ETHICS IN EXTRAORDINARY TIMES: PRACTITIONER EXPERIENCES DURING THE COVID-19 PANDEMIC

Commissioned by the Professional Standards Authority

Acknowledgements

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Executive Summary

This research was commissioned by the Professional Standards Authority and conducted from January to March 2021. The brief was to explore the ethical experiences of practitioners working in health and social care professions during the Covid-19 pandemic. The research methods comprised a scoping literature review, the iterative development of a semi-structured interview and focus group schedule with practitioners via email and 16 interviews and 5 focus groups conducted with practitioners from a range of professions.

The findings from this research offer new and nuanced perspectives, deepening and shifting our understanding of the ethical experiences of practitioners. Although much of what has been described in the literature reflected participant experiences, there were significant areas that have been overlooked and insufficiently emphasised. Those include i) what duties of care to self and others might mean in professions beyond intensive care; ii) how underexplored ethical approaches such as the ethics of care, relational ethics, virtue ethics and narrative ethics resonate with practitioners and relate to their experiences during the pandemic; iii) how practitioners perceive and engage with ethical guidance, including from professional regulators, and the significance of judgement; iv) the extent of moral injury and ensuing moral distress which will endure long after the pandemic. Those were important features of this work. Individuals were given the space to explore complexity, to highlight tensions, to identify what made the pandemic uniquely ethically challenging and to describe experiences, reflecting on the meaning of those experiences, rather than just describing 'categories' of ethical challenge.

Following the data collection, a virtual round table took place for those who worked or are interested in professional regulation. The discussion showed considerable congruence between how regulators and practitioners describe the ethical experiences of professionals during the pandemic. However, the interview and focus group data suggest that many practitioners do not perceive regulators, especially in their own profession, to be a source of advice and support in terms of ethical practice. Practitioner understanding of the role of ethical guidance from regulators, the regulatory response to the pandemic and the statutory remit within which regulators work varied widely with implications for trust and relational regulation. The research suggests that for regulators to have ethical impact, it must be considered at an interactionist and systemic level i.e. to attend to the connections and relationships between regulators, employers, defence bodies and other professional organisations as part of a system of regulation. Attention to concepts such as trust, credibility and legitimacy will be important and difficult questions about the tension between different functions – standards, registration, education and fitness to practise - of regulatory work cannot be avoided.

This research presents a picture of nuance and complexity. The ethical experiences of practitioners across the professions have taken a significant personal and systemic toll and will inform practitioner and patient experiences for years to come. The report concludes that this research suggests it is time to think about and approach ethics in a different way that is grounded in the experience of practitioners and focuses on building ethical confidence and capability. Specifically, by focusing on moral distress, the ethics of care, the role of judgement and practical ways of providing ethical support, learning from the pandemic will be grounded in what has been experienced and has significant potential.

The report makes recommendations for regulators, but also those interested in ethical practice, to consider. Those recommendations reflect the findings of this research and invite reflection, collaboration, learning and development in the interests of professionals and patients.

1. Introduction

The Covid-19 pandemic has created unimaginable challenge and change. The impact on health and social care and its people has been immense. Much has been written about that impact; so much that it can be overwhelming. This research is a focused exploration of one dimension of the professional experience during Covid-19 in the United Kingdom, namely the ethical experiences and perspectives of practitioners in the professions whose regulation is overseen by the Professional Standards Authority. It combines analysis of the large and growing literature on how the pandemic has affected practice with empirical research exploring individual practitioners' experiences. The report describes how ethical questions, choices, concerns and challenges have been experienced first-hand, where practitioners look for support and advice and how they perceive the response of the regulators. It offers an insight into the personal burdens and private fears of frontline staff.

2. Research Methods and Methodology

2.1. Principle and Pragmatism

This research was commissioned by the Professional Standards Authority in January 2021. The timeline was tight: the work was to be completed by March 2021. If it was to do justice to the experiences of those who generously took part, the project had to balance principle with pragmatism, particularly given that it began during the second wave of Covid-19. This research could not place any unnecessary burdens on those in clinical practice. It also had to capture the experiences of people who knew what it was to work during Covid-19. Attention to research rigour and people's needs were equally important.

The research aimed to achieve the balance between principle and pragmatism by prioritising practitioner voices and avoiding additional burden on participants. Originally, the intention was to conduct a survey to identify areas for exploration in interviews and focus groups. However, a considerable amount of questionnaire-based research with all professions exists. To add an additional survey to that published work seemed unnecessary and intrusive. Instead, a scoping review of the existing literature on practitioners' experiences during Covid-19 was conducted. That scoping review is described in section 3.

Ethical considerations were discussed with the Professional Standards Authority ('PSA') as the commissioning organisation, especially as the proposed participants were from a range of professions and settings, including matters of data governance, recruitment and sampling, consent and indemnity. A reference group provided review and comment throughout and proposed possible participation via educational, special interest and profession networks rather than via employers. The PSA facilitated participation by the regulators. The NHS Health Research Authority decision tool advised NHS REC approval was not required. The research did not take place on NHS premises and therefore site-specific R&D review was not indicated. Each participant was asked about local governance arrangements in addition to seeking individual consent. One participant in a non-NHS setting asked that their managing partner be invited to review the project. Information about sources of support was provided both during and following participation. Transcripts were available for review.

2.2. Interviews and Focus Groups

The findings of the scoping review informed a draft semi-structured interview and focus group schedule. An email attaching that draft was sent to 26 practitioners from 8 different professional groups; see *Figure 1*. Recipients were asked two questions: i) did the draft reflect their ethical priorities, concerns and experiences during Covid-19; and ii) was anything missing. 24 practitioners replied to that email. The majority (22/24)

considered that the draft schedule reflected their ethical priorities, concerns and experiences. Two, from the optical and osteopathic professions, made suggestions for additional themes. Several others suggested specific examples within an existing theme.

Figure 1: Responses to Email Contact Following Scoping Review Phase

Profession	Number of Recipients/Respondents	Draft Reflected Ethical Experiences	Suggestions
Medicine	6/5	Yes	N/A
Allied Health Professionals	3/3	Yes	N/A
Pharmacy	4/3	Yes	N/A
Osteopathy	4/4	Yes (3)	More on ethical considerations for those who run own business/do not work as employees
Optometry	2/2	Yes (1)	Conflicts of interest within profession
Midwifery	2/2	Yes	Visits as relate to antenatal care and birth
Dentistry	1/1	Yes	N/A
Nursing	3/3	Yes	Include considerations for mental health settings
Social work	1/1	Yes	Consider any difference between ethical perspective and experience of those in different sectors e.g. NHS cf: local authority

2.3. Sampling and Participation

Invitations to interviews and focus groups were sent to practitioners within a professional network across the professions whose regulation is overseen by the Professional Standards Authority. These approaches were not made 'cold' but with reference to the framework developed via the scoping review. *Figure 2* sets out the participants in the interviews and focus groups.

Figure 2: Participants in Interviews and Focus Groups, Including Professional Backgrounds

Profession	Number of Participants
Medicine	4
Nursing and Midwifery	4
Allied Health Professionals	5
Pharmacy	2
Osteopathy and Chiropractic	3

Optometry	2
Dentistry	2
Social work	6
Clinical Ethics Committee Members and Chairs	8
Advisors from Defence Organisations and Professional Bodies	4
Total	**40**

There were 16 interviews and 5 focus groups. Participants received information about the research in advance and were invited to ask any questions before providing consent. Working virtually, the aim was to create a safe space and to respond humanely to visible distress that was sometimes evident. This project is predicated on principles of research partnership, rather than the research hierarchy. Both the interviews and focus groups had to allow for unexpected responses, to explore emerging ideas in greater depth, to accommodate the dynamic and unpredictable process of hearing and investigating.

2.4.   Analysis

The phases of data collection and analysis were iterative and symbiotic; there was no separation of task and each informed the other. Analysis depended on close engagement with, and immersion in, the data which led to coding. Strauss and Corbin's (1998) three stage model, summarised in *Figure 4* below, was adapted for this research.

- Open Coding: describes a process in which the aim is to separate or group the data according to concepts or themes during close reading.
- Axial Coding: a detailed analysis of a category of data that has been generated as part of the open coding stage.
- Selective Coding: exploring and testing the relationship between categories, especially those identified as 'core'. A category might be 'core' because of its frequency, function or implications.

2.5.   Regulatory Round Table

Following the empirical research with practitioners, a round table event for those who work for, or have a professional interest in, statutory regulators took place. Participants were invited from all of the regulators overseen by the Professional Standards Authority. In addition, several academics, consultants and advisors from professional bodies, unions and defence organisations were invited. *Figure 3* shows the attendees.

Figure 3: Participants in the Regulatory Round Table Event

Organisation	Number of Participants
General Medical Council	2
Nursing and Midwifery Council	1
Health and Care Professions Council	0
General Pharmaceutical Council	2

General Osteopathic Council	2
General Optical Council	1
General Dental Council	0
General Chiropractic Council	2
Social Work England	1
Professional Bodies	2
Academics	1
Consultants	1
Think Tanks	1
Defence Organisations and Unions	2
Total	**18**

This virtual event took the form of a facilitated discussion about the project and it was not part of the data collection. Section 4.6.2 discusses the key points arising from the event.

3. Scoping Review and Literature Analysis

3.1.   Search Methods

A scoping review of the ethical experiences of different professions during Covid-19 was conducted. A scoping review takes an exploratory approach to the literature within a framework (Arksey and O'Malley, 2005; Peterson *et al*., 2017). The steps in the framework are related and iterative rather than chronological and discrete. A scoping review is helpful where the aim is to identify the range of emerging material about a question, i.e. to 'scope' what exists (Munn *et al*., 2018). Searches of *Google Scholar* and *PubMed* were completed using a variety of search terms, supplemented by a close search of specialist journals. Social media were also searched for posts about the ethical experiences of practitioners. The approach led to sources beyond traditional academic literature e.g. newspaper articles, podcasts, radio and tv programmes, including documentaries and news items. Those were valuable context and calibrated the themes from the scoping review. Figure 4 shows the search terms used for each source.

Figure 4: Sources and Search Terms for Scoping Review

Source	**Search Terms**

PubMed	• Covid-19 + Ethics • Covid-19 + Standards • Covid 19 + Regulation/Regulator • Covid-19 + Moral Distress • Covid 19 + Moral Residue • Covid-19 + Professionalism • Covid-19 + Workforce • Covid-19 + Moral Injury • Covid-19 + Dilemma(s) • Covid-19 + Clinical Ethics • Covid-19 + Burnout • Covid-19 + Resource(s) • Covid-19 + named profession (10 in total)
Google Scholar	• As Above
Journal of Medical Ethics	• As Above
Clinical Ethics	• As Above
Bioethics	• As Above
Journal of Nursing Ethics	• As Above
Twitter: • General Search • Focused Search of Specific Accounts	• Moral Distress • Ethical Experiences • Practitioners + Covid-19 • Burnout + Covid-19 • Ethics + Covid-19 •
Blogs identified using Blog Directory: • General Search • Focused Search of Specific Platforms, Blogs and Authors	• As Above

3.2. Review Themes

3.2.1. Covid-19 and Ethical Guidance

The Covid-19 pandemic prompted professional guidance for practitioners of all kinds. The statutory regulators of health and care professions published a joint statement in March 2020 noting the unique context and recommending that practitioners use "*their professional judgement to assess risk to deliver safe care informed by any relevant guidance and the values and principles set out in [their] professional standards*" (Joint Statement 2020). Statutory regulators amended their websites and provided resources for registrants (GMC; NMC; GOC; HCPC; Social Work England; GDC; GCC; GOsC; GPhC, 2020; Timms and Dye, 2021). Further guidance was published by professional bodies, royal colleges, the National Health Service, the Department of Health and Social Care and arms-length organisations. The guidance begat commentary and

discussion; for example, Hurford's legal analysis (2020) of the British Medical Association's Covid-19 ethical guidance.

Alongside the proliferation of guidance came ethical tools and frameworks (DHSC, 2020; Elves and Herring, 2020). Others, using a term that was to become commonplace for other reasons, proposed an ethical roadmap (Fritz, Huxtable, Ives *et al.*, 2020). Interest in ethics was never greater (Bowman, 2020). New clinical ethics groups were established, and existing ones moved to more frequent and focused ways of working. Guidance on providing effective clinical ethics support and governance was developed (NHS Providers, 2020). New guidance prompted discussion of the adequacy of codes of ethics, for example, in relation to uncertainty and Covid-19 (London, 2020). Huxtable (2020a; 2020b) considered the source and credibility of guidance.

Much of the literature focused on specific ethical problems, often within particular professions or settings. It was uncommon to find discussion of different ethical approaches during the pandemic. There were some papers about ethical responses to public policy; see for example, Weinstock (2020) on harm reduction. In relation to individual practitioner experiences, there were few papers exploring what ethical approaches might be illuminating. Much of the published work featured, perhaps unsurprisingly, utilitarian, consequentialist and duty-based analyses. Communitarianism and reciprocity were referenced in some papers, but largely through a primary ethical lens. For a minority, relational approaches were proposed as a valuable way by which to understand ethical experiences during Covid-19 (Jeffrey, 2020) and their impact, for example, in relation to compassion fatigue (Lang and Hester, 2020; Ramji, 2020). For Branicki (2020), the ethics of care and feminist ethics offered a way to analyse societal experiences during the pandemic. Others discussed the value of a virtue ethics approach emphasising patience, adherence and perseverance (Bellazzi and Boyneburgk, 2020).

