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Ethics and Social Welfare

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/resw20

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To cite this article: Denis Adia & Sarah Banks (2023) Ethical Issues in Hospital-based Social Work During the COVID-19 Pandemic: A Case from Uganda, with a Commentary, Ethics and Social Welfare, 17:1, 90-97, DOI: 10.1080/17496535.2022.2117014

To link to this article: https://doi.org/10.1080/17496535.2022.2117014

Published online: 15 Sep 2022.

ETHICS AND SOCIAL WELFARE
2023, VOL. 17, NO. 1, 90–97
https://doi.org/10.1080/17496535.2022.2117014

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ETHICS IN PRACTICE

Ethical Issues in Hospital-based Social Work During the COVID-19 Pandemic: A Case from Uganda, with a Commentary

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ABSTRACT

This paper comprises a case study illustrating ethical and practical challenges for a Ugandan hospital-based social worker early in the COVID-19 pandemic, followed by a commentary. The hospital was under-resourced, with staff and patients experiencing lack of information and panic. The social worker, Denis Adia, recounts his responses to new and ethically challenging situations, including persuading Muslim patients to stop fasting for the good of their health; deciding to keep a baby in hospital with parents although this was against the rules; and supporting a stigmatised former patient in the face of intimidation by colleagues. He reflects on the importance of recognising each person's unique needs and circumstances, seeing this as a vital role for social workers. The case is followed by a commentary from a UK academic (Sarah Banks), who notes the cognitive and emotional effort ('ethics work') undertaken by the social worker to: see the ethical aspects of particular situations; take account of patients' specific needs; ensure they are treated with respect; promote their well-being; and perform as a good social worker. Banks draws attention to the key role of the virtue of courage in pandemic conditions, which involves working with new risks and facing fears with confidence.

KEYWORDS

Ethics; courage; COVID-19; hospital social work; Uganda

The case: practical and ethical challenges for a hospital-based social worker in Uganda

Denis Adia

Background

At the start of the COVID-19 pandemic, I worked as the only social worker in a regional hospital in Uganda. My usual role included patient assessment and the formation and training of regional psychosocial teams. The hospital has a capacity of 278 beds and serves over three million patients annually. At the time, it had no Intensive Care Unit or

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isolation facilities for highly infectious diseases. It had less than 400 staff, leading to chronic burnout and a heavy workload for me as the social worker. The health infrastructure in Uganda is currently in a state of disrepair, with limited space in overcrowded maternity, surgical and pediatric wards. As a result of insufficient capacity for health care in local health facilities (due to staff shortages, drug shortages, poorly motivated staff, and lack of electricity to run primary laboratory machines), the regional referral hospital is highly congested by many self-referral cases of non-communicable diseases, which would otherwise be managed at lower-level health facilities. Most decision-makers in this hospital during Covid-19 were male medical professionals, yet most nursing staff were females. Their voices were unheard since they did not occupy high decision-making positions. Some hospital staff, including me, had previously received training in managing the infectious disease, Ebola. The aspects of this training which were transferable in meeting the demands of COVID-19 were mental health and psychosocial support, infection prevention and control (IPC), and appropriate use of personal protective equipment (PPE). However, other than that, we were ill-prepared for a pandemic. All regional hospitals were instructed to turn Mental Health Units into COVID-19 Treatment Units (CTUs), and such a CTU was established at this hospital.

My role as a social worker during the pandemic

I headed different teams in the CTU, such as the Medical, Psychosocial and Infection Prevention and Control teams, for the first 12 days because the medical officers who were meant to perform this role had disappeared due to fear of contracting an infection and dying. After pleading from me, and fear of reprisal from the hospital management, a few managed to come to the CTU but would not cross to the Red Zone to treat patients. I had to counsel them several times before they reluctantly entered. Some medical workers had preferred treating COVID-19 patients virtually, based on clinical and nursing reports, which I advocated against.

My role in the CTU ranged from attending CTU meetings, counselling staff and patients, and writing daily and weekly reports to conducting psychosocial training and mentorships for trainers, social workers, and health care workers in different hospitals in the region to prepare them to contain a predicted massive community infection outbreak. Using local FM radio stations, I also presented health education for persons at risk of COVID-19. I covered various topics such as the importance of psychosocial support, drug and Standard Operating Procedures (SOPs) adherence and the available emergency hospital services that could be accessed during the lockdown. I set up Psychological First Aid Desks at the screening point for people with suspected COVID-19 entering the hospital.

