Document generated on 11/14/2026 6:56 a.m.

Canadian Journal of Bioethics
Revue canadienne de bioéthique

Canadian Journal of Bioethics
Revue Canadienne de Bioéthique

Impacts of the Early COVID-19 Pandemic on the Work of Bioethicists in Canada

Marilou Charron, Jean-Christophe Bélisle-Pipon, Vincent Couture, Bryn Williams-Jones, Vardit Ravitsky and Charles Dupras

Volume 5, Number 4, 2022

URI: https://id.erudit.org/iderudit/1094693ar
DOI: https://doi.org/10.7202/1094693ar

See table of contents

Publisher(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (digital)

Explore this journal

Cite this article

Charron, M., Bélisle-Pipon, J.-C., Couture, V., Williams-Jones, B., Ravitsky, V. & Dupras, C. (2022). Impacts of the Early COVID-19 Pandemic on the Work of Bioethicists in Canada. *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, *5*(4), 20–29. https://doi.org/10.7202/1094693ar

Article abstract

Bioethics experts played a key role in ensuring a coherent ethical response to the COVID-19 pandemic in the fields of healthcare, public health, and scientific research in Canada. In the province of Quebec, a group of academic and practicing bioethicists met periodically in the early months of the pandemic to discuss approaches and solutions to ethical dilemmas encountered during the crisis. These meetings created the opportunity for a national survey of bioethics practitioners from different fields. The survey, in which forty-five Canadian bioethics practitioners (clinical ethicists, ethicist members of REBs and government health policy ethicists, or any bioethicist practicing outside of academia) participated, explored their concerns, challenges and opportunities during the first wave of the pandemic, with the objective of informing bioethics research about the difficulties experienced by bioethicists “in the field”. Participants reported increased stress levels, increased workloads, and a greater proportion of their work being devoted to public health ethics. Most of their concerns focused on groups other than themselves, such as health professionals, patients, research participants, and people in vulnerable socio-economic situations. An optimism about the future of bioethics was noted due to an increased awareness of the importance of bioethics by the public and by health and research institutions.

© Marilou Charron, Jean-Christophe Bélisle-Pipon, Vincent Couture, Bryn Williams-Jones, Vardit Ravitsky and Charles Dupras, 2022

This document is protected by copyright law. Use of the services of Érudit (including reproduction) is subject to its terms and conditions, which can be viewed online.

https://apropos.erudit.org/en/users/policy-on-use/

érudit

This article is disseminated and preserved by Érudit.

Érudit is a non-profit inter-university consortium of the Université de Montréal, Université Laval, and the Université du Québec à Montréal. Its mission is to promote and disseminate research.

https://www.erudit.org/en/

Canadian Journal of Bioethics
Revue Canadienne de Bioéthique

M Charron, J-C Bélisle-Pipon, V Couture, B Williams-Jones, V Ravitsky, C Dupras. *Can J Bioeth / Rev Can Bioeth.* 2022;5(4):20-29

ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

Impacts of the Early COVID-19 Pandemic on the Work of Bioethicists in Canada

Marilou Charron[a], Jean-Christophe Bélisle-Pipon[b], Vincent Couture[c], Bryn Williams-Jones[a], Vardit Ravitsky[a], Charles Dupras[a]

Résumé
Les experts de la bioéthique ont joué un rôle clé pour assurer une réponse éthique cohérente à la pandémie de COVID-19 dans les domaines de la santé, de la santé publique et de la recherche scientifique au Canada. Dans la province de Québec, un groupe de bioéthiciens académiques et praticiens s'est rencontré périodiquement au début de la pandémie pour discuter d'approches et de solutions aux dilemmes éthiques rencontrés durant la crise. Ces rencontres ont créé l'opportunité d'un sondage national des praticiens de la bioéthique de différents domaines pour conserver un témoignage de ces rencontres informelles. Le sondage avait aussi pour objectif d'éclairer la recherche en bioéthique sur les difficultés vécues par les bioéthiciens « sur le terrain ». Les auteurs ont recueilli les réponses de quarante-cinq bioéthiciens canadiens, visant à connaitre leurs préoccupations, défis et opportunités rencontrés durant la première vague de la pandémie. Les participants ont rapporté une augmentation de leurs niveaux de stress, une augmentation de leur charge de travail, ainsi qu'une plus grande part de leur travail étant consacrée à l'éthique en santé publique. La plupart de leurs préoccupations se concentrait sur des groupes autres qu'eux-mêmes, tels les professionnels de la santé, les patients, les participants à la recherche et les personnes en contexte de vulnérabilité socioéconomique. Un optimisme quant au futur de la bioéthique fut dénoté en raison d'une conscience accrue de l'importance de la bioéthique par le public et par les institutions de santé et de recherche.