For some, the pandemic created opportunities for ethical practice. Newham and Hewison (2021) argue that it allowed for a reduction in 'managerialism' and instead created space for a new focus on wisdom, the exercise of ethical judgement. They distinguish between 'outside in' and 'inside out' approaches to ethical standards and codes of conduct, with the latter referring to an internal sense of ownership and responsibility for ethical practice and being preferable to the 'outside in' approach which looks for direction from external bodies. For Desai, Lankford and Schwartz (2020), Covid-19 was an opportunity to build ethical competence and capability, particularly for trainees. In relation to regulation, there were opportunities to reflect on purpose and approach, with an emphasis on flexibility (Clamp, 2020), solidarity, learning and collaboration (Gallagher, 2020).

3.2.2. Work and Duties of Care

Ethical tensions between competing duties of care have been well-described. Questions have arisen about balancing wellbeing, safety and risk (Bakewell, Pauls, and Migneault, 2020; Schuklenk, 2020; McDougall, Gillam, Ko, *et al.*, 2020; Dyer 2021), and professional and personal duties (McConnell 2020). Those ethical questions are most acute when a practitioner works in a high-risk setting where Covid-19 is prevalent (Dunn, Sheehan, Horden, *et al.*, 2020). The nature and impact of risk at work has particular resonance for students and new practitioners (Schmidt, Gostin and Williams, 2020). Some researchers have focused on reciprocity and asked what society and organisations owe practitioners in terms of duties of care (Johnson and Butcher, 2021). Others have questioned how helpful, or not, it is to represent healthcare professionals as 'heroes' (Cox, 2020).

Relatively early on, it was clear that people from a Black and minority ethnic background disproportionately bore the burden of Covid-19 (BBC 2021), including practitioners (PHE 2020; The Kings Fund 2020; BMA 2021). In medicine, doctors from a Black and minority ethnic background reported feeling more pressured and less protected than their white colleagues (Mahase, 2020). The pandemic brought into sharp focus and exacerbated existing health inequalities (O'Dowd, 2020) and cultural and structural racism (Razai, Kankam, Majeed *et al.*, 2021). Those disparities are fundamentally moral matters enacted through decisions about whether, when and where staff work and how to protect and support them. Practicalities about personal

protective equipment ('PPE'), risk assessments and vaccination are underpinned by profoundly ethical questions about inequity.

3.2.3. Standards, Adaptations of Care and Different Professions

Care was adapted, often radically, during the pandemic and its effects were felt systemically, organisationally and individually (Coombes 2020; RCP 2021a; 2021b; BBC Radio 5, 2021). For students, trainees and those responsible for their learning, questions about placements during the pandemic presented ongoing challenges. Covid-19 shaped ethical fundamentals of clinical practice, such as consent (Turnham, Dunn and Hill *et al.,* 2020). Questions of resources – be those facilities, interventions, people or time – were pervasive (Worku, Gill, Brodie *et al*., 2020). Scarce resources were the subject of much discussion and eventually some guidance (BMA 2021). The limited availability of PPE raised questions about duties in specific situations e.g. resuscitation decision-making (Schuklenk 2020; Perkins, Hamilton, Canniff *et al*., 2020). Concerns about protection influenced practitioners' decision-making about the care that they provided with potential implications for fitness to practise (Dyer, 2020). New intensive care units were created (Robert, Kentish-Barnes, Boyer *et al*., 2020) and were sometimes staffed, in part, by professionals unused to the specialty.

The scoping review showed how the pandemic had altered ethical experiences in different professions. From social workers (Banks, Cai, de Jonge, *et al*., 2020; Sen, Featherstone, Gupta *et al*., 2020) to allied health professionals (Coto, Restrepo, Cejas *et al*., 2020), and from pharmacists (Cox, 2020) to dentists (Coulthard 2020, Fallahi *et al*., 2020), all professions were affected. Whether a practitioner was working at a relatively 'junior' level or in senior management (Newham and Hewison, 2021), the effect of Covid-19 on practice was far-reaching and presented novel ethical questions. Campbell (2021), for example, describes the paramedic experience of sharing bad news during Covid-19. Amidst the ethical difficulties, there was support from, and collaboration between, practitioners from different professions (Cerone, 2021).

3.2.4. Moral Injury and Moral Distress

Much of the literature focused on the moral injury and moral distress (Morley, Sese, Rajendram, and Horsburgh, 2020; Dean, Jacobs and Manfredi, 2020; Shale, 2020, Bowman, 2021; Hines, Chin, Glick and Wickwire, 2021; Sheather and Fidler, 2021). Moral distress was originally described and developed by Jameton (1984, 1993) as a "*psychological response to a morally challenging situations such as those of moral constraint or moral conflict, or both.*" (Jameton, 1984: 6). It describes situations where a practitioner is unable to act in a way that she knows to be ethically right due, for example, to resource constraints or practice changes. Moral distress is often experienced internally but shaped externally. The legacy of moral distress is often described as moral residue. Moral injury has been discussed since the beginning of the pandemic along with its risks to practitioners. (Greenberg, Docherty, Gnanapragasam and Wessely, 2020; Williamson, Murphy and Greenberg, 2020). Regulators and regulation have been identified contributors to moral distress (Cachionne, 2020).

Understanding of moral distress developed as the pandemic went on (Hines, Chin, Glick and Wickwire, 2021). Discussion developed about the concept of moral injury and its reach beyond practitioners to patients, carers and families (Shale, 2020). There were specific factors in the pandemic that created unique ethical challenges and therefore moral distress. Anderson-Shaw and Zar (2020) write about the pervasiveness and changing experience of death, for example as people died alone, as causes of moral distress. An individual's career stage and the workplace setting were also explored. Jacobs and Manfredi (2020) identified that trainees were at high risk of moral injury and distress. Johannson (2021) considered preparedness and the intensive care setting as important influences on moral distress. Authors, such as Shale (2020), Morley, Sese *et al*., (2020) and Hossain and Clatty (2021) offered thoughts on how to address moral distress. Of the different areas identified in the scoping review, moral distress and injury was, and continues to be, dominant. As Gerada (2021) notes the impact of moral distress has worsened as the pandemic has gone on and its legacy in terms of practitioner health

and function (Roycroft, Wilkes *et al*., 2020; Shortland, McGarry and Merizalde, 2020) is likely to be serious and enduring.

4. The Ethical Experiences of Practitioners during Covid-19

4.1.   Work and Practice Context

4.1.1 No Practitioner is an Island: Duties of Care. Responsibility and Risk

Participants identified ethical dimensions of their altered practice environments. For many, the question of whether to come to work at all was an early and significant ethical challenge. Most described their fear, anxiety and worry as they realised the impact of the pandemic on their working environment. These were choices that, for some, reflected what defines and distinguishes health and care professionals:

> "There were a couple of cases that were really difficult, where people refused to come and work on a ward that had COVID positive patients on it. And actually, there were there were quite a few of those within the first peak and again in December. And I found that really difficult, and I had written out to all the nurses to say, you know, '*actually this is our profession, we look after people who are sick, if a patient has got a virus, they are ill and that is our job*'. And unfortunately, the world crisis involves healthcare, this crisis, and that's our job as nurses, as doctors, as OTs, we have to be in there on the frontline. We're not like other jobs. We put patients first. We're there when people need us. I found that really difficult because in some ways I understood why they
> were really worried and really scared. I was too, but that's the deal when we sign up."
> [Interviewee 15]

Ethical reflections about work were often framed as balancing a practitioner's own interests with those of their families and patients. One interviewee, whose partner was pregnant, described how he thought about risk and duties of care, noting that his conclusions differed from those of his colleagues and employer:

> "in terms of my own risk, and particularly because my partner was pregnant, the first time I was back, it was horrible. So, it was even more complicated because my risk as an individual is relatively high in that I would catch it but had a low consequence, but then there was a risk of passing it on at home, and it was a much more severe call. And I grappled with it, really I did. Eventually I asked to be put on low-risk duties. And actually, well, that was not looked upon positively by [institution] or some of my colleagues, because they just kind of said: '*everyone's got it, and everyone's passed it to their family*'. I felt guilty and like I'd let the side down. Did I do the right thing? I just don't know."
>
> [Interviewee 2]

Some practitioners admitted that fear and anxiety about work prompted negative emotions towards colleagues:

> "I've got to admit, and I feel bad, I do feel resentment to other colleagues who are getting to shield or only be in green areas. Honestly, I feel like saying '*doesn't my family matter? Doesn't my life matter?*'."
>
> [Interviewee 11]

In some teams, there were colleagues who moved to working from home which prompted comment from several participants. One noted that the effects may endure and influence professional relationships:

> "I think it was when our psychologists had kind of downed tools and worked from home and I was saying to the lead psychologist, '*it's interesting, isn't it? So why do they feel that it's okay for them to go home, but yet, our domestics and our healthcare assistants, and our nurses, and our doctors, and our pharmacists are all still here*'. Understandably, staff on the frontline thought, '*you think your life is more important than the patients that we're looking after here*'. Actually, I think there's going to be a real difficulty in rebuilding those relationships."
>
> [Interviewee 7]

For those working in some professions, especially in retail settings, for example, optometry and pharmacy, the ethical questions about work had a different ethical hue. Those practitioners talked about whether their work was essential and if they should carry on working, especially in the first lockdown. Commercial considerations added a further layer. Some interviewees perceived that their employers put pressure on them to work when they did not consider that it was safe or appropriate for them to do so:

> "The company I work for, they were doing everything they could to keep us working. And it wasn't on. It undermines us as a profession. In my place, we mostly do stuff that isn't essential. I mean, we do pick up things in routine examinations and the like, of course, but honestly, we didn't need to open to everyone. But you know, it was hard to challenge, impossible really. I lost sleep thinking I was not only putting myself at risk but loads of other people. It wasn't my choice, but you've got to pay the bills, you know?"
>
> [Interviewee 5]

For practitioners, such as osteopaths and dentists, who were working in an independent practice, they felt the absence of an employment structure to inform their decision-making. Ethical questions about work were common and had to be navigated alone:

> "when I started to think that through for myself, I decided that yes, I did. I should work, should continue to work through the pandemic and offer the service. And then then I felt I needed some kind of framework really, for how I, how I decide to run my practice. Should I see some patients face to face and not others? Most of us don't see very sick people. And we are autonomous practitioners. So, we don't have this infrastructure around us, the management structure and, and, and the employment structure. So, there is more freedom to make those decisions. And actually, this is this is one of my reflections on the issue is that osteopaths are clear that we are mainly autonomous practitioners. But the implications of that in a pandemic haven't really been thought through. So, there's all sorts of responsibilities that come with that. And all sorts of skills that are needed actually, thinking skills, reasoning skills to work things out for ourselves, because we're not being told what to do quite so much."
>
> [Interviewee 6]

Some perceived that they were overlooked, comparatively unsupported and less informed than their peers who were working in the NHS:

> "I reviewed lists and we shared it on WhatsApp panic groups of principals. None of the NHS guys, because they're totally funded, didn't care. So, the NHS dentists, really, they have a totally different story from private. They were supported financially; they were supported by Public Health England who never wrote to me once. I don't think Public Health England communicated with me since last March."
>
> [Interviewee 12]

The balance between preserving livelihood and thinking about the wider public interest preoccupied many of the practitioners in private practice. As the first lockdown approached, one participant described how he had decided to provide care, without charging, to people who weren't registered as patients:

> "And we squeezed in as many of anyone's patients in the world that we could. We didn't even charge the last day. We had people ringing us going, '*my guy just closed this morning, my crown is off*'. So, we fitted maybe 30 people into the last day. I had all the dentists working. And to just get people in the door put in temporary, we gave pots of temporary filling, I'm pretty sure we're not allowed do that anymore."
>
> [Interviewee 12]

One interviewee noted that there were longer term and wider implications when individuals who worked in independent or private practices ceased to work:

> "It might seem self-interested to think about our incomes, but it's a reasonable consideration to some extent, because if your practice goes under, and if you become deskilled, it's actually not in the public interest long term."
>
> [Interviewee 6]

Risk dominated the interviews and focus groups. It was the frame through which responsibilities and care were viewed. Many noted that, at the beginning of the pandemic, they were facing a unique situation that combined both uncertainty and serious risk and they were doing so with limited access to PPE and evidencebased guidance. Access to, and the appropriateness of, PPE was discussed, without exception by every interviewee and focus group participant. Across the professions, it was a recurrent problem that represented fundamental ethical questions of value, duty, care and resource. For the majority, PPE had been the biggest failure they had experienced causing distress, confusion and a legacy of feeling undervalued by "the system". Without sufficient or reliable PPE, risk was exacerbated and questions of balancing duties to self and others became more complex. One interviewee described it, with visible emotion, as:

> "the unforgivable irony of being asked to care for others in a life-threatening situation when we were being totally uncared for. Right from the beginning, you know, we weren't even given the basics. Yet, we were expected to just get on with it, fulfil our ethical duties which were only about patients, never about us and our families. Surely, it isn't ethical to do that to anyone? Sorry, I am still so upset and furious about it all."
>
> [Interviewee 14]

The duration of the difficulties varied depending on profession. For example, when access to PPE had improved in the NHS, people working in private practices, such as dentists carrying out aerosol-generating procedures, still struggled to source adequate PPE:

> "I also couldn't get FFP3s [masks] because they were either restricted to the hospitals, correctly, or restricted to the NHS dentist so when we were to reopen the suppliers wouldn't supply us because we were private That meant I continued to have to put myself and my staff at unnecessary risk. Lost even more sleep about that."
>
> [Interviewee 12]

For those participants with leadership responsibilities, the questions of risk, responsibility and the duty of care they owed their colleagues and teams were both difficult and upsetting:

"Ethically I have felt that the decision-making around the use of PPE has been agonising from the very beginning, I feel has left us, you know most professions and especially anybody in the leadership role, in a really difficult position. And I think, again, that has come from the lack of stocks and supplies, rather than being
able to do the right thing for our people. The first ethical part is leaving people really vulnerable to a virus that actually had a high fatality rate. But I think, for me, what is kind of equally as important is the lack of confidence it gave the public and our colleagues in people in senior leadership roles because of the changing rules, which didn't have much logic and science attached to it at the time. It meant staff couldn't trust us [leaders]. I think that lots of people in my position would have felt very, very compromised from that. I actually felt really helpless. Really helpless. I know, there were lots of occasions where I would have like, been at home in the evenings, with my husband just being in tears thinking this is really, it's really uncomfortable, I feel so compromised. But also, I think I've spent so long building my integrity and trust that actually I found it really hard. I know it all sounds a bit selfish probably sounds a bit like it's, it's about me, and it's about people thinking
about me, but it kind of was and I thought I still need to stay in this leadership role. And I need people to trust what I'm saying is the right thing."

