

ETHICAL CHALLENGES DURING CRITICAL PHASES OF THE COVID-19 PANDEMIC: AN INTERPRETIVE SYNTHESIS

Abstract

Background: During the most critical phases of COVID-19 pandemic, dramatic situations were experienced in hospitals and care centers that nurses could hardly verbalize. Especially relevant were deep challenges related to terminal illness, situations of extreme sacrifice, as well as reflections on protective measures mixed with beliefs. We intend to analyze which problems had the greatest impact on professionals.

Aim: The aim is to explore the ultimate basis for action when making decisions and the orientation of their behavior in the face of moral conflicts.

Method: The methodological strategy is an interpretive synthesis. Narrative review of academic articles that analyzed ethical dilemmas during the pandemic was carried out by searching five databases (Pubmed, Scopus, Psycinfo, CINHALL and WOS) between January 2020 and December 2022. Finally, 43 articles were selected.

Ethical considerations: Ethical requirements were respected in all study phases.

Results: The reading and review of the 43 articles initiated the first phase of inductive coding which resulted in fourteen initial sub-themes. Based on this structure, a second phase of coding was carried out, giving rise to six categories or emerging themes. To facilitate the process of identifying the central category, the authors agreed to carry out a phase of synthesis, grouping the six themes into three meta-themes: the identification and acceptance of human vulnerability; the discovery of positive paradigms in traumatic situations in society; the prevalence of the common good over the particular interest, as the core structure of any society

Conclusion: The study has shown the need to consider healthcare benevolence as a new dimension of health care upon global vulnerability. Responsibility is required to ensure the well-being of a global society, prioritizing the common good over particular interests and building solutions on solid moral structures. A new ethical landscape is essential, starting with a humanistic curricular training of all healthcare professionals.

Key words: COVID-19 pandemic, interpretive synthesis, healthcare benevolence, personalist ethics, narrative review, ethics dilemma

Introduction

The explosion of the COVID-19 pandemic in March 2020, generated a worldwide social alarm that put the entire healthcare system to the test, especially due to the novelty of the phenomenon.¹ During the most critical phases (March-April) of the so-called first wave, dramatic situations that nurses could hardly verbalize were experienced in hospitals and care centers. Since then, numerous studies have addressed the ethical dilemmas of the pandemic, particularly from the perspective of psychology.² Especially relevant were deep conflicts, related to terminal illness,^{3,4} situations of extreme sacrifice,⁵ as well as reflections on protective measures mixed with individual beliefs.⁶ This gave rise to a body of literature related to individual and societal vulnerability that has not yet been sufficiently analyzed.^{7,8}

The greater manifestation of its novelty is the multitude of studies devoted to inquiry about the triggers of fear, stress and moral distress caused by the pandemic: problems arising between patient care and infection protection for health care workers; inadequate patient care; conflict between necessary patient isolation and patient freedom; tensions within departments caused by changing health care teams; lack of agreement among colleagues regarding safety standards; divergent views on treatment planning; scarce resources of equipment, time and personnel; conflicts between personal and family roles.⁹⁻¹²

In this review we intend to analyze which challenges had the greatest impact on professionals through a narrative review method of different studies. The final objective is to explore the ultimate basis for action when making decisions and the orientation of their behavior in the face of ethical

conflicts, taking into account the effects caused by the pandemic, with the moral resources available to them.¹³ Then, we will try to draw the conclusions of a phenomenon that has lasted three years and from which, it is expected that humanity will obtain new parameters of moral conduct.

Method

Search strategy

The methodology strategy chosen is an interpretive synthesis.¹⁴ This approach facilitates the analysis of complex and diverse sets of literature, including qualitative, quantitative and theoretical documents without fixing the concepts beforehand. This strategy does not aim to aggregate data but to generate new concepts and theories.¹⁵ It is a method that shares elements with narrative synthesis, thematic synthesis or qualitative metasynthesis, in which emphasis is placed on third-order descriptors and interpretations.