Mots-clés
COVID-19, bioéthique, éthique pandémique, éthique clinique, éthique de la recherche, éthique des politiques de santé

Abstract
Bioethics experts played a key role in ensuring a coherent ethical response to the COVID-19 pandemic in the fields of healthcare, public health, and scientific research in Canada. In the province of Quebec, a group of academic and practicing bioethicists met periodically in the early months of the pandemic to discuss approaches and solutions to ethical dilemmas encountered during the crisis. These meetings created the opportunity for a national survey of bioethics practitioners from different fields. The survey, in which forty-five Canadian bioethics practitioners (clinical ethicists, ethicist members of REBs and government health policy ethicists, or any bioethicist practicing outside of academia) participated, explored their concerns, challenges and opportunities during the first wave of the pandemic, with the objective of informing bioethics research about the difficulties experienced by bioethicists "in the field". Participants reported increased stress levels, increased workloads, and a greater proportion of their work being devoted to public health ethics. Most of their concerns focused on groups other than themselves, such as health professionals, patients, research participants, and people in vulnerable socio-economic situations. An optimism about the future of bioethics was noted due to an increased awareness of the importance of bioethics by the public and by health and research institutions.

Keywords
COVID-19, bioethics, pandemic ethics, clinical ethics, research ethics, health policy ethics

Affiliations
[a] Programmes de bioéthique, Département de médecine sociale et préventive, École de santé publique de l'Université de Montréal, Montréal, Quebec, Canada
[b] Faculty of Health Sciences, Simon Fraser University, Burnaby, British Columbia, Canada
[c] Faculté des sciences infirmières, Université Laval, Québec, Québec, Canada
Correspondance / Correspondence: Marilou Charron, marilou.charron@mail.mcgill.ca

INTRODUCTION

Starting in January 2020, the first cases of COVID-19 were detected in Canada (1). The novel public health situation for citizens and the healthcare system gave rise to unprecedented measures to quell the spread of the disease within the population, especially among the most vulnerable (2). For many workers across the country, this meant adjusting to new work environments, be it working from home (2,3) or the increasingly stressful context of providing frontline healthcare and essential services (4,5). Healthcare organizations had to take drastic measures to care for a large influx of very ill COVID patients (6-9). The intensification in workload, coupled with the need to reduce transmission, necessitated a slowdown of non-urgent health service provision for many hospitals, while at the same time opening the door to the rapid implementation of telemedicine and other innovations to prevent infections (6,9).

The field of bioethics as a whole – that is, academic bioethicists and bioethics practitioners from across the full range of specialties, including clinical ethics, research ethics, health policy ethics, and public health ethics – gained substantial public and institutional recognition from the very early days of the pandemic (10-12). In this study, we refer to "bioethics practitioners" as individuals whose professional practice consists, at least in part, of working in healthcare and social services facilities as clinical and/or organizational ethics consultants, research ethicists in research ethics boards (REBs), or health policy ethicists in government departments or agencies. This recognition of the pertinence of bioethics in public health crises is arguably due, at least in part, to the field's long history in North America of dealing with morally challenging situations in healthcare

2022 M Charron, J-C Bélisle-Pipon, V Couture, B Williams-Jones, V Ravitsky, C Dupras. Creative Commons Attribution 4.0 International License
ISSN 2561-4665

organizations, contributing to health policy (e.g., fair resource allocation), and ensuring the implementation of ethical norms across disparate areas (e.g., protecting participants in research and responding to public health crises) (13,14).

