cues in risk assessment. These perceptions influence adherence to protocols, willingness to treat, and overall moral reasoning. During the SARS outbreak, Koh et al. (2005) observed that healthcare workers in Singapore maintained their professional obligations despite heightened risk perception, particularly when adequate institutional safeguards and clear communication were in place.

The tension between the duty to treat and personal well-being has become increasingly relevant in pandemics such as COVID-19. McConnell (2020) and Malm et al. (2008) argue that the moral imperative to treat cannot be unconditional. Circumstances involving inadequate PPE, overwhelming patient loads, and the risk of transmitting disease to loved ones justify healthcare professionals' reluctance or refusal to engage in care.

This ethical complexity is further supported by Bensimon et al. (2007), who found that a significant number of healthcare workers considered it morally acceptable to prioritize family welfare over professional duty during health crises. These findings echo earlier sentiments by Treanor (2000), who recognized the underappreciated occupational risks-including psychological distress-endured by healthcare professionals.

Institutional readiness plays a decisive role in shaping healthcare workers' ethical conduct and psychological resilience. As Gesser-Edelsburg et al. (2014) report, the presence of ethical governance, transparent communication, and logistical support significantly improves staff morale and reduces ethical strain. Conversely, a lack of institutional accountability can lead to moral injury, burnout, and attrition.

The Competing Obligation Scale incorporates dimensions such as Work-Life Balance Support and Ethical Governance and Compliance to assess how institutional frameworks either mitigate or exacerbate ethical conflicts. The COS thereby operationalizes abstract ethical concerns into measurable dimensions that inform policy and training programs.

Healthcare workers subjected to prolonged exposure to crises often experience psychological consequences including anxiety, guilt, and moral distress. Grailey et al. (2021) and Migisha et al. (2021) documented the psychological toll of the COVID-19 pandemic on frontline staff. These professionals navigated internal conflicts using coping mechanisms such as adaptive self-regulation, peer support, and goal reorientation.

The COS dimension of Adaptive Self-Regulation captures these behavioral adjustments and cognitive strategies used to balance ethical obligations with self-care. Tools that measure these strategies are vital for designing mental health interventions and resilience training programs in healthcare settings.

The concept of competing obligations is inherently complex, involving the intersection of personal safety, family responsibilities, and professional codes of conduct. The Competing Obligation Scale developed in this study offers a psychometrically robust framework for assessing these pressures.

With strong reliability (Cronbach's alpha = 0.803) and factorial validity (explaining over 80% of the variance across five dimensions), the COS provides a meaningful structure to understand the ethical stress landscape of healthcare professionals. It integrates individual perceptions and systemic structures, allowing for a nuanced understanding of ethical behavior in health emergencies.

Through this literature review, it becomes clear that competing obligations are not abstract philosophical dilemmas - they are lived experiences that shape the everyday functioning of healthcare systems. Recognizing and addressing these tensions is crucial to building ethical

resilience, safeguarding healthcare personnel, and maintaining quality care during public health crises.

Dimensions of Competing Obligation

The Competing Obligation Scale (COS) encompasses five empirically derived dimensions that encapsulate the multifaceted nature of ethical strain experienced by healthcare professionals during contagious disease outbreaks. These dimensions are grounded in both individual psychology and institutional context, offering a comprehensive framework for assessment and intervention.

- **Resilient Accountability:** This dimension reflects the capacity of healthcare professionals to uphold their professional responsibilities in the face of adversity. It encapsulates emotional resilience, decisiveness, and a proactive attitude toward patient care. Professionals scoring high in this domain exhibit a strong moral compass and a willingness to act despite fear or uncertainty. This trait is foundational for sustaining healthcare delivery during crises, though it may also lead to burnout if unaccompanied by institutional support.
- **Perceived Occupational Health Risk:** This refers to how healthcare professionals assess their vulnerability to infection in the workplace. It includes confidence (or lack thereof) in institutional safeguards, availability of PPE, and clarity of safety protocols. When perceived risk is high and protective systems are inadequate, ethical conflict escalates as workers must choose between fulfilling professional duties and protecting personal and familial well-being.
- **Adaptive Self-Regulation:** Adaptive self-regulation pertains to a healthcare worker's ability to cognitively and behaviorally manage competing responsibilities. It involves strategic time management, prioritization, self-monitoring, and goal adjustment under pressure. Individuals who demonstrate strong self-regulation are better equipped to maintain performance and emotional balance during extended periods of crisis.
- **Work-Life Balance Support:** This dimension assesses the extent to which healthcare institutions facilitate a sustainable balance between professional obligations and personal life. It includes organizational initiatives related to workload management, flexibility, stress reduction programs, and family-oriented policies. A perceived lack of support in this area can exacerbate ethical strain, making workers feel unsupported and morally conflicted.
- **Ethical Governance and Compliance:** This dimension evaluates the perceived integrity and fairness of the institutional environment. It measures awareness of ethical codes, transparency of administrative decisions, and the presence of policies addressing conflicts of interest and workplace ethics. Strong governance structures serve as moral compasses and buffers against ethical ambiguity, reinforcing healthcare professionals' commitment to duty.