The starting point is a set of three questions: a) Did the critical phases of COVID modify the moral conscience (behaviors, judgments or decisions) of the individuals? b) Did these modifications generate existential or moral distress, affecting their identity? c) What is the ethical assessment of the decision making that took place?

We began the study with narrative review of articles -excluding comments, reviews, interviews or opinions published in non-specialized journals- with search algorithm "covid-19 AND dilemmas" carried out in five databases (Pubmed, Scopus, Psycinfo, CINHALL and WOS) between January 2020 and December 2022, taking into account that the phenomenon studied had developed specifically in this period.

Inclusion/exclusion criteria

The study eligibility criterion in the selection of studies was the presence of ethical evaluations or discussions on clinical actions in the development of care activity during the critical phases of COVID. As inclusion criteria, we selected those qualitative studies that included: a) description of conflictive situations in the care activity; b) discussion of the moral dilemmas generated by this activity; c) ethical assessment of the intervention and the decision-making process.

Exclusion criteria were: a) studies on ethical dilemmas of the pandemic, without moral evaluation of the decision-making process; b) clinical studies on conflictive situations of the pandemic without ethical reflection; c) empirical studies of the pandemic without ethical reference; d) philosophical or theoretical studies on moral conflicts without reference to the pandemic situation.

Data extraction

The selection was made by two reviewers (IM and LE) who independently applied these criteria and in case of doubt, a third reviewer (MVR) was involved. This methodology is not free of intrinsic difficulties dealing with complex concepts which may lead to limited outcomes in database searches due to poor indexing, information lost and information gathering by personal contacts.¹⁶ Therefore, a detailed reading and rereading the articles was necessary to exclude those that did not meet the requirements to achieve satisfactory results. Out of 965 initial articles, 43 studies were selected after a filtering process (Figure 1). The indications method proposed by Dixon-Woods¹⁵ was used to evaluate the quality of the studies (Annex 1), which provided a first orientation. The final assessment was carried out based on the inclusion criteria. The description and conclusions of each study were then extracted and tabulated (Annex 2).

Data analysis

After the review of the 43 selected articles in the inductive coding phase (phase of coding) 14 initial codes or sub-themes were identified. These sub-themes responded to the most visible phenomena considered to be central to the ethical challenges by their authors. In addition, an attempt has been made to illustrate these situations by adding short statements drawn from the authors' professional experience - that could be considered representative of each situation. Based on this

structure, a second phase of coding of the fourteen categories was carried out, giving rise to six categories or emerging themes, representative of the profound conflicts raised by the health care professionals. Once the six categories had been identified, the synthesis process began (phase of synthesis), aimed at outlining an integrative idea of all the findings.

Results

Phase of coding

The result of this first and second coding is summarized in 14 subcategories, which can be grouped into 6 themes:

Theme 1. The phenomenon of death in solitude: the need for an explanation vs. the need to comply with the norms. The most dramatic consequence of the pandemic was death, with the aggravating factor of being an unexpected death, due to respiratory failure and frequently, alone. Obviously, attitudes towards patients had to be redefined. In other contexts, this situation would not have caused distress, but reality led many professionals and patients to face death unprepared, with the patients separated from their families, which is never desirable in any healthcare structure. The great dilemma arose as to whether it was necessary to reach this extreme of isolation, caused by the seriousness of the contagion dynamics, and the proximity of death caused by the infection. In this context, two categories of problems were detected: death in the company of strangers and family mourning dissociated both in time and space from the event.