[Interviewee 7]

"what I was fearful of is the member of staff, who catches it from here, which is predictable, and then gets poorly or worse. And then it's on our watch, we've allowed that to happen, especially at the beginning when PPE was just a car crash and what felt like gas-lighting by government and others. Now, if you look at the percentage of staff who could catch it, either at work or from home, whatever, the uncomfortable reality of something that's affecting so many people is, it's going to happen. So, it was almost that bit about not if, but possibly when? And how could you live with saying you've put people into that situation. There was a real fear there in that sense."

[Interviewee 15]

Another participant believed that the context of the pandemic meant that the tension between the inevitability of risk in clinical work and the need for reassurance about safety prompted new questions for his staff:

"There I was sanctioning people doing work. And people were discussing about being safe. Well, how safe? Do you mean 100% safe? So, there's all these discussions about what's an aerosol generating procedure or not. And again, this was made binary, because in the textbooks it was. But it's a spectrum, the sizes vary across, you know, breathing generates aerosol. It isn't as cut and dried as we want it to be, especially when we're scared. The guidelines are right, you've just got to draw a line. But I know that my, you know, the level of PPE we had here wasn't 100%. It was never going to be. Now it wasn't 100% for flu the year before or for other things. But the media on this was so in your face all the time, that people were asking questions that they'd never really asked before. And I had an ethical obligation to answer them."

[Interviewee 8]

Many practitioners identified the ethical considerations about risk, duties of care and access to PPE as the first issue when asked an open question about their ethical experiences. The impact was far-reaching: taking a toll on health, causing people to question their value, prompting visible emotion and, for some, shaping how they were able to adapt and cope:

"So, doctors and nurses have been saying, you know, I think in the first wave that there was a sort of element of heroism, and you know, Blitz spirit. And then they didn't, people didn't feel like that anymore in advance of the

second wave that felt like, actually people hadn't been properly looked after, at all, not at all. And bad decisions had been made by people we should be able to trust, and why should we have to be thrown into the front line again?”

[Interviewee 4]

4.1.2. Strange Lands: The Challenge of Redeployment

Many interviewees, particularly in hospitals, were redeployed, often at short notice and to unfamiliar settings. For some, redeployment was an ethical decision:

“It was right to go where need was greatest. I mean that's what you do as a healthcare professional, isn't it? Or at least it ought to be. I didn't agonise, it was a case of '*tell me what needs doing*' and then I just tried to be useful even though it was years since I'd been in acute medicine.”

[Interviewee 13]

For others, redeployment was not a choice. A trainee described leaving general practice to return to the hospital:

“So, I ended up being told '*get back to [hospital name]*'. I've hardly done anything that is relevant to Covid – no intensive care, no infectious disease, not even much general medicine. I did, you know, I'd done, psych, paeds, O&G – whatever. I was terrified. Scared of not being able to help, scared of messing up. And there was no choice. I ended up in an extended ICU and – and everyone was lovely, but you know, it was overwhelming. I felt sick every time I'd leave for the next shift. And this is kind of a selfish thing to say, but I wasn't, well, wasn't getting the training I'd chosen, and I was preparing for exams and stuff which is all forgotten now. I've still got no idea when I'll be back in GP.”
[Interviewee 14]

The extent to which practitioners felt prepared for, and supported, in redeployed roles varied. Whether practitioners were working within their scope of practice following redeployment was an ethical question that many participants felt acutely. Several commented that they believe too little consideration had been given to the support needed to work safely (in all senses) during a pandemic in a practice setting that is utterly altered:

“I think there's something fundamentally ethical around redeployment. I think it was a kind of, '*right, we need to redeploy people*', there wasn't necessarily a thought of how skilled or ready those people were for that, a very
different practice context, and how we somehow gone from saying, '*you can't possibly work in this environment unless you've done this course, this course, this course*', to suddenly, any all-comers that, I think bothered me
when I saw it. And some really extreme examples, like speech and language therapy techs, or assistants who'd been working in special needs schools, for example, who suddenly found themselves parts of proning teams, when actually their roles had been about sticky-back plastic and laminators and preparing some education materials. And, and I and the, what those people were exposed to, that was so outside of their anticipation. “

[Interviewee 1]

The same interviewee noted that there was a wider ethical dimension to redeployment that was considered:

> "I kept thinking to myself, what if I were, if I was banking on a special needs school to support my very needy child, how morally justified is it in pulling that person? Those very skills? So, it was almost like there was a skills currency, like there was a, you know, but some things were seen as more valuable. That's a moral assumption, judgement if you like."
>
> [Interviewee 1]

Risk was a dominant theme for both interviewees and participants in focus groups. Those who had been redeployed talked of learning to practise anew. Many felt an ethical responsibility to negotiate, in a crisis, what was within and beyond their competence:

> "look, you're a consultant urologist, there are lots of things you can do in ICU, you can take bloods, you can do, you know, all sorts of simple things. It might take you back 20 years, but there's plenty of things you can do. You may, you know, you may be the consultant, but you might actually be guided and mentored by an SHO in anaesthetics in the ICU. And all that sounds a bit strange, because you're the consultant, well, it's not really. You know, it's a question of everybody doing what they can do and working, you know, outside your comfort zone, but not stupidly outside, you know. So yeah, that's an ethical judgement you're making all the time."
>
> [Interviewee 13]

The spectre of regulatory sanction and fitness to practise loomed large for several practitioners who were working in unfamiliar settings with critically ill patients who had a novel disease about which little was known:

> "And you know, people were worried about *'will I be covered? Will [regulator] support me if it goes wrong? Does this sit within my scope of practice? Am I permitted to do this?'* Because all my regulated professional life, I've been encouraged to think about what's at the top of my licence and how not to step outside of it. So, I think all of that was very confusing, and disorientating, and created enormous amounts of uncertainty for people."
> [Interviewee 15]

For some, redeployment was an opportunity to situate themselves as health professionals with more transferable skills than had perhaps been appreciated:

> "we're so often seen as, you know, limited say to rehabilitating people or helping with injuries, you know, unless you're a specialist physio. In the pandemic, I worked in acute medicine where I was able to do so much more. I was there alongside the rest of the team, and often doing stuff that I think no one expected. We've got much more to offer, and the pandemic got rid of some of the stereotypes."
>
> [Interviewee 10]

For a minority of participants, redeployment prompted questions about the degree of specialism in health and social care and transferable skills within the wider system:

> "So, we're specialist in one area, we're very good at one thing, and that's fair enough. But, we also all need to be re-deployable. And that's, because that's in the public interest. I think it is good for everyone to get more diverse experience. I hope that might be something we think about as a profession when we emerge."
>
> [Interviewee 11]

4.1.3. All Changed, Changed Utterly: Practice Context

For many participants, wherever they were working, their experience of their professional practice was transformed. There were multiple manifestations of that transformation, each of which brought with it ethical questions, concerns and problems. First, there was the change to the volume and duration of work. For many, the demands on their time and the intensity of their work increased exponentially. The impact worried several, with one participant articulating the ethical choice as being between:

> "keeping going, even when I was on my knees and weeping behind my PPE with exhaustion because it was hours later than my going home time or, you know, going home. Even just taking a break was hard because you'd leave your team short-handed, and we weren't coping as it was. Hospitals and organisations bang on about wellbeing, but the truth is we were making impossible choices and our wellbeing had nothing to do with it."
>
> [Interviewee 15]

One interviewee wondered how much work was too much when he received requests from employers and locum agencies to do additional shifts:

> "one of the things I had to think about was how much work could I take on. So, I was asked to do full time hospice with a one in five on call, but which is a normal busy post, but I was also asked to still do a one in five on call for [hospital]. So, I was essentially working every other night and every other weekend and all week and was that okay? And how do these organisations know? Should I have pushed back? I think they were just 'we need the help. We need the personnel'. It was exhausting but I don't think it affected my clinical judgement but then the risk is people say that without realising when they're tired, how they've been affected. But I think it was stepping up to a level of need that wasn't there before."
>
> [Interviewee 2]

Others emphasised that the pace of the work, especially in the early stages, was unique and inevitably influenced judgement and decision-making:

> "Oh, and decision fatigue, I really felt that in the first wave, between March and June, thereabouts, March, April, May, I just, I don't think I've ever made as many decisions that had potential big ramifications in such a short space of time, with so little time to process each one. I mean, it was just, it was it was it was like being constantly assaulted. And that was very, that was very hard. So, I think those judgments felt much less considered, then, than I think they ever have in my professional life."
>
> [Interviewee 9]

Across the range of professions, practice became virtual and remote with little or no preparation. Many participants spoke about remote and digital practice in both the public and private sectors. Interviewees and focus groups discussed ethical considerations about confidentiality, privacy, inequity, access and quality clinical care. One interviewee recognised that moving to remote and digital practice could have profound implications for patients:

> "we made the switch over to video consultations very easily. Actually, they're quite problematic, video consultations. You know, people don't have confidential places to do them. They don't know the technology, even if they have the technology, they're not familiar with, you know, how to get shots of the right bit themselves, etc. on video. Fair enough. I'm not sure I would either."

[Interviewee 4]

Some described positive impacts from remote and digital practice, especially for the professionals who could see more people, mitigate serious risks from Covid-19 and continue to provide care. For a few it was a less tiring and intense way of working. Others disagreed, particularly in focus groups, describing exhaustion from virtual consultations and missing the peer support and structures that characterised their practice. Some said that for certain people, the young or those with simple problems, the transition to digital care and remote interactions had been positive:

"there's another group of patients, I think, and families that have really found it really brilliant, and I've actually had more contact, I have been able to message people a lot quicker and have been able to do things. And involve their families probably in a very different way than they might have done beforehand. So, I think that's been really positive, particularly for our young people who are really familiar with digital." [Interviewee 7] "If it's straightforward enough, then we'll see them on the video call instead. And it's interesting, managers think that's not such good quality care and we need to try to get back to do more face-to-face stuff. But it has real benefits in terms of promoting more self-management among patients. Patients don't have to travel in all the time. And it's changed that sort of power balance. So now, now we can give people the education information and tell them how to go off and get on with it [exercises] themselves. And then we're reviewing it with things like standardised self-assessment, rather than doing more impairment-based assessment." [Interviewee 11]

For other practitioners, especially nurses, GPs and social workers, the loss of being able to see people in their homes was a fundamental change that presented significant risk, often to the most disadvantaged:

"there are things with our clients that are really important to see them in their home environment, see how it looks, you see how they are, you see what they're wearing, you see how they smell, look at interactions with family if there are others in the home, there's a lot of things that you get from a face-to-face contact, and so on. I think a lot of our clients, it's really, I think it's been probably quite challenging. And I think my worry is that they'll get isolated or relapse in terms of function and health and we haven't seen yet how damaging that will be. You know, remote work may seem technically do-able, but we have no idea what it does to clients who we might have worked with for years." [Interviewee 16]

Several people in different professions and practice contexts, noted that the move to digital or remote practice had an inequitable effect. Questions of digital exclusion, disproportionate harms and technological confidence arose frequently:

"people couldn't book face-to-face directly, they had to talk to a doctor first. And whilst that works extremely well, for many patients, it works very poorly for some patients. And there's a debate to be had about whether it should work better for those patients. But for those patients with mental health problems, a mixture of intersecting problems, stroke, complex health needs, who were used to face-to-face contact with a GP, they found it very difficult to adjust. They all found it difficult. So, I think, you know, there was definitely a change to the relationship and a barrier to access." [Interviewee 4]

> "it is the polarising of inequality: vulnerable patients are even less accessible, the ones with complex needs. It's been really hard, and I have become more aware as it has gone on. It's become clearer and clearer that the telephone and the remote and the platforms they just don't work for a lot of those groups. Actually, I did know that, but it's become more and more evident. Equality of access matters and it has been seriously damaged"
>
> [Interviewee 9]

Many practitioners talked about the impact of the pandemic on standards of care. It was a recurrent theme with participants often recognising that they were providing care that was not ideal and wondering at what point that diminution of care became unacceptable. The discussion often reflected on the impact both for patients and for professionals, especially in terms of potential errors, complaints, litigation and ultimately fitness to practise. The participants from general practice were particularly concerned:

> "not being able to examine the patients and other things being open to missing diagnosis. I have often had sleepless nights about not being able to make an accurate diagnosis and missing things, serious life-threatening things, like cancer. And you know, lots of stuff. I mean, for another example, you know, how do you rule out cord compression in a phone conversation?"
>
> [Interviewee 3]
>
> "Will the [regulator] be sympathetic if I miss something? You know, it's all '*be flexible, we understand*', but really? We're sitting with that dilemma every time we make a decision without seeing people face-to-face because, you know, it's just more risky. It just is."
>
> [Interviewee 9]

For those who were not directly involved in looking after patients with Covid-19, the systemic effects of the pandemic and the ethical responsibility to balance risk and a patient's clinical interests had been overlooked:

> "the knock-on effect on other health needs is significant. We've got a list of patients at the practice who are waiting for non-urgent scans, diagnostic investigations, and of course, being general practice, you know, that's, that's a low-risk list. But inevitably, there might be one or two people who it transpires in the future, it's not low risk, and actually, they should have had this scan three months ago. And certainly, after the first surge, hospital colleagues were seeing people with late diagnoses of this that and the other presenting."
>
> [Interviewee 4]
>
> "I think what we were seeing is that patients were less willing to go to hospital to be checked so they were leaving things later. When they did get to hospital, they were rushed in and out and possibly not as well patched up. When they were there, the staff that were covering, seem to maybe not have the same continuity, or there were staff in the wrong place where the i-s weren't being dotted, and t-s not crossed which meant that when they were coming out, they weren't, they weren't in the best, best, nick. So, some people, you know, all the elective stuff obviously was getting stopped anyway. And the emergency stuff either was being delayed, or it got there
> or being rushed in and out would mean that the quality of care was more was more dubious. What we were finding is we were really struggling to get to the bottom of what was going on with our patients."
>
> [Interviewee 8]
>
> "in primary care, it's often been very difficult to make sure that we are doing the right thing for the patient under the circumstances: taking into account their needs and also balancing that with the risk to ourselves, our

colleagues and the rest of the population because we could be a vector for transmission of disease. These are ethical decisions no one mentions in all the talk about ventilators – we're making, you know, these every day."