In this pandemic context, frontline healthcare workers had to quickly adjust their definition of “best practices” and care priorities, often in ways that they might not have considered optimal in pre-crisis circumstances (15). Health research in Canada and internationally rapidly prioritized medical and public health research to understand the epidemiology of the disease and develop effective prevention measures, therapeutics, and vaccines. Administrative and regulatory approval processes were accelerated (16), and hospital and university REB services were streamlined to help in these efforts (13,17). The most evident public challenges, however, involved the need for health professionals and institutions to shift from an individual-based approach to clinical care and ethics to a more community-centred approach focused on population health (15,18). Clinicians and bioethicists rapidly developed a heightened awareness of the need to consider the whole organization when making decisions, while also maintaining a sufficient quality of care and services for individuals. There were also many uncertainties and knowledge gaps about COVID-19, including mechanisms of transmission, symptoms, consequences, and most effective means to contain or mitigate the spread of the disease (19).

These issues inevitably led to ethical tensions between competing sets of duties (18). For example, ethical questions and dilemmas arose regarding the duties of healthcare organizations to protect their workers, in addition or in opposition to providing optimal and equitable care to patients (6,10). Other important ethical questions surrounded the fair allocation of resources and the implementation of triage and prioritization protocols in case of major bed or equipment shortage in intensive care, all of which solicited rapid input from bioethicists (9,18). In parallel, REBs were put under increasing pressure to respond quickly with their ethics evaluations of COVID projects while maintaining standards of evaluation quality and ensuring the protection of research participants (13,17). As such, the pandemic presented real challenges for health professionals and their organizations, as well as for bioethicists working both within and outside these institutions.

Drawing from past pandemic experiences such as the influenza (H1N1) pandemic in 2009, it has become clear to various stakeholders that involving bioethics analyses in public health preparations and interventions can help manage risks and enhance public awareness and understanding of risks. This increased understanding can contribute to continued support for public health measures (20). Recommendations for best practices for health professionals (who were dealing with scientific and clinical uncertainty, a surge in patients, and overstretched and exhausted health teams) during the lockdown phase of the pandemic showed that clinical ethicists were vital resource people for supporting the public health network during a crisis situation (14) and could play a critical role in ensuring the resilience of the system over the long term (4).

During the pandemic, officials and policymakers sought the expertise of bioethicists in academia, healthcare organizations, and government agencies to support the development and implementation of ethically appropriate responses to the COVID-19 crisis. Yet, to date, few studies have focused on the professional challenges that bioethicists faced or the emotional well-being of these key actors during COVID-19 (21). Given the important role played by bioethicists in Canada, empirical data on their roles and experiences during the intense early phase of the pandemic (i.e., the first few months of 2020) is an important contribution to the literature. This study documents the attitudes, emotional responses, needs, and views of bioethics practitioners. Not included in our study were academic bioethicists who solely hold positions in universities as researchers, professors, or academic associates. While important actors, this group did not experience the challenges faced by bioethics practitioners.

During the first wave of the pandemic in Quebec, a group of bioethics practitioners and academic bioethicists (the authors) organized regular (weekly and then monthly) online meetings in order to leverage and transfer analytic and decision-making tools from academia to those working on the front lines (i.e., in health settings, REBs, and government) and so contribute to the collective response to the challenges of COVID-19 in healthcare, research, and public health policy. During these meetings, bioethics practitioners informally reported moral challenges and difficulties adapting to the novel situation and thus welcomed aid from their academic colleagues. Notable discussion topics included moral distress (of both bioethics practitioners and health professionals), the use of ethical frameworks to support decision-making and influence health policy, the implementation of triage policies, and vaccination passports, amongst others (22). Participants also noted the importance of keeping track of the issues raised in these discussions, recognizing that careful record-keeping could potentially support practitioners after the crisis by capturing insights gained during the early days of the pandemic. In light of this request and given the paucity of empirical data in the academic literature, we conducted an anonymous survey with Canadian bioethics practitioners in different fields of practice to gain a better understanding of their responses to the pandemic and how they foresaw the pandemic affecting the future of bioethics practice (23). This survey aimed to contribute to the literature by providing an opportunity for bioethics practitioners in Canada to communicate their needs and perspectives.