Once risk allowances were introduced for staff of the CTU, there was pressure to get rid of me and some nurses who had volunteered to work in the CTU without risk allowances at a time when other health care workers were afraid to work there. Replacing us with those considered loyal to a section of the health workers' leadership aimed to reward them with money. However, when they realised that the risk allowances were not forthcoming and faced rejections from the patients due to professional incompetence, those who succeeded me in playing the social work role left the CTU, and I was asked to return. On my return, I linked recovered patients with their families, with foreign embassies (if patients were from another country) and with other patients in the CTU using digital

technologies to share their recovery experiences to reduce fears and anxiety. I was guided and occasionally supervised by the hospital director in these tasks.

Additionally, I lobbied for the renovation of dilapidated washrooms, provision of sanitary pads, personal effects, installation of sockets in all wards, as well as the provision of free rosaries, audio Bibles, copies of the Koran, mats and small jerricans for prayers for Catholic, Anglican, and Muslim patients respectively. I mobilised the staff to collect fresh fruits from the CTU compound to make juice for the patients. Maintaining key service providers' email addresses and telephone numbers was another noble duty that I conducted. Making decisions in the CTU was complicated for me. I had to consult colleagues in the national referral hospitals and multi-disciplinary teams in and outside the CTU, which consumed much of my time. At times I would be permitted to make decisions without the required resources to implement them. Sometimes I was told to wait for weeks before getting the required resources, or I was told by those I contacted that they did not know what to do. This made me feel frustrated, powerless and, at times, irritated. I became physically and mentally exhausted due to the increased workload, stigma within the hospital, and limited supplies, making it extremely difficult to stay in the CTU. After reflecting on my professional and ethical codes of conduct, seeing the joy of patients recovering, and the support and encouragement from my family, supervisor and some colleagues, I was motivated to remain in the CTU.

Examples of ethically challenging situations

1) Working with fasting Muslim patients

One of the ethical challenges I faced was addressing cultural and religious beliefs that contradicted the COVID-19 treatment protocol. I had to dialogue with the Muslim patients who were fasting during Ramadan to stop their fasting in a bid to boost their immunity for the commencement of treatment. Many patients were hesitant to adhere to the protocol. It was an uphill task for me as a Christian to persuade Muslim patients to stop fasting. They viewed me as a pagan who was against their faith. This prompted me to link up with Muslim leaders who were part of the regional COVID-19 psychosocial support team. After thorough counselling, with the support of the Muslim leadership, most patients accepted the recommendation to forego their fasting during this time. They were also able to talk to fellow Muslims in hiding due to fear of stigma. Because of being treated professionally in the CTU, they could convince other Muslims to undergo testing and seek treatment if found positive.

2) Deciding how best to safeguard a baby with parents in hospital

When a male truck driver returned home from South Sudan, his neighbours notified the local leadership of the area, who in turn informed the district COVID-19 task force. They took his samples and requested him to self-isolate at home as they awaited his test results. When his results were eventually returned, they were positive, and he was evacuated to the CTU. His wife and son were told to self-isolate, and eventually, his wife was also found positive. Thus, she was admitted to the CTU with the baby, who was negative. In observing the baby's rights to safety, I was torn between keeping the baby close to the parents so they could oversee his care or preventing the baby from being infected by the parents

by removing him. When they arrived at the hospital, I had no prior experience with such a case. I consulted colleagues serving in national and regional referral hospitals for guidance on how to proceed. On consultation, I was advised to liaise with the district probation officer and the district COVID-19 task force. However, they were unable to arrange care for the child. Therefore, I decided to create a room for this child and place him there while providing basic necessities. Despite working within limited resources, uncertainty and lacking prior experience in looking after children in the CTU, I made this decision based on the child's best interest, safety and the fact that I had no other options left. I faced the ethical challenge of deciding whether to follow the guidance offered by the medical team and CTU rules, regulations and policies (which required separating the baby from his parents) or to use my professional judgement in this circumstance where their guidance and regulations seemed inappropriate and confusing for me. Later I was able to locate the grandparents to whom I handed over the child with a bit of money that I had mobilised from colleagues to support his feeding after a comprehensive discussion with both parents.

3) Challenging stigmatisation of people with COVID-19

I regularly held family meetings and daily and weekly meetings with patients. One patient was in denial that he was suffering from the virus and felt that his business competitors were framing him. Despite several health education and counselling sessions, he refused to listen. When he was discharged, he was asked to self-isolate for two weeks, which he refused to do. The day after his discharge from the hospital, he went to the lorry park where he usually operates, and his friends almost killed him there. They thought he had come to infect them with the disease. He later called me to go and talk to his workmates about stigma and discrimination. It was a dilemma for me whether to go or not due to fear of being attacked by the community. However, I went and provided health education to the man's friends about COVID-19 and requested them to provide him with psychosocial support instead of stigmatising him as he remained under two weeks' observation from home. This indicates to me that a professional social worker can only handle such social challenges because of our knowledge and understanding of community norms, values and cultures and the required empathy skills and interpersonal communication skills to convey the messages appropriately.