Becoming the last family member: "Our patients died alone, without family, with no one to hold their hand before their last breath, except ourselves, when the situation allowed us to do so". It was common, in the context of the absence of family members to have health care professionals do their role, something for which few professionals were prepared and therefore, had to improvise. Healthcare professionals wondered whether it was necessary to reach that extreme scenario. This phenomenon was not new but has always been considered a system failure.¹⁷

Family mourning and the restrictive conditions of the last farewell: "They have generated great problems in people who have lost a family member and have not been able to accompany their loved ones during their death, nor identify the corpse, nor make a burial". On many occasions, the death took place within a process that included burial without participants, which made it 'fictional' for their relatives. The duty to accompany arose in those circumstances. Uncertainty caused anguish and it was often difficult to cope with it. The health care professionals questioned whether this extreme measure was essential, since such situations had been only reported in disaster situations.^{18,19}

Theme 2. The phenomenon of hyper-responsibility: blaming vs. poor preparation. Many professionals were faced with extreme situations in which their decisions generated consequences beyond their control, such as bed allocation, distribution of available ventilators or allowing patient accompanying persons. The other recurring choice was the duty to sacrifice. The result was greater stress than they could cope with, and on many occasions, their only escape led to blame themselves. The conflict focal point was whether this was the best course of action or whether it could have been managed with better emotional preparation, something scarcely contemplated in their curricula. The positive part was the appreciation and maturity acquired among the most involved healthcare workers.

Self-blame and sense of helplessness: "It has overwhelmed us, and in most cases, we have not known how to deal with the situation." In cases of self-blame, health care professionals recognized their personal helplessness,²⁰ which was alleviated with psychological or spiritual resources, although without clarifying what the ideal situation or future solution could have been.²¹ This attitude responded to a psychological escape system, but without approaching the territory of solutions.²² Guilt, then, was sometimes blurred.²³ Those who suffered the most were the nursing staff, who suffered the consequences more directly: moral distress, stress and depression.^{24,25}

Uncertain decision making due to lack of preparation: "But is it possible to decide who deserves to go on living and who does not? Does an elderly person have less right to life than a younger person?"

Some professionals had to make heroic, dramatic decisions²⁶⁻²⁸ while others did not assume responsibility directly but called on others to participate in the decision holding the organization accountable. All these situations materialized in indignation or anger and, above all, led to questions that should have been answered beforehand and were not conveyed to them.²⁹ Undoubtedly, failures in nursing home management were the most glaring.³⁰ But there were other decisions with psychiatric consequences which are slowly unraveling.^{31,32}

Theme 3. The phenomenon of digital media: the benefits of communication vs. the harms of its abuse. The pandemic brought to the surface a new phenomenon that was already latent in society. The use of digital media reached unexpected heights, acquiring the role of protagonists in society. In this way, a flow of communication was kept alive although eventually it became a double-edged sword. On the one hand, it was possible to maintain communication between isolated territories, and on the other hand, there was a clear abuse of the media, to the point of turning them into a substitute for personal contact.

Online communication: *"It made it easier to make video calls to families, before their situation worsened, generating in many cases that the patient could be at peace on a spiritual and emotional level"*. Online technology brought together what seemed impossible: reducing the isolation between patients and families, between citizens, as well as professionals, when remote consulting was needed.³³⁻³⁵

Telephone consultations: *"Consultations were conducted via telephone, but without physical exploration, how could one diagnose appendicitis over the phone and, perhaps, mistake it for gastroenteritis?"*. Sometimes telephone consultations facilitated rapid care, but the risk of trying to replace face-to-face diagnosis was pushed to its limits.^{36,37}

Theme 4. Distributive injustice: arithmetic equality vs. inequality in care. In the pandemic scenario, the permanent problem of the supply of services and resources became a reality, generating a variety of biases. Decisions affected on life or death of an individual, generating discriminations, including racial ones.