[Interviewee 3]

4.1.4. The Realities and Ethics of Care During Covid-19

For those working directly with patients who had Covid-19 and in acute settings where significant changes were made to their practice, there were specific areas of ethical challenge and choices. Often these were as a result of working within a so-called 'command and control' model informed by national policy. Several participants noted the volume and changing nature of guidance and its effects on the nature of their work and ethical decision-making:

"in the first wave particularly, the message from the Government was that seven days after a positive COVID test, somebody could go home if they were well. So that could be to the nursing homes, or it could be back to their own home where there might be a vulnerable relative. And so, as foot soldiers, we're pushing that and getting people home. And then, of course, that all became a big scandal and the guilt that - as well as guilt about having pushed people back to care homes, you might, you know, have caused the death of other people potentially. I mean, I don't know how, how often that's been true. But that's the feeling."

[Interviewee 15]

"There's a 'no-choice policy' at the moment, for example, if a care home has been found for you, so if you're if you're medically okay to go home, and your care needs have been met by the team, and they set something up for you, then you've just got to go. Whereas in the past, people and their families could explore different care homes and nursing homes and sometimes people doing that stay in hospital for quite a while, while that process went on, and now there's something concrete that says '*here that I'm showing you this piece of paper that shows you that that's not allowed*'. And the thing is it's for the greater good because it means that there's room for people to come into hospital if you can get the people out of it. It's interesting on that whole topic of patient autonomy, isn't it, which is such a funny one anyway. So, it might be that the OTs have been working on, I think it's, I don't think it's standard that this could happen, but it might happen, that they've been working on certain things and setting things up with the patient, and then suddenly, they've just gone. And, you know, all that work has been for nothing."

[Interviewee 11]

Caring for Covid-19 patients, even for those trained in specialist skills, was difficult and frightening. One interviewee vividly recounted the complexities of proning:

"Oh, my gosh, so you've got, you've got somebody who is already very vulnerable, you know, they've got no clothes on. And they've got all these tubes, so they've got the, you know, lifeline on the ventilator, keeping them breathing. If you remove that, or remove this, then, you know, you've literally got less than a minute, a minute to sort that out. They've got arterial lines, pull that thing out, there's blood everywhere, they've got catheters, and, you know, no control over their bowels. Things are so complicated. And you've got other IV lines, sometimes they're on dialysis. Already, with somebody being there flat on their back, you have to be right on top of your game and be careful not to move things. If you prone somebody, everything is going to be flipped. So, you've got to think about moving all of the stuff that I've just mentioned, you need an anaesthetist there in case you do lose the vent. And then you've got a body, who knows how much it weighs even the lightest of bodies when they're under anaesthesia, and often they have them paralysed as well, are heavy – dead weights. Nothing, no tone - they feel much, much heavier. You're worried you're going to dislocate a shoulder

or something. So, you need somebody on the airway, a bunch of people on all the other attachments. You can detach the attachments. But you know, you need to foresee all of that. And then you've got to carefully move this person. And then you've got to make sure they're in the right position. Because if you have their arm up like this [gestures], you give them a brachial plexus injury, and now, can you access them to be able to nurse them? The whole process is massive, and then the actual turning is scary, because there's never enough room to do it. And you're working with people who probably never or rarely did this before. I suppose actually by the end of the pandemic we'll be experts on proning, but before, we'd have one every three months that we would prone, and it'd be like '*whoa! this is a big deal'. It's really scary, incredibly scary*."

[Interviewee 10]

The experience of caring for dying patients during the pandemic was devastating for many participants. Even those who worked in settings where death was sadly a feature of their practice were shaken and distressed:

"we, our ICU, we had fantastic results. You know, when this started, we were a unit people left. Although patients didn't always get back to you know, how they were before they were in the ICU, but they did leave. But these days, most, most people in ICU are not getting better. What's more, you're there in full PPE – well, eventually – and you know, you can't easily comfort people and you're running between beds because there're so many patients. You'd leave a shift and come back to find many had died. That - that's so traumatic for everyone. I don't care how experienced you are."

[Interviewee 14]

There's just such a lot of death – death on an unprecedented scale. The end-of-life care, well, it's not what we want to give, nowhere - I mean, just nowhere near. And often they're horrible deaths. You're seeing that and not able to do anything over and over – I mean, all the time – then you've, got, you've got to talk to the families and often it was sudden deterioration. Especially at the beginning, we were surprised by how fast people went off. I – it – it's been awful, awful."

[Interviewee 15]

In talking about death and dying, many practitioners noted that what they considered essential to good end-of-life care was undone by the pandemic. Staff faced an unfamiliar disease with a trajectory that, particularly at the beginning, was uncertain and often surprising. There were limited treatments and clinical interventions, and none with a strong evidence-base. The pace and intensity of decision-making was a further consideration for several interviewees:

"One of the things I was most worried about which I think probably has come to pass has been about decision making about end-of-life care, and how that's been a different environment from normal. So, it's been a very compressed, very intense environment. It's caused me a lot of sleepless nights."

[Interviewee 9]

The physical effects of working in PPE exacerbated the emotional effects. Teams struggled to find the time and space to debrief about patients and losses. Conversations with families were often conducted remotely and staff did not feel able to support people effectively. People were working extra shifts and when they arrived, they were often looking after more patients than they would previously have considered safe. The ability to escape work was compromised by lockdowns, lack of time with friends and family and the amount of media coverage of Covid-19. Sometimes, colleagues were caring for colleagues who had become seriously unwell:

> "Horrible mixed emotions when he [colleague] came in. I was afraid – seeing him, it was like looking at your own future. Plus, there's the awful guilt that it wasn't you in the bed. Plus, I - anger that someone - just because they're doing their job. Most of all though, grief. He's one of us, you know."
>
> [Focus group participant 4]

The ripple effects of changes in end-of-life care were felt beyond intensive care and acute medicine and extended to the whole system as two interviewees working in primary and social care respectively described:

> "It has impacted on family decision-making, as well. So, you know, for example, someone's grandmother got Covid, and they decided not to send her to hospital. I think the kind of fear of Covid has also probably, consciously and unconsciously affected decision-making about end of life, for people with non-Covid conditions as well. That was a Covid example, but you know, I can think of a patient who I've looked after, in the last six months who died of cancer. He was terrified of going to hospital because of Covid. And so that affected care, not that he didn't have what he could have had, but certainly in his own decision-making. It affected his decisions about whether, you know, to seek medical help in certain situations as well. That's a big, really big thing."
>
> [Interviewee 4]
>
> "In the home, it was kind of carnage. We'd – there'd been a wave of infection and, because you know, our client group – well, it ripped through. We weren't coping, - not - not coping at all. People might've gone to hospital normally, there was no way – you know, everyone was dying and - it's terrible, terrible, but these people, well, they're not top of the list. Paramedics – they tried, but – they couldn't get to us in time and, even if
> they'd come, would they've taken them - our sickest, oldest people? And we're, we know people die – we'll be their final home – but not like we saw back in the Spring. It was hell. Hell."
> [Focus Group Participant 6]

Where patients remained in hospital, many practitioners described ethical challenges arising from changes that reflected a lack of understanding of their patients:

> "what I think was really, really difficult for people to understand. And was that patients with mental illness, it's not like working in an acute hospital, where you've got people who are probably most likely very compliant and a bit scared, have got a broken leg or have had surgery, and are going to stay up in their beds, our patients just are not able to do that. And it's really hard for them. And they were really scared as well. So, I think trying to balance that was really challenging. And no one spoke about it – we just had to get on with it. I think people were saying, '*this is so unfair*', especially I think, if you think about forensics, and some of our older adult wards, I think were particularly difficult and, and long term to do it all again, to make people stay in their own room to not allow people to mix with each other. And I think was really, really difficult, and went against everything that we want to do as nurses."
>
> [Interviewee 7]
>
> "patients who wander without purpose: usually in the hospital, they'd have some sort of freedom or, you know, supported freedom to roam, and they might be helped to go out and about and get some fresh air. But now they're in kind of sealed-off bays. I'd ask myself, are we caring properly for these people? And what could I do for them? No one talks about the ethics of this stuff, but it is tough, really tough"
>
> [Interviewee 11]

The subject of visitors came up for almost every practitioner who worked in an in-patient setting. It prompted considerable ethical discomfort and disquiet. Often there was visible emotion as practitioners remembered specific examples. Many spoke at length about visits not being permitted or being restricted:

> "The bit that's hurt. Or seems to have penetrated the shield is the distress in the families. And having to deal with distress but with most of the tools removed, especially visits. It's a sense of impotence because all the things you would normally do you can't do in this scenario. And you're having to ask people which of their adult children they want to see before they die and pick one."
>
> [Interviewee 2]

Discussion of visitors by participants exposed ethical tensions. Many acknowledged that they had sought clearer guidance. Yet when apparently clear rules on visitors were communicated, practitioners struggled with the relationship of that rule to their professional judgement about person-centred and ethical care. One interviewee described the complexities and, sometimes the contradictions:

> "The visiting issue was the one thing that really hit home, and we all found difficult, because staff were conflicted, because they, their duty of care in terms of infection control public health, we're saying we mustn't have visitors, but our philosophical approach to care knew it was an essential part of the process. And, and we were torn. And it was interesting that people would be very vocal about saying, we must not have visitors, when you talk about our policy. But on the day when they were looking after the patients, they would say, course so-
> and-so can visit. So, there were, so there were people that were within the organisation that were all for and also all against it – the same people. A lot of people were kind of a foot in both camps, depending on whether they're
> looking at the guideline, or the patient that they're looking after."
>
> [Interviewee 8]

The question of whether there might be exceptions to the visiting rules was fraught for many who described the, often impossible, balance of risk, care and different interests. Some participants noted that these ethically difficult decisions were being made by relatively junior staff:

> "one thing that often comes up at the moment is relatives visiting and the ethics of exceptions, and who is an exception and what is an exception and what counts and how and who gets to decide what risks other people run. So, classically, if a patient had a sibling who wanted to visit a positive patient who was at the end of her life, incidentally COVID positive rather than the primary. Was it the hospital's job to stop them visiting to protect them? Or was it their choice to risk exposure?"
>
> [Interviewee 2]
>
> "But there was one set of relatives where three turned up, not two as they agreed. And they asked the nurse on the ward, the band five, was that okay?"
>
> [Interviewee 15]

Transparency, reasoning and consistency were identified by one participant as markers of ethical leadership in relation to visitors. He described what was a crucial moment in the ethical culture of his workplace with far-reaching implications:

> "So, we're all grappling with the impossible visiting choices when the Chief Executive let one of their friends have relatives visit outside of the clinical and ethical guidance. You know, yep, the guidance that she is telling

us must be followed. Well, - that there was a leadership failure. It was an ethical failure. That was a kind of Dominic Cummings unifying moment when we all just thought '*right, there goes any moral authority or credibility you might have had*'. It really affected morale. Frankly, no one trusts or respects her now, not since she did that."

[Interviewee 2]

The effects of restricting visitors were felt across practice settings. Mental health professionals described the distress of young people on an eating disorders unit who were unable to see their parents. Those working in oncology remembered patients who had received life-changing bad news, undergone surgery or received chemotherapy without the support of family members. One participant, working in neurology, spoke about a patient that he would not forget:

"I haven't been covering the COVID wards, I've been covering the general wards, with the occasional COVIDpositive patient in a side room, but that, you know, often people who are brain injured, confused, whatever.
They're really not coping with not having visitors, you know, and that's, that was hard when I was on 10 days ago, or whenever it was, I went in that day, and, and there's one particular woman who's got severe autoimmune encephalitis, and who's got some, you know, and she's just permanently terrified, and on a daily basis is going but why can't I go home, and where my family now she might be like that anyway. But, but you kind of think, if only her family could visit her, you know, that would help, you know, it must be just so hard if you've got a non-COVID disease like that. That. Yeah, I think that's really hard. I am not sure we were doing right by her or her family."