Concluding comments: recognition of each person's unique circumstances

Recognising and understanding that each patient and staff member in the CTU was unique in terms of their medical conditions, languages, and material and psychological needs was important because recognition is an existential human need or desire and a precondition for a successful identity formation that human prosperity depends on. Some patients had other underlying conditions besides COVID-19, while others did not. Muslim patients were fasting while the Christians were not. Some patients spent months in the CTU before discharge, whilst others spent less time there, depending on their body's immunity. This required the social worker to differentially use social work principles and methods to assist the staff and the patients towards the desired social change. Treating the patients and the staff as individuals is based on their rights as human beings to be individuals and as human beings with personal differences.

Commentary

Sarah Banks

Denis's account gives a detailed picture of the difficult circumstances facing a hospital social worker in an already under-resourced Ugandan health care system at the start of the COVID-19 pandemic. It shows the courage, creativity and commitment he deployed to develop new ways of working in the face of institutional inadequacy, lack of information and panic on the part of colleagues and patients. His account focuses more on the practicalities of what he did than the details of the ethical dilemmas faced, how he made decisions, how he felt or his reflections afterwards on whether what he and others did was ethically right or wrong, virtuous or vicious. The main reflective point he makes is at the end, when he comments on the importance of recognition – that is, seeing and treating each person as unique, in terms of their psychological and religious beliefs, as well as their health needs.

Whilst recognition in this sense is a key tenet of social work and indeed is the basis for its distinctive contribution to society, particularly in hospitals and other institutional settings, nevertheless, it often goes unappreciated and unrecognised by managers or colleagues in other disciplines. A previous article in this journal, which discussed a case from the UK, featured a social worker advocating for the distinctive needs of particular young people in the face of COVID-19 rules and restrictions in a residential home (Banks and von Köppen 2021). This is what social workers would be expected to do (assess and advocate for people's specific needs), but it became both more difficult and more necessary in pandemic conditions as blanket rules and restrictions were introduced, more people were in need and resources were stretched. People's individual circumstances and needs were more likely to be ignored than usual.

Denis gives examples of his responses to particular people (Muslim patients who were fasting, a baby with sick parents in the CTU, and a lorry driver who was stigmatised). These examples show him putting significant energy and effort into understanding people in context and striving to ensure better outcomes for them. Taking the example of Muslim fasting, Denis's efforts entailed an exercise in ethical seeing or framing (i.e. perceiving religious fasting as a key feature of Muslim patients' lives yet inhibiting their recovery) but also a commitment to tackle this issue. Possibly (although not recorded in this account), he also undertook a process of reasoning or thinking through how best to influence Muslim patients (via Muslim leaders) and displayed a willingness and capability to arrange this. These are all components of what I call 'ethics work', that is, 'the effort people (in this case professionals) put into seeing ethically salient aspects of situations, developing themselves as good practitioners, working out the right course of action and justifying who they are and what they have done' (Banks 2016, 36).

Ethics work, as an integral part of everyday social work practice, is often invisible – inter-twined with practical work. It only becomes visible when the moral agent (in this case, the social worker) publically reflects on their challenges or actions through an ethical lens (identifying issues relating to rights, responsibilities, harms, benefits or qualities of character, for example) or when an observer or commentator interprets or evaluates someone's demeanour or actions in ethical terms.

In addition to the reflections made by Denis himself about the importance of recognising individual needs and circumstances, what strikes me about this account is Denis's

courage, manifested in his continuing to work while others had fled, his call to senior medical colleagues to return, and his willingness to confront challenging issues such as religion, conflict and lack of resources. Courage can be regarded as a moral virtue, often included in lists of virtues for social workers (Banks and Gallagher 2009, 174–194) and particularly important during crisis conditions such as a pandemic. A virtue is 'a moral disposition to feel, think, and act in such a way as to promote human and ecological flourishing, entailing both a motivation to act well and, typically, the achievement of good ends. Virtues are often described as excellent traits of character and entail a reliable disposition to act in certain predictable ways across contexts' (Banks 2021, 182).