Together, these five dimensions provide a robust analytical structure to understand how and why ethical conflicts arise in healthcare settings and what institutional or psychological resources can help mitigate them.

Objectives

1. To assess the ethical, psychological, and institutional conflicts experienced by healthcare professionals during contagious disease outbreaks.

2. To identify and evaluate the key factors contributing to competing obligations in clinical settings.
3. To propose strategies for mitigating ethical strain and improving professional resilience.

METHOD

Design

We conducted a psychometric analysis of the questionnaire's design and its validation, assessing competing obligations against contagious diseases. Data collection took place between November 2024 and April 2025.

The individuals were healthcare professionals (doctors and nurses) working across multiple hospitals of West Bengal. The only inclusion criterion was to be an individual who has dealt with contagious diseases. Data collection was anonymous and no negative consequences ensued from non-participation.

Sampling and Sample Size

The selection was made via stratified random sampling. A sample size of 300 individuals was sufficient to ascertain a representative mean population with a confidence level of 95% and a margin of error of 5.

Design of the Scale

Vased on the literature, an *ad-hoc* questionnaire was designed by a panel of ten experts for the evaluation of competing obligation against contagious diseases. The instrument was constructed, piloted, and validated in accordance with Lynn's (1986) recommendations. The expert panel was composed of psychologists, two specializing in health psychology and two in behavioral change, two professors each specializing in education, medicine, and nursing. This scale is unique in that it bridges individual psychological experiences with systemic institutional frameworks, providing a holistic understanding of what it means to serve on the frontlines during public health crises.

Procedure

Data were collected individually from participants through direct administration of the questionnaire. Each participant was personally approached and provided with a clear explanation of the study's objectives, the voluntary nature of their participation, and assurances of confidentiality and anonymity.

Participants were given a printed version of the questionnaire. Before completing the questionnaire, participants were informed about the approximate time required to complete it and the number of items included.

Informed consent was obtained individually prior to data collection. The researcher remained available during administration to address any questions or clarify any items, while ensuring minimal interference with the participants' independent responses.

Each participant completed the questionnaire only once, and to ensure the integrity of the data, no identifying information was linked to the responses unless explicitly consented. Data were collected over a period of six months and securely stored for subsequent analysis.

Statistical Analysis

The statistical software used was IBM SPSS Statistics 25. Principal component analysis with Varimax rotation was used to do exploratory factor analysis. We used Cronbach's alpha to check for internal consistency and inter-factor correlations and average variance extracted (AVE) to check for convergent validity.

Ethical Considerations

The researchers reported no conflict of interests. Data processing methods guaranteed the confidentiality of the data and study-related information. Before beginning the questionnaire, following the letter of presentation of the study, the respondent had to tick a specific box, thereby consenting to participation in the study, which may be corroborated from the completed questionnaires.

RESULTS

A total of 300 healthcare professionals responded to the questionnaire. In all, 72% were female (n = 216), and 28% were male (n = 84), with an average age of 35 years.

All experts agreed that the instrument and both its qualitative and its quantitative contributions to content validity were very appropriate.

The competing obligation scale was formed by twenty-eight items. The factor analysis identified a five-factor structure (Kaiser-Meyer-Olkin sampling adequacy measurement of 0.902, Bartlett's sphericity test $p < 0.001$, correlations matrix determinant <0.001), which explained 80.62% of the variance. Six items each were included in the first three factors and five items each in the last two factors in accordance with its factoring load, with saturation values higher than 0.40. The VARIMAX factor rotation solutions formed a well-defined structure. The questionnaire results yielded a Cronbach's alpha value of 0.830. The item-total correlation values fluctuated between 0.208 and 0.401. All the questions were answered by 99% of the respondents.