[Interviewee 9]

Outside in-patient settings, practitioners also noted the impact of family members not being present, from dentists to optometrists to GPs. As well as the effect on rapport and ethical care, some of these participants were also alert to potential risk:

"we added children into appointments by maybe September, October. And then no parents could be in the room with children. Imagine. In a dark room with a stranger and your mum can't come in. Was that right? What about
safeguarding?"

[Interviewee 5]

The drive to continue to provide humane and humanising care, even in the most extraordinary circumstances, was a theme for many participants who emphasised the importance of the ethics of care, relational ethics and narrative ethics. There were lots of examples when a practitioner supported compassionate, dignified and person-centred care. One interviewee described a trainee on her intensive care unit:

"She was basically looking for I think donations or help with donations to try and get some really decent hairbrushes for her patients on ICU. The hospital just has rubbish combs, and you know, you know people in ICU get really matted hair and she's thought about that and tried to help. Such a small thing but also such a huge
thing about care in the most difficult times."

[Interviewee 10]

The importance of narrative and the ethical responsibility to account for lost time and experiences was a common theme. In this example, the ways in which staff completed the patient record illustrate how care and narrative identity were prioritised:

> "I was so struck by the incredible, just so wonderful, way people were writing their notes. People on the wards were, I think the doctors were aware that the family couldn't visit. And so, they were making up for it by writing lots of detail, lots of really thoughtful detail about what was going on for the patients. So that if somebody phoned up for an update, they could somebody would be there to read it out. I couldn't believe it. With everything that's going on, you think it would be the bare, bare essentials only, but they were writing these
> really thoughtful, very human sorts of things about people."
>
> [Interviewee 11]

4.1.5. Fair Shares: On Resources

Allocating resources was an ethical question for many of the participants. Several participants noted that resources dominated the ethical discourse at the beginning of the pandemic. Interviewees referenced political statements about ventilators and campaigns to recruit volunteers, as well the Nightingale facilities. One practitioner questioned those early choices:

> "there's quite a lot of resources thrown at things like re-registering the volunteers, only for people not to be used or even trained. Yeah, I do wonder how effective some or all of that was. But, you know, just like the Nightingales, if we hadn't done it, you know, damned if you do, damned if you don't, aren't you? We had members of staff go to the Nightingale and all that meant was we were short-staffed – you can't magic people up right, so they were pulled from NHS services when we most needed everyone. And when there's not enough PPE and you're building new ICU beds, literally over weekends, you've got to wonder about how resources have been thought about. I don't think healthcare voices were really part of these political decisions, which may be inevitable, but well, you get cynical about what was happening and why."
> [Interviewee 1]

The high-profile ethical question of who should receive intensive care, especially ventilators, was less frequently mentioned than might have been anticipated. It was a concern for one interviewee who observed that access to ICU had not been an "*ethical reality*" for his team in the first wave. However, during the second wave that changed:

> "there are terrible decisions having to be made about resources. You know, there's the obvious in terms of who we can admit to the unit (ICU) with its precious resources like ventilators, but there's other really awful choices too, like how much time you can give to people or where to send them for care. It has been hard. So hard."
>
> [Interviewee 3]

Demand on services meant that some patients were transferred to locations a long way from their homes. When rates of serious illness and hospitalisation grew, so new and temporary facilities were created. Even with redeployment, the numbers of staff available, especially those skilled in specialist and intensive care, did not keep pace. Practitioners described the increasing numbers of seriously ill people for whom they cared and the worsening staff-patient ratios. The impact caused many to wonder about their own responsibilities and risk:

> "I think there have been rationing decisions being taken internally, that then that, you know, that people have been very, very uncomfortable about that. Those issues have been going on – they have, but not talked about.

> You know, and patients have been moved around the country to intensive cares, staff are covering huge numbers, some patients are admitted etc etc. And I don't know how much it is an ethical duty to speak up and say, '*it's not good enough – the care isn't alright anymore*'. You know – is it better to have some care than no care? And what about the doctors, nurses and others who are providing what they know isn't optimal then? That's when I think - that's where the issue around protecting healthcare workers around rationing decisions must come in. At the moment, I can't see the [regulator] jumping in with that very quickly. And I think it would be the government who would have to take liability for that. We don't know who will though – we just keep going and cross our fingers."
>
> [Interviewee 9]

For some practitioners, especially allied health professions, restrictions to their skills and services were difficult and often led to poorer outcomes:

> "what is very hard is having as an OT to hold off meeting someone, because you have to check first if they're going to die or not. But you don't know who will make it and some people need us. A patient last year wasn't seen, because we were told to only do essential work. And she became very – you know, got severe contractures - and had to go to a nursing home. Basically quite a few patients, you're told they're end of life, and then they don't die, and they're disabled. I know that if I could have gone earlier, it might – probably would – be different. We're only just seeing the legacy of these resource limits on what OT was able to do and it isn't pretty."
>
> [Interviewee 11]

4.2.   All in It Together? On Inequity

Inequity and differential experiences for staff, and those for whom they care, was a dominant ethical theme. Numerous participants described the ways in which Covid-19 and the response had exposed and compounded social injustice, economic disadvantage and health inequity:

> "the first thing that comes to my mind with regards to ethical challenges is the issue of the disproportionate impact that Covid has had on ethnic minorities. It is fundamentally a moral and ethical problem, but isn't seen as such, even by peers never mind, you know, the great institutions of medicine. I think our [professional] roles are serious in terms of socioeconomic inequalities and racial inequities"
>
> [Interviewee 3]

Several practitioners described realising, relatively early on in the pandemic, that there was a disproportionate effect on people from Black or minority ethnic heritage. A couple of interviewees had tragically lost colleagues to Covid-19:

> "We've had a relatively small number of deaths from Covid-19 in our hospital, but they have all been Black or from a minority ethnic group. You know – these are the people – we're the people, 'cos I'm of Pakistani heritage – who're taking the risks all the time and have paid with their lives. It haunts me. Every time I come to work, I think of them and think 'that could be me – it could be me leaving my family without a father'"
>
> [Focus Group Participant 2]
>
> "In my hospital, we've had colleagues dying, and they've all been the ones from minority ethnic backgrounds. So that's guilt. I'm white, my feeling guilt is nowhere near what these colleagues and their families have experienced, but I do feel it – and shame too."
>
> [Interviewee 1]

Several participants talked about the ways in which systemic and structural racism contributed to increased risk. For example, a midwife spoke about the poorer outcomes and increased maternal mortality for women of Black and minority ethnic heritage. She observed that too often those women were not heard, respected, advocated for or taken as seriously as their white counterparts. Another participant referred to evidence that people from a Black background were more likely to be compulsorily detained and restrained in mental health settings and were therefore also more likely to be exposed to Covid-19. For another interviewee, the ways in which race and ethnicity influenced whether someone felt able to express concerns:

> "most ethnic minority people in nursing, doctors and healthcare associates, they were working in very, very dangerous, risky environments and, and a lot of people from my personal experience, are very reluctant to raise concerns, because they're concerned about the consequences of doing so. They're working in an environment because they have no agency, they have no power within that system to raise concerns. They fear what will happen, will they be singled out, and be labelled as a troublemaker?"
>
> [Interviewee 3]

A couple of interviewees with educational roles described how students and trainees were affected:

> "Inequity's a big thing in my mind for the students. It's a bit similar to risk assessments for staff. And I've got a student in mind, she's shielding and at greater risk than her peers, so is having to stay away from placements. Actually, she's much better on placement than she is academically. So, doing the remote placement is a bit more like being academic. And she doesn't like it. She's doing all right, but it's not ideal. So, I have really worried about, about people having reduced opportunities based on their ethnicity or other protected characteristics. And it builds. We know that there's educational inequity, and we know that there's health inequity, and we know there's an economic inequity, and all of those things come together."
>
> [Interviewee 11]
>
> "A proportion of our students are having to take enforced interruptions of studies because they are vulnerable, and we can't adapt the course enough to ensure they get the experience they need. Often these are students are already coping with a lot – their own illness, perhaps caring responsibilities, a disability or poverty. You know, an extra year of not earning, when they'll inevitably get deskilled and losing contact with their cohort. It's a big deal – who's looking out for them?"
>
> [Interviewee 9]

Vaccination was a subject in focus groups and interviews, particularly in relation to structural attention to racism and inequity. For some, the way in which risk had been conceptualised and decisions made about priorities was revealing:

> "as we speak, the Joint Committee for Vaccination Immunisations, it has failed, the committee has failed to prioritise high-risk ethnic minority staff. A Black person is twice as likely to die from COVID than a white person, and the hospitalisation cases are significantly higher. So, it stands to reason, therefore, that they should be prioritised for vaccination. But that hasn't happened. And I think it underlines the concerns and the issues, that people, ethnic minority people are not a priority."
>
> [Interviewee 14]
>
> "Vaccine hesitancy is such a problematic, you know, it's an ignorant term. It ignores decades, centuries of history and racism. It completely misses the point about power, abuse and mistrust. It's about blaming people who are already stereotyped and makes no effort to understand or to listen – you know, I am really struggling with what I see as divisive language which can't be bothered to think about why people might be worried. Compulsion isn't the answer, but I am nervous that the NHS might go down that route."
>
> [Focus Group Participant 5]

Another practitioner in the same focus group reflected on mandatory vaccination and suggested that the lack of understanding meant that important virtues such as openness and compassion were not being prioritised:

> "I've had a couple of members of staff who are ex-military, and, and who were petrified that they were going to have to have it because of some of the some of the testing that they had done on them when they were part of. I think one of them worked in, one of them was in Afghanistan and had lots and lots of military trials of lots of different kinds of drugs and tests. And, I had no idea. You wouldn't know unless you ask and are prepared to listen, not judge. He was actually so distraught by the fact that actually it might have to be mandatory. He doesn't want to have to relive his trauma and explain himself to the world and his wife. Why can't we be a bit more open and compassionate rather than judge and assume?"
>
> [Focus Group Participant 7]

Other participants expressed the view that vaccination should be accepted by any health or social care practitioner. That opinion was explained with reference to a professional's obligation to others, especially those perceived to be vulnerable, without explicit regard for diversity and plurality of perspective, experience and identity:

> "And that duty to do your bit, especially as a healthcare professional, goes to the heart of it. Of the whole sort of ethics, isn't it or immunity, it is actually, it's much about the, or more about the population than it is about the individual, especially when some of those putting themselves first work with the vulnerable."
> [Interviewee 13]

A small number of participants felt cautiously optimistic that society and those organisations, including regulators, that provide leadership to professionals had begun to recognise the impact of racism, social injustice and health inequity during the pandemic:

> "People started issuing statements. Very, very conservative institutions in medicine and regulators and the like who I had never thought would do at least started saying that these are, this is a problem, and we need to deal with it. But I haven't seen a lot of, in terms of action, beyond the statements, that a lot of people that are a lot of good intentions are trying to do things. But it will take a long time before we see any, any change, but at least people are beginning to talk about it. I do feel cautiously hopeful, because people, at the very least people are starting to think about it and talk about it. And there's still a lot a lot of resistance, even to the very idea that there is anything to do with the systemic problems. Anything would be cultural, structural problems, all these things, but it is it is moving in the right direction there."

4.3.   Moral Injury and Moral Distress

The subjects of moral injury and moral distress were pervasive in all the interviews and focus groups. It is important to note that these were *moral* injuries and *moral* distress. Emotion was often evident, but it was the <u>ethical</u> dimension of practice that caused specific injury and distress as practitioners sought to practise in accordance with their values and professional norms, but they were unable to do so.