Courage is one of Aristotle's core virtues, which he describes as 'a mean with regard to feelings of fear and confidence' (Aristotle, 350 BCE/1954, 1114b22–1115a9). For Aristotle (whose ideas still underpin much present-day virtue ethics), striving towards a 'mean' state entails avoiding an excess of courage (which would amount to foolhardiness or over-confidence) or a deficiency (which would amount to cowardice or under-confidence). Courage, therefore, entails facing fear in the right way for the right reasons, depending on the context. It is associated with risk-taking and being prepared to take a considered risk. To give an easily recognisable example from ordinary life, courage entails being confident enough in one's swimming ability to jump into the sea to save a child from drowning, while it would be reckless (not courageous) to enter a rough sea as a weak swimmer. Acting courageously is not necessarily easy, and as with all the virtues, courage needs to be cultivated over time and accompanied by practical wisdom.

According to Fowers et al. (2021), courage is a key virtue in the context of COVID-19 (along with justice and practical wisdom), associated with fear and risk, and understood as an appropriate degree of risk-taking. Fowers et al. examine courage theoretically and normatively in terms of how people would need to think and behave in crisis conditions. However, they do not present empirical examples of how real people have actually deliberated, acted and reflected in the complexities of their daily lives during the pandemic. This is where Denis's account is helpful in giving details of what he did in a particular context as a social worker.

However, Denis himself does not mention courage, nor does he elaborate upon his fears or the details of his reasoning around risk-taking. What he gives us, largely, is a picture of his confidence. He took on roles and responsibilities in the CTU way beyond his remit as a social worker, staying when others succumbed to fear. We catch brief glimpses of his emotional state when he describes his exhaustion, frustration, and irritation, which made him question whether to stay in the CTU. However, he was motivated by seeing the good outcomes of his work despite all the challenges. He took on the 'uphill task', as a Christian, of trying to persuade Muslim patients to stop fasting for the benefit of their health. He used his professional judgement to enable a baby to remain in hospital near the parents despite medical guidance and rules to the contrary. He decided to go to a lorry park to support a stigmatised former patient in the face of fear of being attacked by other lorry drivers.

The reader cannot judge whether Denis was courageous or over-confident/foolhardy in these situations as we do not know the full details of his risks nor his risk assessments. But we can see that they were situations where courage would be a relevant virtue as they involved fear, confidence and risk. And this may provoke readers, and Denis himself, to

reflect upon: how we know if our confidence is well-founded; when we should overcome our fear and when it is right to heed it as a warning of excess danger; how we assess risk intuitively and whether our intuitions are reliable. The COVID-19 pandemic created conditions in which these questions have come to the forefront for many people across the world, albeit living and working in very different contexts.

I have written this commentary from my perspective as a white, UK academic, and am inevitably imposing my ethical lens on Denis's account of his practice in Uganda. There may be aspects of his narrative that I have misunderstood or misinterpreted. Yet there is great value for me, and hopefully for journal readers, in hearing about Denis's courageous, creative and committed social work in a particular setting. Practical or everyday ethics is always situated in a context – embedded in institutions, norms and practices, and embodied in the people who practise as moral agents. Denis's case study vividly illustrates the particularities of the context of scarcity, inequity and fear in the Ugandan hospital, alongside aspects of his courage, creativity and commitment in that setting. At a general level, these themes and moral qualities will resonate with social workers across the world and have messages for all who have lived through the COVID-19 pandemic and many other humanitarian crises and emergencies.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The case and commentary were generated during research on 'Ethical Challenges for Social Workers during COVID-19', funded by Durham University through the Economic and Social Research Council Impact Acceleration Account (reference ES/T501888/1).

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References

Aristotle. 350 BCE/1954. *The Nichomachean Ethics of Aristotle*, translated by Sir David Ross. London, Oxford University Press.

Banks, S. 2016. "Everyday Ethics in Professional Life: Social Work as Ethics Work." *Ethics and Social Welfare* 10 (1): 35–52.

Banks, S. 2021. "Between the Local and Global: Placing the Virtuous Practitioner in Context." In *Virtues and Virtue Education in Theory and Practice: Are Virtues Local or Universal?*, edited by C. Darnell, and K. Kristjánsson, 182–197. London: Routledge.

Banks, S., and A. Gallagher. 2009. *Ethics in Professional Life: Virtues for Health and Social Care*. Basingstoke: Palgrave Macmillan.

Banks, S., and M. von Köppen. 2021. "Ethical Issues for Practice and Research in Congregate Settings During the Covid-19 Pandemic: Cases and Commentaries." *Ethics and Social Welfare* 15 (3): 328–335.

Fowers, B., L. Novak, A. Calder, and R. Sommer. 2021. "Courage, Justice, and Practical Wisdom as Key Virtues in the Era of COVID-19." *Frontiers in Psychology* 12: 647912. doi:10.3389/fpsyg.2021.647912.