The distribution of ventilators: *"The greatest dilemma was the prioritization of resources, so every time new patients were admitted with in a serious condition, it was necessary to select who may have a ventilator and who may not"*. This was the most paradigmatic case since there seemed to be no therapeutic alternative. Decision-making was based on parameters of dubious validity, with a marked utilitarian bias. The healthcare system did not satisfy those need and generated injustices, especially among the terminally ill or vulnerable patients and among the health care workers themselves.^{38,39}

The distribution of urgent care: *"Lack of resources should never be an excuse to offer or not to offer such care and, much less, a criterion to 'select' who is a candidate to 'enjoy' them"*. At times, the trouble was not the absence of a specific resources but rather basic patient care. The scarcest resource in this situation was the time dedicated to the person, the place to care for him/her and the fitting personnel. Undoubtedly, there were groups that felt discriminated against, especially because of their age or race.^{40,41}

The distribution of resources, vaccines and tests: *"What responsibility do I have, as a conscious and free person, to accept a vaccine, when I know from my training that I do not have the same risk as another colleague who puts his life on the line daily in patient care?"* In a second phase of the pandemic, a subsequent supply problem regarding vaccines and screening tests was detected.⁴²

Theme 5. The phenomenon of violated freedoms: autonomy vs. precaution. Undoubtedly, the most talked-about aspect of the pandemic was the confinement of the population. This measure affected the potentially infected population group which extended to the entire population. This brought to the surface the great perplexity of contemporary society, where personal autonomy seemed untouchable.

Compulsory confinement and limited cohabitation: *"The beneficence attributed to physical presence must give way to the maleficence of contagion, since there are epidemiological deficiencies*

that demonstrate this". The most elementary rights of the individual, such as the right to free movement and assembly⁴³ were confronted with the safety of oneself or others. In fact, in recent decades this scenario was only detected in very local situations and for periods of hours or days. This situation came to alter the very coexistence and to generate violence,⁴⁴ but helped to outline the concept of common good, which sometimes contrasted with particular interests.^{45,46}

Compulsory isolation and separation of people: *"During the birthing process, mothers were denied skin-to-skin contact, the establishment of breastfeeding, and accompaniment during the process, among others".* The second right which was violated was freedom of assembly, i.e., compulsory isolation in case of infection.⁴⁷ The problem that arose was the subjective limit of the need for contact with others, which was more dramatic for newborns, children or the dying.^{48,49}

Mandatory vaccination and uncertainty: *"Misinformation and ignorance play an important role. The frequent response of patients to my question as to why they did not want to be vaccinated was "because the vaccine has been made too fast and we don't know what they are putting in us".* At a later stage, the vaccination dilemma was again uncovering the concept of the common good *versus* the particular interest.⁵⁰ Discriminations and societal biases according to sex, race or economic position appeared.⁵¹ The consequences affected psychological and physical health, as some additional measures such as use of gels and masks, also had adverse effects and consequences.⁵² The question was even raised as to whether excessive information could be harmful.⁵³

Theme 6. The material support of society: global health vs. the private economy: Finally, there was the problem of the consequences of inactivity and the health measures imposed. The phenomenon of confinement could affect territories of great social confluence, but it implied the freezing of vital economic activities. Compensation policies appeared, which were accepted by some social sectors and not by others. Moreover, once the situation was normalized, the question of job discrimination arose.

Restrictions on economic activity: *"Is it ethical to confine a person to his home on suspicion of infection, having as a consequence the cessation of his benefits and, with it, family welfare?"* It was clear that the priority of economic sustenance was imperative, because of sustained consumption and reserves were depleting. Economic conflicts arose across cultures but estimates and forecasts were widely disparate.⁵⁴⁻⁵⁶

Discrimination of the infected at workplace: *"They have enabled some separate spaces in their canteen for unvaccinated workers with more severe safety measures (safety distance and individual partitions). The principle of non-maleficence (do no harm and prevent harm) prevailed over autonomy".* The problem of the unvaccinated surfaced at the end of the vaccination process, also when vulnerable groups, such as oncology patients, were involved.⁵⁷ It was not a particularly serious phenomenon, but it caused tension between those who had complied with the rules and those who prioritized their opinion, giving rise to suspicions of opportunism and also feelings of guilt.^{58,59}

Phase of synthesis

Once the main elements that provoked the moral disruption had been described, the process of integrative synthesis began. To facilitate the process of identifying the central category, the authors agreed to carry out a phase of pre-synthesis -or third coding-, that gathered the commonalities of the themes according to their socio-anthropological foundation, grouping the six themes into quasi-definitive categories or meta-themes. In this way, the process of synthesis and inductive generation was stepwise. Three meta-themes were synthesized, summarized as follows:

(a) Themes 1 and 2 note the vulnerability of the human being in the healthcare context. This includes the identification and acceptance of human limitations, the ability to accept death and pain in the healthcare system, rediscovering the meaning of life, the value of suffering and the efficacy of empathy, even if not always has been managed fittingly.⁶⁰

b) Themes 3 and 4 suggest the discovery of positive paradigms in traumatic situations in society: more agile communication, empathy at a distance, global solidarity and the demand for a universal common law which implements distributive justice on solid foundations for all humanity.⁶¹

c) Themes 5 and 6 refer to the prevalence of the common good over the particular interest, as the core structure of any society: prioritizing the general over the particular, valuing sacrifice and solidarity for survival, discovering the balance between personal freedom and the good of all,⁶² although it sometimes may imply a certain degree of limitation in rights.⁶³

Discussion

The selected studies have uncovered a variety of major existential issues that, until now, had not been discernable except in periods of major catastrophes.¹² The possibility of categorizing such studies has made it possible to circumscribe the real problem underlying each case. Hence, six major categories or themes affecting the moral dimensions of man have been detected by an induction process: death, responsibility, justice, communication, freedom and survival. It is therefore worth asking what is common to all of them.

Probably the first deduction is that the pandemic has shown how vulnerable human beings are even to something apparently insignificant which, naively, we thought was under control, such as the development of a virus. In light of this intrinsic vulnerability, the first question posed at the beginning of the study may be answered: did the critical phases of COVID modify the moral conscience (behaviors, judgments or decisions) of individuals? Without a doubt, people's conscience has changed, especially after they discovered that utilitarian criteria for decision making did not work. In fact, utilitarian approaches became widespread as the only valid argumentation, generating evident injustices, where the particular interest prevailed over the common good.^{64,65}

Certainly, the existence of global threats to the entire planet has always existed, but they have always been linked to human decisions (e.g., nuclear danger, bacteriological war, generalized financial crisis), which are easier to foresee. In addition, thoughts (knowledge, attitudes, and skills), fashions and behaviors have also been globalized, with their advantages and disadvantages. In our case, the benefits of globalization (exchanges between societies, the opening of markets, the fluidity of the transport of goods and people) have not been able to hide its somber side, upon a pandemic, revealing the new concept of vulnerability, which may be called 'global vulnerability'. This vulnerability originates from the new ease of connection and dependency between all the members of widespread the societies on the planet. Thus, the action of one ends up affecting all human beings, as demonstrated in the COVID-19 pandemic. This concept of 'global vulnerability' compels us to rethink worldwide prevention strategies. Unlike in past times when these events were limited to a single territory or region, this is no longer the case, since globalization has meant that all of humanity is involved to different degrees. Although it is beyond the goals and objectives of our study, we consider necessary to put it forward, since it is yet a concept to be integrated and assimilated.⁶⁶⁻⁶⁸ Furthermore, it appears confusingly in the fields of ecology, urban planning or mental health, but it hardly appears in the healthcare arena. The response of healthcare professionals to this vulnerability has put forward the true, valid values that should govern society, some of which may be present in some ideologies and religions,^{69,70} and which had not been tested until now, or may have even disappeared over time.

This perception leads us to the second question: did these modifications generate existential or moral anguish, affecting one's identity? It is obvious that anguish has been generated, but we do not think that it may have raised identity problems. It is a fact that all the items described reflect a deep moral suffering that could hardly be assessed nor measured. There have been many studies reporting anxiety, stress, moral distress or insomnia as known consequences of the pandemic,⁷¹ although the experience of some groups were neutral⁷² or negative.⁷³ At first sight, one might have thought that the primary driver of action was fear, but the data disprove this phenomenon in the healthcare setting. Healthcare personnel did not act out of fear, although caution was perceived at every instant. These considerations may lead to rediscover the essential paradigms that govern human behavior and that have been repeated throughout history,⁷⁴ so that another pandemic will probably produce similar effects. However, at present, technology has become the priority tool, indispensable in governmental decision-making which generated feelings of failure for not meeting the desired