The source of moral injury varied depending on profession and practice context. Everyone talked, often movingly and memorably, about ethical experiences and the impact. Much of what is described, including the changing work context, inequity during the pandemic, the effects on the provision of care, the concerns about standards of practice during the pandemic, the challenges of working with limited resources and the prevalence of death and dying, were cited as moral injuries. That is, they went to the heart of what it is to be a professional, and work to standards and ethical expectations. A nurse told me about the moral injury arising from access to PPE:

> "In the first wave, one of our staff nurses contracted COVID and died. I mean, he died. A week before he was teasing me in the nursing office. And I kind of - I feel, you know, personally responsible, and thought was that because I didn't – couldn't - give them what they needed? Is that - was that my decision? I mean, it wasn't – I know that, but should I have said '*this isn't okay?*' Should I – I mean, nurses look after people and I wasn't – right? Was it because I didn't give them enough PPE? It is still weighing on me – heavily. I never, in a million years thought I'd be feeling, kind of part of something that let nurses down this badly."
>
> [Interviewee 7]

For those practitioners who were not caring for people who had Covid-19, there were still many ways in which moral injury occurred. As their practice changed and they perceived themselves to be less effective, inclusive and person-centred, they experienced moral injury. One focus group participant described the impact of "*complicity*" in making choices that were going to cause harm, both in the short and longer-term. For others, navigating the competing expectations of clients, employers, policy makers and regulators made them wonder about what they had taken for granted as ethical precepts in their profession. Moral questions abounded. They covered a range of ethical experiences and choices, including about privacy, confidentiality, therapeutic relationships, dignity, risk and safety, balancing public and individual interests, trust, professional identity and moral purpose. For some, the focus on the so-called 'frontline' workers overlooked the moral injury that others in different settings experienced:

> "It's not the headline that you see with the NHS rainbow stuff, you know, you picture the people in their hospital uniforms, but the people working in all different sorts of roles and settings – social work, community practitioners, teachers, you know loads of us - who are going to be affected by that [these ethical choices]. So maybe if there's a way of just acknowledging that and acknowledging the load that we've all been carrying."
>
> [Interviewee 11]

Moral injury was not solely located in the workplace. For many participants, the ethical responses of society, high profile figures, particularly politicians and their advisors, and the wider public challenged their values and ethical assumptions:

> "And how to deal with the intense feelings, So, there's almost amazement. About the patients and the families and their resilience and their dignity, through this and the sacrifices they've made. And then counterbalancing that with when you go outside, and you see people who aren't wearing masks and all the risk-taking behaviour,

> and then all the commentary in the press and, and Dominic Cummings and the political leadership doing. Those are things that have struck me as what I've struggled with most. And that probably talks to something about how to bear witness and having to make awful decisions. And having no outlet. I think having to talk people through how which relative to choose, as the only one they can see before they die, those kind of things are the things I found the hardest. I'm trying to cope with that and lots of people just didn't seem to get it or care enough to do
> simple stuff."
>
> [Interviewee 1]

The impact of moral injury and moral distress manifested in serious ways, particularly on health and the ability to work. The type of moral injury and distress varied, but its significant effects did not: burnout, ethical erosion, cynicism, compassion fatigue, despair, flashbacks, disturbed sleep and appetite, illness and psychological distress were mentioned often by practitioners working in a range of professions and settings:

> "So early on, until it really built up and I realised it was just not healthy and I felt myself slipping, you know, and I thought '*oh, I am going to end up on antidepressants again unless I do something about this*'. I need to. So, I recognised it and thought '*okay, I've got to do something here or I'm not going to carry on functioning*'."
>
> [Interviewee 9]
>
> "they're all, I mean we're all, really brittle and stretched by now. People will end up going off sick…Many will just lose their love of the job which will be a tragedy."
>
> [Interviewee 14]
>
> "I can't tell you how badly I feel let down by the profession. It's highly angering – traumatic. That's it, traumatic [tearful and visibly distressed]. You know, I've high blood pressure now. I've. I didn't used to be hypertensive and and - and angry and not sleeping and grinding and, loads of stuff you don't want to know about. God, but
> I'm so let down. I feel so let down."
>
> [Interviewee 4]
>
> "there's going to be, you know, ongoing impacts and burnout as well. So, all sorts of impacts on staff, fear, exhaustion, PTSD, a phenomenal rate of death that they're just not, you know, accustomed to, really quite unpleasant deaths I think. The moral – and it is moral as well as emotional - distress of not being able to allow families into people dying, and be with people, etc. So, so all of that added on top of that, our own personal distress, at whatever our family and social situation is and dealing with the pandemic."
> [Interviewee 15]
>
> "I'm not sure I want to work, you know, certainly not until I should be retiring – 67 or whatever. I think I need to stop earlier. The toll – it's just too much… I think lots of us will decide to leave earlier than we would have done before the last year happened."
>
> [Interviewee 16]

For many, there was a disorienting unpredictability to moral injury and its effects, with one interviewee noting it was not easy to predict who would be affected and how:

> "some of the people who I thought would be most robust weren't. You couldn't tell who was going to be robust and who wasn't going to be robust. Or indeed, how do you even know what robust is because who knows

what's going on underneath? But I was really struck by somebody who had been, who worked in critical care, who had

also had spells where they volunteered to go out to Sierra Leone during the Ebola outbreaks, and they've done a lot of going to disaster zones and whatever. More undone by what was going on. And it made me wonder whether when you put yourself you know, this is not what I expected or anticipated or predicted – those norms again - you know, this is my safe zone. This is the NHS that works, has values, and stands up and holds up. I go to Sierra Leone, and I expect some of this stuff to be risky or fall over, but I also know it's time limited. I'm going there for a six-week deployment. And then I'm coming back to the familiar. So, there's this sense of there was no familiarity or ethical reliability if you like."

[Interviewee 1]

Some realised taking part in this research was itself a moment when they acknowledged and expressed the extent of the moral injury and distress that they, and others, had experienced:

"Oh, I think, actually I do think I might have some PTSD, with regards to it all, because I can get – I am now - really choked up and really shaky and really anxious, not at work obviously but. When I talk about it, it just stirs up so much stuff that I – hate to admit is even there. So yeah, it has made me think, lots of people – even really senior people - who I don't know if they would be brave enough to, you know, to say that's how they feel, let alone get help, support, whatever."

[Interviewee 3]

"As I talk about it now, I realise how much people are carrying, and not talking about. And it's only when you start scraping away a little bit, and then it all comes out. There's just so much that's been traumatic that we haven't even begun to process or had the chance to process."

[Interviewee 11]

Given the predominance and seriousness of moral injury and moral distress, all participants were directed to resources and sources of support. In response to an open question about what might help with moral injury and distress, participants emphasised relationships, expert support and being valued. For one interviewee, there were structural approaches that have the potential to prevent and respond to moral injury and distress:

"I think we do this well in the hospice, because of the nature of doing the usual aspects of care, the end-of-life care comes with such costs, we have lots of reflection here in different types. So, we have Schwartz rounds, we have proper MDTs, we have reflective practice, and we have the ethics committee – which wasn't just set up in response to the pandemic but is, you know, established and trusted. So those four different things are all really reflective practice but looking at things in a slightly different way. We're always looking out for everyone – are they okay? It's about how we do the job as a team. It's saying how it felt as well as what we did. And then we question, if it's not feeling right, are we doing the right thing? And so, we do those regularly, so we have that kind of mindset, and those kind of discussions in between time, so that they're kind of like the poles that always guide us. And because it's embedded, it's also strung together through loads of conversations and decisions all the way along. Now, I don't know, necessarily, whether other settings have quite the same level of that. It keeps us going. It's an investment sure, of time, people and that, but it matters. What's more, I think it works."

[Interviewee 8]

One participant located moral injury and distress more broadly than in the professions. She had a novel approach which recognised a collective and societal need to reflect on the pandemic and to foster constructive understanding between practitioners and the public:

> "I would hate that to be some sort of thing sent out, you know, that is rolled-out to people across the NHS or public sector to deal with it in a prescribed way. Please, not a toolkit or anything awful like that. And I think what would be really useful, would be things on telly, and things on the radio and things just in the media, things that make sense of everyone's experience, not just clinicians, but wider - other professionals, the public. You know, what did we all assume ethically? Why? What happens when that's undermined? Stuff that is from different points of view and helps us all make sense of it and recognises different experiences."
>
> [Interviewee 11]

4.4. Guidance

All the participants in both interviews and focus groups were asked about ethical guidance and advice during the pandemic. Everyone recognised that Covid-19 prompted a large amount of information and guidance. Guidance performed a validating function as well as guiding behaviour and choices:

> "Everyone was desperate for these, the validation of what they were feeling they were having to do, and you can understand why they wanted it. But actually, most professionals already had ready-made approaches and, if they took the time to think it through, answers. But it perhaps shows that people didn't know their ethics and their professional stuff, as well as they should do. So, they invented all this extra stuff on top, partly to validate and partly to remind."
>
> [Interviewee 8]

The temporal element of guidance was commented on by many who agreed that timeliness was essential, but often disagreed on what constituted a timely response:

> "I think if you look at it right at the start, I think, how to best respond to a crisis, and how to travel in uncharted water. I think really is the first issue for me, because I think we were unprepared. But then it led to a little bit of blind panic then about we've got to fix things. And what we were, weren't able to do is to use our skillset of the transferable skills, we felt compelled to invent new things, meeting something that was new. And then we got trapped between the two of, of inventing things that maybe weren't so fit for purpose. And because of the speed and that element of panic that was there, I think there was an element of oversimplification that came in, and things became very binary. And right and wrong."
>
> [Interviewee 9]
>
> "They [professional bodies and regulators] were so slow. We were there heading to work, trying to deal with unanswered questions from everywhere, just making it up as best we could and what did we get from the [regulator]? Zip all. And the professional organisations – God love 'em – they were hopeless too. I was literally scouring the internet, talking to others, doing my own research to work out what to do about the practice, PPE, who to treat and how. When guidance did come it was like '*really? Now? You think this is the moment?*' It was way, way too late."
>
> [Interviewee 4]
>
> "Yeah, there was guidance, but it hardly ever seemed to be there when you needed it. When you're trying to make sense of this scary, new infection in a high street setting which isn't frontline or even thought about, not even by those who ought to be thinking about you."
>
> [Interviewee 5]
>
> "If you said, who was more prominent at that time, early, no one really stepped up. Then the voices that felt more prominent were - interestingly, I think the unions and colleges were more prominent. The [regulator] was relatively quiet, and a bit slower to the party compared to the other, the other parties."

[Interviewee 13]

The content of the guidance that practitioners consulted was perceived by some to be insufficient, albeit for different reasons. For one interviewee, the distorting effect of the pandemic was that too often universal norms were generalised from a particular context which led to ethically problematic recommendations:

> "People started mixing up what was right in the given moment, because it was necessary to then thinking we can blanketly say everybody in nursing home is not for resuscitation or nobody can have any visitors and then because it had been allowed it then became a good and people weren't willing to question it and individualise and look at it. There was that bit about it might have been necessary in that moment. But then you've got to stop and think of what you do as you go along."
>
> [Interviewee 8]

For others, the focus on access to intensive care and resource allocation overlooked the range of ethical questions and experiences, particularly of altered practice across the whole system:

> "One of the first, you know, from an ethical point of view, one of the first major queries we had was about use of images. And the [regulator] has guidance on use of images, which isn't perhaps one of their greatest pieces of guidance, it's very much geared towards research and recording things for, you know, exams, and assessments and that sort of thing. And doctors have been doing telephone consultations for years, you know, but not in the way that they have recently where it's become this sort of predominance of all sorts of images landed in inboxes, often uninvited."
>
> [Interviewee 13]
>
> "we were looking at ethical guidelines anew and everyone seemed to be focusing on one or two things, like who gets the ventilator. And that's important, but it is far from being the only thing we needed to consider. And again, it's a bit about are people looking for brand new ethical principles, in which case they existed pre-Covid. So, we don't need to reinvent that. But they did and then if you look at what the guidance that was coming up, well it was very much limited. The bits that were coming through to me for sure, to justifying the withdrawal of treatment in patients when the resources were too scarce. So that's fine. That's one strand. But it was like then 'that's ethics done'. And it just felt a little bit like, 'sorry?'"
>
> [Interviewee 14]

All participants were asked about the relationship between professional judgement and ethical guidance. A minority suggested that referring to judgement was unhelpful:

> "I think it [judgement] is a word that means nothing except when you get it wrong. It's a way to dodge giving any help with the really hard stuff – you know, that's not our [the regulator's] business – when it's the reality of what we all have to cope with, how can't it be their business?"
>
> [Interviewee 5]
>
> "judgement, yeah – it's a cop out. I think there's often a feeling that, you know, *'we've given you the guidance, it's your job to work it all out and decide how to do it'*. Right, well you'll be all over me when you decide I haven't worked it out as you think I should, won't you?"
>
> [Interviewee 12]

The majority of participants recognised the importance and inevitability of judgement. Some practitioners from professions including osteopathy, optometry, dentistry and pharmacy, observed that the acknowledgement of discretion, the interpretation of guidance and skills, and the application of ethical judgement were, in their view, relatively underdeveloped:

"A regulator can't, can't spoon feed your profession that's supposed to be autonomous. Set the parameters, and then it's up to the up to the practitioners, and in our community of practice and community of learning, to develop ways of coping with this situation. But we're not used to doing that. I think it's because it's unprecedented. We hadn't rehearsed that very well. It doesn't help either that lots of us work alone, you know, in isolation and we're also a tiny profession."

[Interviewee 6]

"I think we don't emphasise judgement or value ethics as a profession. We get all caught up often in practice stuff and don't think about the values that lie behind it, whatever setting you work in. I didn't train in the UK, and I'm amazed by what passes for ethics in dentistry.

[Focus Group Participant 9]

Maybe it's because we have a big business element to lots of optometrists with kind of lots of regs or rules and direction, but we aren't great at judgement. I don't think I hear anyone mention ethics much, at least explicitly.

[Interviewee 5]

One participant who has a special interest in ethics wondered about whether any guidance, indeed any ethical resource, can ever capture the specific and complex nature of clinical work:

"I don't even know if it's ever possible to write a guideline that will talk to the bedside in a way that a clinician needs in the heat of a clinical encounter. And I don't know how you. Because they are necessarily vague and necessarily hedge things. Lots of well-meaning things but it's not you at the bedside. As someone who has also got some skin in the game as an ethicist but also as a clinician I don't know if that gap is ever truly
bridgeable."
[Interviewee 2]

An interviewee described many practitioners as craving clear guidance for its apparent reassurance. Yet, if that guidance impeded or challenged professional judgement or created tension with other ethical values and expectations, it was unwelcome:

"It is a case of '*give me guidance and be clear*' and then often '*no, not that kind of clear guidance*'. Right so, people weren't willing to make individualised decisions or take accountability for judgement, because I think they felt the pandemic was bigger somehow. It was it was too important for them. In this massive national thing, how could they start interpreting and so they needed black and white guidance because they're not doing what they normally do. And so, they got they got sucked into that. But then when you knew that you wanted to do something different, say around end-of-life decisions, not eating in certain parts of the hospital or visitors, the guidelines wouldn't let them. So, they asked for it [extra guidance], but then didn't like it when it came."