Descriptive Statistics

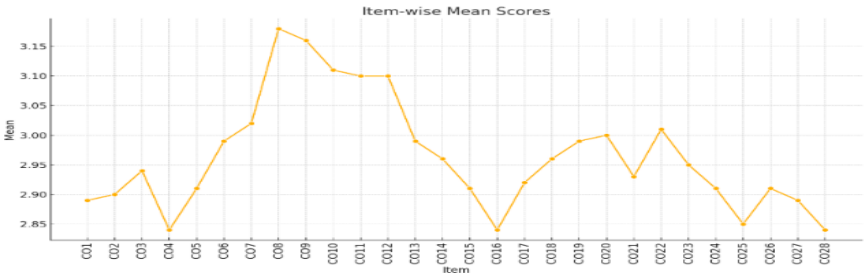

Figure 1: Item-Wise Mean Scores

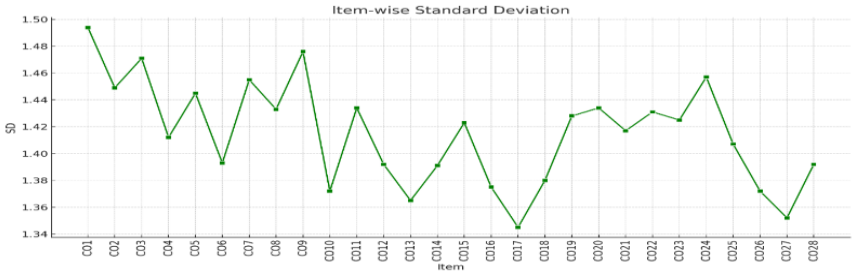

Figure 2: Item-Wise Standard Deviations

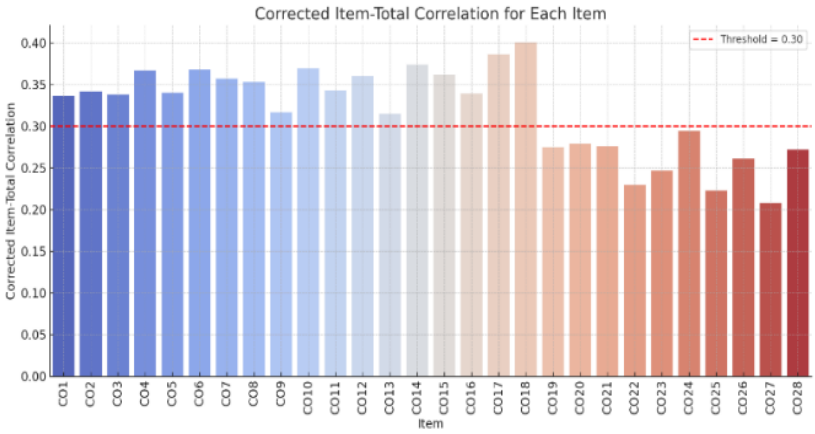

Figure 3: Corrected Item-Total Correlation

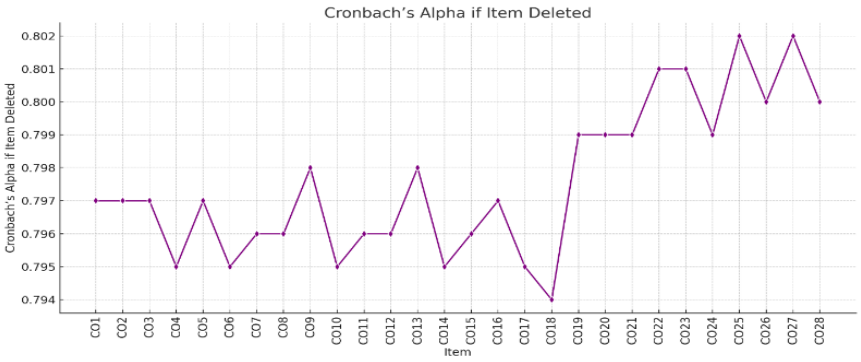

Figure 4: Cronbach's Alpha if Item Deleted

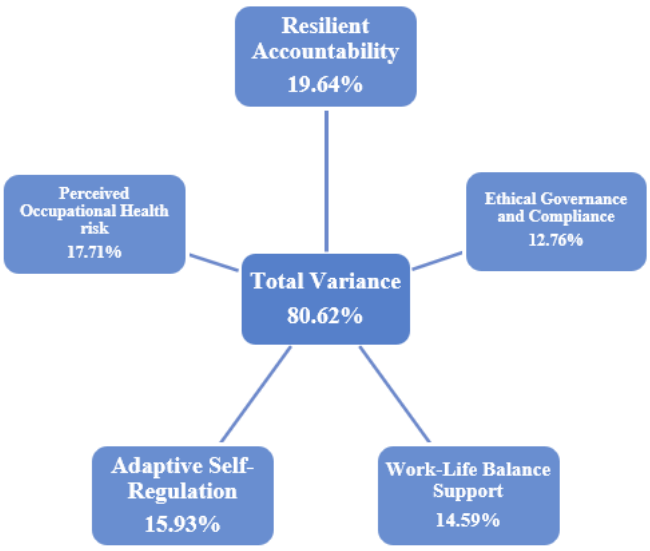

Figure 5: Factors and their Variances

The five dimensions emerged in Exploratory Factor Analysis (EFA) and were collectively explaining 80.62% of the total variance in competing obligations among health care professionals, indicating strong construct validity of the model.

The *first* dimension emerged as resilient accountability, contributed the highest variance of 19.64%. It can be inferred that healthcare professionals' capacity to fulfill their professional

responsibilities, even in the face of adversity, plays a central role in managing competing obligations.

The *second* dimension, perceived occupational health risk, accounted for 17.71% of the variance, highlighting that professionals' perception of their susceptibility to contagious diseases and the adequacy of institutional safeguards significantly influences their role performance.

The *third* dimension, adaptive self-regulation, explained 15.93% of the variance, reflecting the importance of goal-oriented behavior, time management, and learning from experiences in balancing multiple responsibilities.

The *fourth* dimension, work-life balance support, contributed 14.59% of the variance, emphasizing the role of institutional support in helping professionals maintain a sustainable balance between their personal and professional lives.

Lastly, the *fifth* dimension, ethical governance and compliance, accounted for 12.76% of the variance, underscoring the relevance of perceived ethical standards, fairness, and regulatory adherence in guiding professional behavior under pressure.

The questionnaire was therefore formed of 28 items, with good psychometric properties, in order to measure competing obligation against contagious diseases.

DISCUSSION

This study provides a multidimensional perspective on the ethical strain experienced by healthcare workers amid contagious disease crises. Each identified domain reflects a specific facet of ethical and psychological conflict.

Resilient Accountability captures the internal motivation to continue care despite risks. Perceived Occupational Health Risk quantifies concerns around safety and exposure. Adaptive Self-Regulation reflects the cognitive-emotional mechanisms used to navigate competing priorities. Work-Life Balance Support evaluates perceived institutional efforts to accommodate personal and professional needs. Ethical Governance and Compliance measures the integrity of institutional practices in ethically ambiguous situations.