METHODS

From May to June 2020, we conducted an anonymous survey using the LimeSurvey platform (hosted in Canada). Respondents were bioethics practitioners (academic bioethicists were excluded) professionally involved in the domains of clinical ethics, organizational ethics, research ethics, or public health and health policy ethics. Invitations to participate were sent by e-mail to approximately 50 people in the province of Québec (Canada) who were involved in the regular weekly discussions with researchers during the early days of the pandemic. We invited these respondents to forward invitations to their professional networks. In addition, we solicited the help of organizations such as the Association Québécoise d’éthique clinique (AQEC,

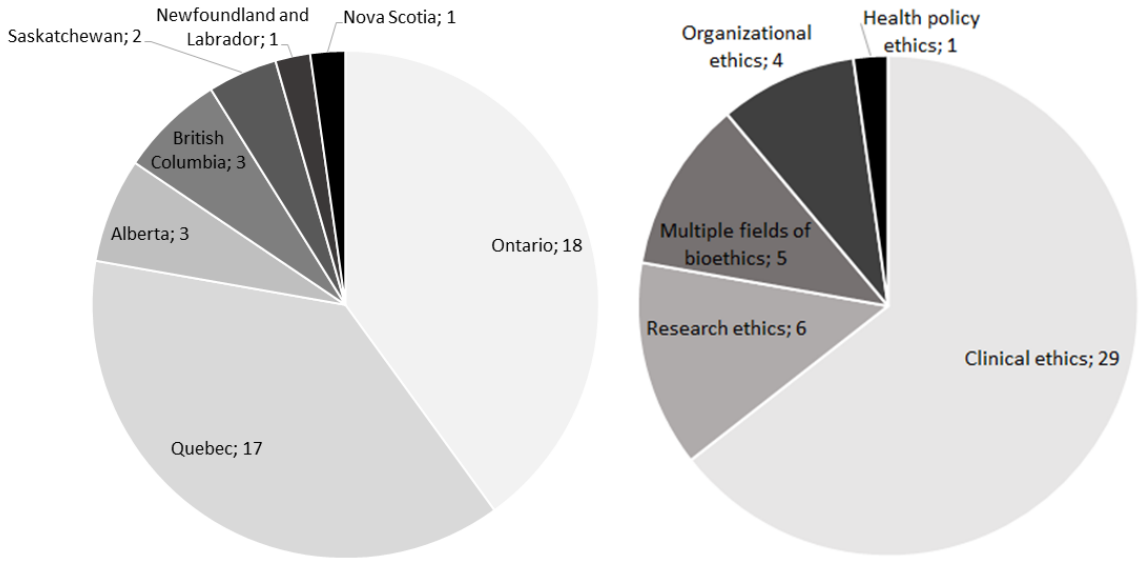
Québec Clinical Ethics Association), the Canadian Bioethics Society (CBS), and the International Association of Bioethics (IAB) to widely disseminate the invitation to participate in the survey. We also posted links to the survey on social media platforms, e.g., Twitter, Facebook, and LinkedIn. Research data were collected anonymously. However, respondents were given the option to provide contact information to be updated on the study findings and/or receive invitations for follow-up studies. Initially, the survey collected international responses, but analysis of the data was restricted to Canada due to an insufficient number of responses from other countries.

The survey questions sought to capture the changes that bioethics practitioners had perceived in their practice, their emotional responses, their adaptation and coping strategies, the ethical challenges they encountered in carrying out their professional responsibilities, and their hopes, apprehensions, and needs for a post-pandemic future for bioethics. The survey was divided into 14 sections. It included multiple choice and open-ended questions, as well as questions asking respondents to rate their level of agreement with various statements on a 5-point Likert scale. While some of these questions presented potential for quantitative analysis, the focus of our analysis in this paper is mainly on the qualitative data. The survey could be completed in either French or English, the two official languages of Canada. A panel composed of bioethics practitioners reviewed the early drafts of the survey and provided suggestions for its improvement. Ethics approval of the survey was obtained from the Comité d'éthique de la Recherche en sciences et en santé de l'Université de Montréal (Université de Montréal's Science and Health Research Ethics Board) (CERSES-20-064-D).