[Interviewee 8]

For another participant, there was a difference between internal and external conceptualisation of, and responses to, ethical guidance, including that which came from regulators:

> "I think it's, it's professionally owned, rather than thinking that I'm doing this for [regulator name], I think it's just kind of innately it's part of my professional identity, really. And it's expressed through the language we use and our relationships with other professionals as well. I think it just is an innate part of our, our language, really, and it feels internalised. So, so I think, yeah, so I suppose my initial thoughts were, well, you know, I can't imagine the [regulator] ever responding quickly enough to anything like this, you know, so it just wouldn't be a go to place. And if there were ethical dilemmas, you know, that COVID presented, then it would be you know, it wouldn't be them, it would be drawing on my internal identity, thinking, approach and then talking it through with trusted colleagues."
>
> [Interviewee 4]

Both interviews and focus groups spent time exploring what judgement means and whether it is sufficiently considered, articulated and valued within professions and by regulators. Several participants offered examples from their own practice of how they understand and apply judgement in their work, for example:

> "I don't think I ever thought about calling the [regulator]. There were a couple of times I thought, I wonder if I should talk this over with the [defence organisation]. And then I just sort of reflected on it more myself, and thought 'oh no, I've thought it through, considered the options and I'm sure that I can evidence that this is the right thing to do so in this situation and that, and that I've made an informed decision with the patient and, and taken into account some of the new guidance that they've recently brought out, the sort of informed consent stuff."
>
> [Interviewee 9]
>
> "Judgement? It's a cocktail of three things: it's what's in the literature, what the books say, the patient's values and preferences, and your experiences and responses as an individual. So that's subjective, and this is subjective. And while that's objective to a point in the literature or evidence, it's still your reading of it. Your stool has actually got three very subjective legs to be sat on for your judgement."
>
> [Interviewee 15]

The majority of those who identified judgement as important, even essential, to ethical practice believed that too little attention was given to exploring the concept of judgement in education, training and practice. Several believed that it was an area in which regulators could develop their approach to support the profession and to enhance ethical practice in the service of patient care:

> "I don't think we think or talk nearly enough about judgement. I mean we do; we say it all the time – you know, '*it's a matter of judgement*' - but we don't really get into it or even reflect on what it means and how you get comfortable with it. And [regulator] is always referring to judgement but with hardly any – at least nothing I've seen – to back that up and unpack it. But I guess it's hard, I think, to work out how to. And it's about how you develop thinking, reasoning and judgement. It's hard to teach them and to assess them. And so, they tend to get rather neglected, I think. Even so, if we're, especially people like [regulator] are going to rely on judgement as an essential skill, we ought to do better."
>
> [Interviewee 14]
>
> "And if my decisions feel reasoned, rather than random, it mitigates moral distress. I think that the regulator could have helped a little bit with that – decision trees, prompts, case studies, people like you Deborah showing us how to think carefully and explain our choices. You know, make it clear what judgement looks like rather than just referring to it. I think I've learned but it has taken years."
>
> [Interviewee 8]

> "I think judgement – what it looks like - should be made explicit. Although, I think my fear is that it would be a kind of drive to something very safe, that if you made it all explicit, you could end up with a kind of safety situation, where care for patients really suffered. And that's not judgment, is it? That's the opposite of judgement in a way. It's got to be about using discretion well and recognising there are lots of viable options. It's difficult, sophisticated stuff. We should try though. Deal with uncertainty and ethical complexity, use it to enhance care not as a scary monster under the bed you're somehow supposed to know how to manage."
>
> [Interviewee 4]
>
> "how much to what degree does osteopathic education really prepare graduates? You know, there's a lot of emphasis on. I mean in Covid, the regulator gave out lots of guidance on infection control, keeping your practice safe. And there's a lot in our training about clinical reasoning. But somewhere that something has fallen
> through a gap where I don't think we've focused enough on graduates' ability to think other things through, to be ethical or even think about ethics properly, wider things in society as well, and to construct their mental framework for doing that."
>
> [Interviewee 6]
>
> "the ethical tightrope that people walk when they're in this position between implementing policy and dealing with the human faces. And I think that's something that could be looked at a lot more and talked about a lot more. And this idea of, what do we do when we're faced with being asked to implement something that we've got qualms about? Should we be encouraged to have qualms about things or not? You know, I think those sorts of things I don't think that's talked about at all. And we have got to stop calling it 'soft skills' – this is the toughest stuff of all."
>
> [Interviewee 11]

As to how practitioners might learn to develop confidence in ethical judgement in a context of moral uncertainty, one interviewee referred to her doctoral research on developing the permeable practitioner:

> "permeability is a cluster of behaviours and characteristics that support you to anticipate and seek to resolve the uncertainties you encounter in training and eventually in practice. It isn't soft or quick or easy, but it will remain impossible if we, including regulators, never talk about it, let alone value it. At the moment, it just seems like we expect people to get this, if they're lucky, by osmosis. You know, we say 'here are your standards, use your judgement' which is like starting at the destination and not giving people a map."
>
> [Interviewee 2]

4.5.   Education and Training

Some participants described ethical choices in relation to education and training as a result of the pandemic, many of which had an ethical dimension:

> "there's been, you know, there's been judgment making about flexing the course in all sorts of ways for the situation. Taking into account the practical situation. And the individual situation for students in all sorts of different contexts really. And then also, you know, there's particular issues around assessment and graduating students. What's fair? Should vulnerable students take an interruption? What duties of care do we owe individuals and year groups? There were loads of ethical issues."
>
> [Interviewee 4]

For many, there were early questions about whether students should be on placement at all during the pandemic, particularly given the ongoing ethical challenges:

"should we be putting students into this space? When actually, those of us who are experienced in a space also are a bit at sea and not sure what it looks like, and there were debates about, you know, if PPE is limited then should students be using it? But equally, if this is the new world, shouldn't students be exposed to this?"

[Interviewee 3]

The relationship between courage and vulnerability was often discussed. Practitioners with educational roles described the heterogeneity of cohorts and recognised their duty of care in supporting different needs. The language used was often about virtues – altruism, courage, loyalty, fairness and responsiveness:

"I've seen so much courage in a lot of them [students]. You know, there're the ones who last spring were like, 'no, we want to go out and be making a difference. Send us out there. How do I how do I get myself a paid placement?' And then there'll be others who have, you know, messaged me and said, 'I'm really scared'. And I've gone, 'yeah, do you know what? So am I, let's see about how we can make sure you're not as scared or, or we talk about maybe making an adjustment for you'. I've got a duty to care for them all and to work out how to be fair but recognise the huge range of needs."

[Interviewee 10]

Some of the interviewees reflected on the potential impact of the pandemic on student learning and opportunities, with several expressing concern:

"I do, you know, I do think these cohorts are going to be much less experienced than previous cohorts as they go through."

[Interviewee 4]

"this year's graduates I'm much more worried about and next year's even more, so. I think it's very tough for them. And we've got those students, you know, mentioned we've got some who are on a sort of enforced interruption. And I don't know how we're going to handle those. I still don't know, you know, are they going to be allowed back? I don't know."

[Interviewee 9]

However, other participants considered that the pandemic strengthened preparedness for practice:

"what I feel better about is that, gosh I think these people are going to be so well prepared for work better than they would have done before because they've had this experience of just having to adapt and help and be proactive and get stuck in wherever they're sent. And I think I think that's going to be a real asset for them when they go out into professional work. They're bright, they'll make up content, but they have developed something no book or learning objective could pin down just by being there and adapting."

[Interviewee 11]

"I wonder if they're going to be there's a sort of resilience starting to build in that population, because this is on their radar from the beginning. Whereas I think, people my generation, and either side, this wasn't on our career narrative. It wasn't in our career narrative, it wasn't on our radar, it was it's been more of a disruption to our professional sense of self than it is for our students."

[Interviewee 15]

4.6. Regulators

4.6.1. Participant Perspectives

Interviews and focus groups explored participant perspectives of the regulator, especially its role in supporting and guiding ethical practice. Understanding of the regulator role and remit varied widely:

"what is the remit of the [regulator]? Because it doesn't seem to be understood by the profession. The remit is not just to castigate us, is it there to protect us and lay down guidelines? Well, where were they? Where were they? And, and accountability, they have zero accountability to anybody. They don't care about anything, you know, really, they don't care about the people that they are supposed to regulate. So, if they don't care, because they're all lawyers now."

[Interview 12]

"I had so much in place, I was absolutely obsessed with making it be above reproach, because I know that the regulators are all about reproach. There's no support. Like, that's how we feel as a group of professionals. There have been petitions and everything, for good reason."

[Interviewee 5]

"The regulator could be something more, maybe not human, but more human and, you know, more imaginative and thoughtful and not just about generalities. Great if they think about standards, professionalism and risk. But it'd be lovely if it wasn't just such general and expected things – help us think better, be better, together. Model ethics and put relationships higher on the regulatory to do list".

[Interviewee 11]

Participants often referenced the language of virtues in their explanations of how they saw the regulator, with trust most frequently mentioned. Several participants said that they did not find it easy to trust their professional regulator:

"I don't see the [regulator] as an ally particularly. They're not easy to trust. And the more I work in the NHS I don't really feel that the [regulator] and the disciplinary systems and the systems designed to improve practice are that practitioner supportive and they are political. Issuing any kind of ethical material in that context is bound to fail really, especially when it is just, you know, high level generalities that don't get you far in a broken system in a global pandemic."

[Interviewee 2]

"I'm afraid to say that the [regulator] has failed, failed people, ethnic minority professionals, and, and, by extension, they have failed ethnic minority patients. Because the [regulator's] conduct has been to single out people and we can see this in statistics that the number of people, ethnic minorities, that are referred and disciplined, and disciplined more severely than others, is disproportionate, absolutely disproportionate… I'm afraid, for me, the [regulator] is part of the problem, not the solution. Trust is very difficult, there is absolutely no trust whatsoever. Absolutely none. The people are very afraid, ethnic minority practitioners that I know and including myself, we are very afraid of the [regulator]."

[Interviewee 3]

"I know they say, 'we want to learn, not blame', but, well it just isn't how its functioning. Not by the regulator. I don't think I will ever really trust what they say – no amount of warm words about well-being will change that
for me. Sorry."

[Interviewee 9]

A few participants described how they perceived regulators of professions other than their own. Such comparisons were inevitably unfavourable:

"So actually, it was horrific. I can't underestimate I can't overstate it. We were left at the mercy of hearing from a physiotherapist friend what their body was advising, nothing came at a useful time from [regulator]. The- they disappeared. I don't think we got one email. One thing from the [regulator] until at least a few months after I'd reopened in June. It was so badly handled."

[Interviewee 12]

"My colleagues, they're a lot less nervous about their regulator, than we tend to be which I've often thought was interesting. You know, we don't need to be subject to such a fierce, aggressive approach all the time. Most of us are trying to do a good job in terrible circumstances and we're suffering. Recognise that, the way [comparator regulator] seems to do".

[Interviewee 5]

"[Regulator] is well-known for being much harsher than [comparator regulator]. Oh yes, they're awful compared to [another regulator] and probably others too. I've seen it with colleagues when different professions are involved in the same situation. At least be consistent, that would help."

[Interviewee 13]

Different aspects of the regulator response to the pandemic were mentioned, including adaptations to appraisals and revalidation, statements about flexibility and recognising practice context (although these were variably trusted), information about practical matters such as infection control and the nature of essential work, and adaptations to education, quality assurance and training requirements. Only one participant had approached their regulator directly to ask a specific question about remote consultations. About half of participants were aware of some, if not all, of the regulator's guidance during the pandemic. There was variable engagement with resources and, perhaps inevitably, a range of views on the timeliness and relevance of those materials. In both interviews and focus groups, participants were asked what they had found helpful about the regulator response. Only two participants participant offered positive examples with both moving onto concerns:

> "I think some things have been good. Say in education and being flexible about graduating students. I think the difficult area is around, kind of, you know, if someone dies because of a mistake and that person was exhausted because of the pandemic. Or not able to practise safely because of all the stuff going on out of your control. Everyone's been very anxious about that, I think."
>
> [Interviewee 8]
>
> "So, they did defer it [the appraisal] because mine was due, I think around about now. And it's now been put back to next year. So yeah, they did pause the need for appraisals, which I think was necessary during the first wave. Certainly, I mean, it was just impossible. And anyone who was asked to do something during that would have just gone '*Really? For [expletive] sake? Seriously, you really think so?*'. And now it's back on. But deferred, there's been some interesting stuff about. And I've been saying, 'so how do I get patient feedback? How do I do that in a digital world?' Practice has changed, work has changed, you can't just stick the old way back up again."
>
> [Interviewee 9]

Interviews and focus groups explored the role of the regulator in relation to the range of functions – education and training, standards and guidance, registration and fitness to practise. One of the regulators – the General Osteopathic Council – was noted to have an additional remit: to develop the profession. Participants reflected on those functions, especially how they relate to each other:

> "Can you do all those things? I'm not sure. Can they do the looking after and supportive bit as well as the fitness to practise and deciding whether people stay in a job? In an ideal world, great, but I'm not sure I'm not sure if
> you can."
>
> [Interviewee 9]
>
> "a regulator can't be effective in what they want to do to protect the public if they don't have their registrants on board. To have your registrants on board, you've got to be you've got to be empathetic, you know, I mean otherwise they're not going to engage, and you'll lose them. And then you can't do your job properly without them. So, I can see that's actually it's very important to look after your registrants. And for them to feel looked after. Whether that can really happen though, when you're also doing discipline, practise fitness stuff and people are scared of you, well, I'm not so sure."
>
> [Interviewee 11]
>
> "I think the bottom line is that the regulator is only concerned about practitioner insofar as it protects the public. The professional bodies and unions more support and represent people. The regulator always has to keep in mind public interest. And I think that's, that's misunderstood, widely misunderstood and that is partly because of
> how the regulators themselves muddle the message and the conflicts of interest they need to be honest about."
>
> [Interviewee 6]