expectations. Among the expressions that best describe the situation experienced by the healthcare professionals are helplessness in the face of harsh reality, indignation at the system and moral distress at not knowing how to manage the suffering.^{75,76} We consider that an exhaustive analysis of moral distress is not part of the study, but it is worth highlighting that, along with the negative consequences of the pandemic, some dimensions of the personality and character of health professionals emerged which lead to give the best of themselves without modifying their identity.^{77,78} This aspect of their moral flourishing has barely been studied and it may call for future analysis which would enrich the practice of the health profession.^{79,80}

This perception moves us to address the third question: could it be said that we acted with moral coherence? What is the ethical assessment of the decision making that was carried out? We could say that a common perspective focused on the survival of the other existed, although the real events did not allow success in all cases. In this sense, the themes and meta-themes suggest a fundamental principle that governs the survival of human beings, which is beyond their technical skills upon natural accidents, but rather it is rooted on their capacity for unconditional support for each other.⁸¹ This capacity would coincide with the Aristotelian concept of benevolent friendship, something that all societies assume and present but with little reflection.⁸² This concept of ‘healthcare benevolence’ is what underlies distributive justice in the allocation of scarce resources; the prioritization of the common good over the particular interest; the need for freedom oriented towards the good beyond the mere opening of options; solidarity in the face of irresolvable conflicts; the balance between vulnerability and the human capacity for transformation, without giving rise to technological arrogance; and even the meaning of existence, which rests not so much on the completion of ideals as on the unique authenticity of each moment directed toward an end. Thus, the integrative synthesis of themes and meta-themes would lead us to the central paradigm of healthcare benevolence, which would explain the responses of the healthcare professionals (Figure 2).

Without a doubt, ‘healthcare benevolence’ is what encourages many professionals to develop an authentic social policy, although they may recognize that solutions may be reached very slowly.^{66,83} The causes of this apparent failure seem to lie in the superficial ethical perspective of patients and agents lacking humanistic preparation.⁸⁴ In response, a multitude of initiatives are now emerging including communication of experiences;⁸⁵ strength before the challenge;⁸⁶ acceptance of self-sacrifice;⁸⁷ and the most obvious practical initiative: adequate training in emotional management. These are aspects which should be included in the curricula of all healthcare professions including suitable humanistic training without ideological loopholes.⁸⁸ We think that the most obvious and at the same time most strategic challenges are found in this area, because no health system is prepared for the unforeseeable. Therefore, it is mandatory to trust in the flexibility and creativity of the people who constitute and integrate it, from executive managers to the direct practitioners. Consequently, it would be advisable to audit the degrees and postgraduate degrees in healthcare to identify which ones are prepared, or have received the necessary training, to make decisions and, furthermore, make the correct decision. This would imply to define and state the most basic principles of healthcare behavior, and to ensure means to implement them from the first years of learning (e.g. undergraduate training) until the end of professional practice (e.g. continuing training). The vital experience of COVID has allowed many structural elements of globalized society to emerge and we think that the opportunity to reform these structures should not be lost nor taken for granted.

Limitations

As with any qualitative study, subjectivity in the interpretation of data is one of the main limitations of the study. We have tried to alleviate it by using readings and re-readings with two reviewers and a backup reviewer for conflict resolution.

Conclusion

The study has shown the need to consider ‘healthcare benevolence’ as an identifying dimension of health care, able to confront an increasingly emerging global vulnerability affecting everyone. Such benevolence requires responsibility to ensure the well-being of a society that is also

global, prioritizing the common good over particular interests, subjecting personal autonomy to the dignity of the person and building solutions on solid moral structures. To this end, a new ethical landscape is essential, starting with the humanistic curricular training of all healthcare professionals.

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