RESULTS AND DISCUSSION

Fifty-five (n=55) bioethics practitioners from different countries initially answered the survey. However, due to insufficient responses from countries other than Canada (8 international participants from Europe and the United-States), only the 46 Canadian respondents were retained for this analysis. Of the 46 respondents, one was excluded due to not working in the practical field of bioethics (the person was a student in bioethics as opposed to a practising bioethicist), bringing the final sample to 45 respondents. Most respondents were from the provinces of Ontario (n=18) and Québec (n=17), with at least one respondent from each of 5 of the other Canadian provinces (Alberta, British Columbia, Nova Scotia, Newfoundland and Labrador, and Saskatchewan); there were no respondents from the Canadian territories (Figure 1).

Figure 1: Demographics of survey respondents



The pie chart on the left indicates the provinces where the respondents worked. The pie chart on the right indicates the fields of bioethics to which respondents identified.

Of the 45 respondents, most reported working in clinical ethics (n=29), with other fields of practice including research ethics (n=6), organizational ethics (n=4), and health policy ethics (n=1). No respondent in our sample reported specializing in public health ethics. A few respondents indicated that their work included multiple areas of practice from the above-listed fields of bioethics (n=5) (Figure 1). The low recruitment of respondents from fields other than clinical ethics limited our ability to compare results between the different fields or specialities of bioethics. Nevertheless, we included all fields in our survey so as to provide a perspective on the status of practical bioethics in general, as opposed to only one subfield (e.g., clinical ethics).

Changes in Workload and Tasks

More than half of respondents (n=31) reported changes in their work tasks because of the pandemic, and all but two reported an increase in their workload (n=29). Most of the changes in tasks were related to the proportion of time allocated to different

portions of their work. Increases in the workload of respondents was mostly attributed to additional health policy and public health work, such as framework creation and supporting resource allocation decision-making. Some respondents mentioned undertaking new tasks, such as being involved in the development and implementation of triage protocols on top of their other duties. Some clinical ethicists reported a decrease in workload related to clinical case consultation, with two respondents indicating that they were reassigned to other tasks such as frontline clinical work in long-term care centres. This could indicate that in cases where there were acute staff shortages on the frontline, ethics was deprioritized in favour of other duties for which clinical ethicists might be less experienced or competent. Respondents working in research ethics reported no change in the nature of their tasks but noted that they were much busier because of the need to respond in a timely manner to COVID-19 research projects. These respondents did not report being involved in additional health policy or public health work, nor were they involved in the frontline healthcare response.

Work-Related Challenges

Tables 1 and 2 summarize the work-related challenges of bioethics practitioners identified by respondents in their answers to quantitative questions of the survey. These questions explored the effects of the pandemic on various aspects of practitioners' work, their emotional and psychological response, and their needs.

Table 1: Perceived effects of the early COVID-19 pandemic on bioethics practitioners' work, relationships, and emotional lives

Aspects of work	Positive impact (%)	Negative impact (%)
Relationship with colleagues in ethics	58	18
Relationship with the people who use their services	49	13
Feeling recognized and appreciated at work	48	26
Relationship with hierarchical superiors	48	12
Feelings of usefulness at work	44	34
Ability to fulfill main mandate	33	42
Ability to communicate with others at work	33	24
Comprehension of their mandate	30	36
General Mood	14	48
Stress	10	70
Missing percentages (i.e., total less than 100%) can be attributed to the participants who scored a neutral response to the questions.		

Most respondents (n=40) reported that the challenges they faced due to the COVID-19 pandemic were new to them. However, they also indicated that these challenges could have been better anticipated (n=39). For example, drawing from previous pandemic experiences such as the H1N1 pandemic of 2009, for which Canadian preparedness had been praised (24), would have helped healthcare and health policy organizations to better cope with the uncertainty of the first wave of the pandemic. As one participant noted, "*It also upsets me that very little of what we learned in SARS has been even considered in this pandemic*" (P43, clinical ethics). Nevertheless, most respondents reported that they were adapting well to the pandemic situation and had been able to respond to the ethical needs of their respective workplaces or position (n=40).

Respondents who reported working mainly in organizational ethics all agreed on the positive effects of the pandemic on their work-related tasks (n=4), such as increased trust and reliance from their organizations. Respondents from all other fields of bioethics also reported similar positive effects of the pandemic on their work, although not unanimously. However, as we detail further below, this sense of positive effects did not necessarily translate into a positive emotional response.