For some, it was important for regulators to contribute to the system in which practitioners work. These participants talked about the importance of regulators looking beyond their own profession and interests to work more openly, collaboratively and with attention to the environment within which multiple organisations co-exist:

> "I think where it becomes problematic is going back to where the regulator or the professional body is holding out for the body and not for the wider system. If it's being protectionist about a particular perspective. Think what they could do if they thought about us all as part of a system, working together."
>
> [Interviewee 1]

Specifically, several participants suggested that the regulator had a role in influencing and, for a few, in advocating within the system:

> "maybe, so maybe we need to be honest about what the regulator does. But if it's not happening within – there because it can't or it conflict with the other stuff, then work collaboratively to make it happen elsewhere. The regulator ought to be bothered about, concerned about how moral distress, well-being, ethics support, development, you know these other functions, this other vital activity is happening elsewhere in the system and I am not sure they are. Because at the moment, I see there's lots of little, you know, blue touch papers have been lit. But to what extent are they coming together with a consistent way of doing this? There is a role for moral leadership and also a values-led approach to collaboration."
>
> [Interviewee 1]
>
> "they could – should - be advocating with employers and the government, much more than they do. And it kind of, you know, I think it feels often to us that you're required to be perfect. And there's no backup you know. Well, they're much better in terms of health backup now than they used to be. But in terms of that, in terms of backing up with employers or backing up with what contracts of employment should be, or safety should be, or workload should be, you know, or hours should be or training for specialist registrars should be, you know, they
> say nothing about that, do they? It's just 'not our concern'."
>
> [Interviewee 4]

4.6.2. The Regulatory Round Table

After the interviews and focus groups, a virtual round table event was held for those working or interested in professional regulation. The event was not part of data collection, but an opportunity to i) describe, in high level terms, this research; ii) explore how those working in regulation perceived the ethical challenges for practitioners; and iii) reflect how the perspectives of the two groups related. It provided a space for thought, sharing and connecting those who are interested in developing the ideas and recommendations arising from this research.

The commonality between the ethical challenges identified by the practitioners and those described by the attendees at the round table was striking. Significant amounts of time were given to discussing the:

i) specific problems arising from the transformation of practice as a result of the pandemic with the concomitant enormity and intensity of the ethical challenges practitioners faced; ii) choices practitioners had to make e.g. in relation to risk, PPE, duties of care, redeployment, raising concerns and allocating resources; iii)　moral injury and moral distress, including the impact of the same on practitioners;
iv)　inequity, especially racism and the disproportionate impact of the pandemic on people – patients and professionals – from racialised ethnic minority groups;
v)　effects and legacy of the pandemic that extended across the entire health and social care system

e.g. in delayed or deferred investigations and treatment; vi)   the ethical experiences of students and trainees arising from a changed work context with unique moral challenges; and vii)   anxieties and concerns about potential errors, complaints and litigation and the possible implications for registration.

There were few additional ethical questions that the attendees at the regulatory round table discussed that were not emphasised by the practitioners who participated in this study. A couple of attendees at the regulatory round table discussed how a minority of practitioners communicated on social media about the pandemic. Others noted the ethical implications of the loss of the patient voice and co-production. There were also some specific ethical considerations that arose in certain professions, for example, so-called 'price gouging' on items such as hand sanitiser and over-the-counter analgesia in pharmacies, and those were referenced in the discussion.

In addition, attendees at the round table reflected on wider considerations for regulation during, and as a result of, the pandemic. Although most of the participants in this study had not contacted the regulator, many of those working for regulators noted that contacts from practitioners had increased exponentially. Others, for example those who work in outreach activities, explained that, although their contact had continued, it had been limited by moving online, as well as by the constraints on practitioner availability. Many attendees reflected on the ways in which the pandemic had prompted questions about the purpose of regulation, both within their own organisation and beyond. Some, like the practitioners in the research, wondered about the tension between different regulatory functions. Others questioned whether models, such as relational and responsive regulation, were possible given their statutory remit, particularly in relation to fitness to practise and registration.

For many attendees, there was potential to effect positive change on how regulation is understood and practised. Several people noted that the pandemic had fostered greater flexibility, agility and collaboration by and between regulators which was welcomed. There was agreement that building on that sense of shared endeavour and avoiding a return to what was described by one attendee as "*silo-working*" was to be encouraged. For many, the case for thinking systemically had been made by the pandemic. Finally, there was a thoughtful discussion about the role of the regulator in relation to judgement which was such a dominant theme for the participants in this research with the majority believing this to be an area in which further collaborative and structured work by regulators would be valuable.

The round table session ended with attendees invited to express an interest in participating in further discussion and work arising from this project; the majority of attendees asked to remain involved in what might follow.

5. Ethical Experiences: What Have We Learned and Why Does It Matter?

This project has explored the ethical experiences of practitioners from different health and social care professions during a unique time. When the research began, there was a significant and growing literature capturing the ethical considerations and challenges for practitioners across the professions. That literature provides a valuable map of the ethical landscape, both nationally and internationally, during Covid-19. It was though, only the starting point. The experiences, perspectives and voices of practitioners are the essence of this research. It is work that is grounded in what individuals describe and the meanings that they attach to those experiences. If the literature provided the map of the ethical landscape for practitioners during the pandemic, the empirical sections of this report might be the equivalent of travel writing in which individuals act as a guides to specific areas of that ethical landscape providing depth, complexity and specificity as we realise the significance of landmarks and notice that which matters and has perhaps been overlooked.

Whilst much of what was discussed by participants in interviews and focus groups reflected common themes in the published literature on the ethical dimensions of the pandemic, they offered new and nuanced

perspectives, deepening and shifting our understanding. For example, considering **what duties of care to self and others might mean in professions beyond intensive care**. This research revealed much that has been under-considered or even omitted altogether in the published literature about ethical practice during the pandemic, for example, **the prioritisation of the ethics of care in practice** and **how practitioners perceive and engage with ethical guidance**, particularly from regulators, including their views on the significance of judgement. Conducting interviews and focus groups allows for both **depth and exploration of self within systems**. Those were important features of this work. Individuals were given the space to sit with complexity and to elucidate complex experiences reflecting on the meaning of those experiences rather than just describing 'categories' of ethical challenge.

It was not just our understanding of the type of ethical questions and challenges that was deepened in this research, we learned too about **the ethical approaches that resonated** with practitioners. It was the language and **importance of virtue and values** that was commonly invoked to articulate ethical choices and priorities. Ethical practice was more **concerned with care and relationships** than it was with quality-adjusted life years and utilitarianism. **Narrative ethics was prioritised** as practitioners described the changing attention to notes. **Relational ethics imbued the findings**, for example in long discussions about **visits and visitors**. For those who have an interest in how ethics is learned and practised, these findings suggest we might look again at how we teach, develop guidance and support ethical practice.

The research captures the perceptions, experiences and enduring effects of what exists between the boundaries of organisational and systemic structures. These accounts and reflections from practitioners raise questions about **the nature of ethical guidance** from any source. The perceived credibility and value of guidance is often viewed in relation to trust, source, understanding of context and timeliness. Ethical guidance from regulators is inevitably received and approached by practitioners in the context of other statutory responsibilities, particularly fitness to practise. In a time of uncertainty, the interpretations of adaptations to guidance matter. Related to credibility, trust and legitimacy, are the **questions that arose about what constitutes ethical expertise** with many practitioners considering the regulatory perspective to be too distant, insufficiently focused or shaped by other priorities.

The place and significance of **judgement and its relationship** to ethical confidence and competence is an important finding of this study. The pandemic has demonstrated that judgement is unavoidable and discomforting, especially in situations of pressure and uncertainty. Articulating and modelling what judgement is in ethical practice and why it matters might be essential tasks in supporting practitioners and improving care. To assume that judgement is understood and that any understanding about it is common may be a mistake. There is much work that could be done to engage with, and ameliorate, the challenges relating to judgement that were a recurrent feature of this study. Moreover, that work should acknowledge both the skill of judgement and the system within which it is expected to flourish.

The **extent of the moral injury and ensuing moral distress** captured by this research matters and its impact is likely to be far-reaching. Many practitioners describe working in an environment that might be described as ethically iatrogenic. The implications for professionals, patients and service-users and society are painful but must be faced. There are multiple ways in which moral injury and distress might be mitigated in future. The act of talking about moral injury and naming the potential for moral distress in education and ethical guidance is a crucial first step. **Creating space for, and structured engagement with, the moral dimensions of practice matters**. Clinical and practice-based ethics debriefing, support and training (as distinct from theoretical learning) with skilled facilitation has much potential. Ethics coaching, action learning sets and active engagement with the moral character of health and social care work within continuing professional development have value. Those responsible for leading, supervising and managing model moral leadership and building their awareness and confidence in doing so is fundamental. No single intervention will 'solve' the challenge which is deep and complex. No one organisation will be able to respond alone, but response there must be.

There are, of course, limitations to the research: the total number of participants is small, the work was conducted in an unforgiving two-month timeframe and the context was constantly changing. Nonetheless there are two points which matter. First, the methodology and combination of iterative methods facilitated work at both **breadth and depth**. The scoping review and analysis of the literature captured a wide range of professional experiences and ethical perspectives across professions. That analysis was explored in depth with the email group who contributed to the development of the interview and focus groups which were grounded in what was known about ethical experiences whilst remaining open and flexible. They were spaces for deep and careful listening. The repeated and ongoing engagement with the data sought to capture as much as to explain. The perspectives that emerged from this research must be heard if we are to understand and respond to the impact of the pandemic on practitioners in a range of professions. Ethical practice is a human endeavour. It exists in the relationships, perceptions, assumptions and stories of those who work in all parts of health and social care. Unless guidance, standards, teaching and advice can engage with and reflect on those aspects of ethical practice, there will remain a gap that affects trust, professional choices and ultimately the care provided.

6. Conclusion and Recommendations

This research presents a picture of nuance and complexity. The ethical experiences of practitioners across the professions have taken a significant personal and systemic toll. It is not enough merely to identify the areas in which moral challenge has arisen. Perceptions and the impact of that moral challenge will inform practitioner and patient experiences for years to come. The implications of the ethical experiences described in this research represent both threat and opportunity. If ethical guidance and practice disregard these experiences, trust and credibility in those who set standards will be compromised. Responsive and relational regulation are aspirations for many and what is described in this research must shape how those concepts are enacted. Ultimately, without attending to the findings of this research, the quality of care will be affected. There are though opportunities. First, to think about and approach ethics in a different way that is grounded in the experience of practitioners and focuses on building confidence and capability. If human experience and interactions are seen as where ethics resides rather than in a booklet or checklist, there is great potential. To focus on preventing and responding to moral distress, on the ethics of care, the role of judgement in working with guidance and practical ways of providing ethical support may be the type of learning from the pandemic that is most needed.

The practitioners' perceptions of their regulator were often critical. They did not always understand the regulator's remit, sometimes misrepresented their response to the pandemic and occasionally idealised regulators of other professions. For some, their natural disposition towards the regulator was one of suspicion and even hostility. Others appeared indifferent and did not consider the regulator to be an obvious or useful source of ethical advice and support. Many commented that the regulator seemed not to have an understanding of what it was like 'on the ground'. Yet, at the round table event, it was clear that regulators had both engaged with, and reflected on, the impact of the pandemic and the ethical experiences of practitioners. There was congruence between many of the ethical concerns identified by the participants in the study and the discussion between those involved in regulation. How then might a responsive regulator engage with the ways in which practitioners have experienced the moral dimension of the pandemic and perceive ethical guidance?

Regulators exist as part of an ethical system, comprising different elements and encompassing multiple interactions. The people and organisations in the system have distinct functions and responsibilities, but the power to effect ethical impact has to be considered at an interactionist and systemic level, not least because that is how ethics is experienced in practice. Systemic thinking would allow consideration of the ethics that underpin regulation itself: what are the values that underpin ethical guidance? It would require attention to concepts such as trust, credibility and legitimacy and not avoid difficult questions about the tension between different functions of regulatory work. It would open up new possibilities for collaboration and connection that recognise that there may be others who are responsible for a particular task, profession or domain, but also appreciates that organisational boundaries can be barriers. It would think about how the system interacts as much as the outputs from different elements of the system, recognising that it is dynamic and complex.

Whilst shifting the lens on the approach to ethics, judgement and systems thinking has the potential to be transformative for regulators and those professionals they oversee, it is no small undertaking. Change is, of course, difficult and never more so than when everyone – regulators and professionals – have experienced the most intense and demanding period of their working lives. What practical changes might be possible in the short to medium term? The following recommendations may warrant consideration by regulators:

1. Reflect on the contents of this research and map its finding against ethical guidance to identify where and how it might be developed;
2. Review whether the concept of judgement is well-articulated, modelled and supported in ethical guidance and resources;
3. Evaluate the purpose and format of ethical guidance: how effectively does it meet the practice-based, human and interactionist elements of ethical practice captured within this study?
4. Describe what ethical preparedness might look like for the profession and its practitioners.
5. Describe what ethical approaches are embedded in, or even assumed by, the ethical guidance that is offered to professionals and what might be missing or under-emphasised;
6. Develop resources and guidance that recognise the prevalence and significance of moral injury and moral distress; and
7. Develop a systems-based approach to thinking about and fostering ethical practice. Building on the flexibility and collaboration that emerged during the pandemic to identify ways in which a systems approach would engage with practitioners' ethical experiences during the pandemic.

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