These dimensions reveal the practical realities of managing care responsibilities during pandemics and other contagious disease contexts, pointing toward the need for comprehensive policy, training, and support mechanisms.

This study's limitations include limited generalizability beyond India and its timing post-pandemic, when knowledge had significantly evolved.

CONCLUSION

Healthcare professionals facing contagious disease crises operate under complex, often conflicting sets of obligations. This study assesses these tensions through a structured framework that reveals both individual and systemic dimensions of ethical conflict. The findings advocate for ethical clarity, institutional preparedness, and mental health resilience in frontline healthcare settings. Future research should explore longitudinal impacts and evaluate cross-cultural applicability.

Implications

The findings of this study carry significant implications for healthcare systems, policy frameworks, and mental health support mechanisms. By identifying five core dimensions-Resilient Accountability, Perceived Occupational Health Risk, Adaptive Self-Regulation, Work-Life Balance Support, and Ethical Governance and Compliance - the study provides a structured lens to understand and address the ethical and psychological challenges faced by healthcare professionals during contagious disease outbreaks. The Competing Obligation Scale (COS), as a validated tool, can guide policymakers and hospital administrators in identifying areas of ethical strain and implementing targeted interventions that promote institutional preparedness, ethical clarity, and professional resilience. Integrating the COS into training programs can enhance coping strategies and decision-making skills among healthcare workers, while also informing the development of transparent communication systems, protective infrastructure, and psychosocial support. Furthermore, the results underscore the importance of embedding mental health resources and ethical governance within routine clinical practice, not only during crises but as a standard component of healthcare environments. Addressing these concerns proactively can reduce moral injury, prevent burnout, and support the long-term sustainability of the healthcare workforce.

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Conflict of Interest

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