Table 2: Feelings and needs of bioethics practitioners during the early COVID-19 pandemic

Feelings and Needs	Agree or Strongly Agree (%)	Disagree or Strongly Disagree (%)
Feeling like you have the right tools to face the pandemic	71	29
Feeling overworked	65	35
Need for literature support (in general)	62	38
Need for legitimacy	62	38
Need for better peer connection (in the academic field)	58	42
Need for better peer connection (in the same field of bioethics)	56	44
Need for better peer connection (in different fields of bioethics)	51	49
Need for psychological or emotional support	32	68

Some clinical ethics consultants specifically reported a lack of support from their superiors and institution, a lack of influence to instigate meaningful changes in their institutions, or even a general devaluation of their usefulness regarding their work: *"My approach and views to human rights aspects during COVID-19 planning and policies may not align with those of administration and staff. This may have a negative influence on how my work in the organization is perceived"* (P40, clinical ethics). Some bioethics practitioners felt that they were under-solicited in areas where important ethical concerns arose: *"I wish I were more solicited/recognized by my organization; the current pandemic context probably highlights the fact that, at the organizational level, ethics were not all that well positioned pre-pandemic"* (P24, clinical and organizational ethics, translated by the authors).

Despite the above-described concerns, respondents provided mixed responses when reporting on the impact of the pandemic on their relationships with their superiors (Table 1). This suggests that strained organizational relationships were not experienced by all bioethics practitioners and that the effects of the pandemic on their working environments were multiple and varied.

The specific challenges reported by research ethicists had to do with research integrity and the ethics review of research involving humans during a time of crisis. Some respondents observed that REBs had to respond rapidly to any research touching on COVID-19, while being expected to maintain a high standard of quality in their review of the projects. Two of the six research ethicists saw this as particularly challenging. Some respondents also feared that this could result in mistrust in the function and work of REBs. As one of these respondents explained:

> *The most worrying ethical issue, in my opinion, with regards to research during the pandemic is the maintenance of the principles of research ethics and scientific integrity. There is currently a high degree of precipitation in the preparation of research projects which results from the pressure of finding solutions to the current pandemic in record time. The pandemic cannot become a justification for noncompliance.* (P27, research ethics)

Another challenge that was identified related to non-compliance of researchers to REB recommendations. Some respondents reiterated that neglecting participant protection to achieve research goals is unacceptable, even during a public health crisis.

Concerns for other groups

Clinical and organizational ethicists identified similar worries and apprehensions in their survey responses. Most of their concerns focused on the pandemic's impact on individuals, groups, or organizations other than themselves, such as patients, healthcare staff, and people in situations of vulnerability. One respondent summarized:

> *The most worrying ethical issues include the moral/emotional/psychological impacts […] that working in the pandemic will have on some health care providers, which is a concern by itself, and could lead to negative impacts on the function and sustainability of the health system overall. This is related to the extent to which health care providers have trust in the organizations within which they work, and whether they believe that the organization is truly looking out for their interests. […] Other issues which have emerged relate to restrictions on visitors, which have caused great distress for everyone […]. Even though the rationale for limiting the spread of COVID is strong, this has been a great source of concern and even harm for many.* (P19, clinical ethics)

Many other respondents expressed concerns regarding vulnerable populations, such as the deleterious effects of long-term isolation and its impact on mental health. They were also worried about the potential for further neglect of these vulnerable populations. Examples of concerns included potentially ageist (i.e., favouring younger people while seniors are more at risk of complications and fatalities) and ableist (i.e., people with disabilities being systematically disadvantaged) emergency policies or triage protocols. They were also concerned about potential breaches in the protection of patients' privacy because of the strategies adopted to quell the public health crisis. Some respondents feared the silencing of some important stakeholders in individual healthcare decisions, such as patients themselves and the patients' families. Overall, respondents saw respect for patient autonomy as important despite a greater focus on public health during the crisis.

Public health measures in response to COVID-19 sparked concerns about the side effects of these measures on the general population, such as mental health risks and the delaying of elective surgeries (25), and in turn, concerns about the ethical implications of such measures. Restrictions contributed to an increase in mental health complications and to the worsening of already existing mental health complications in the general population and in healthcare workers (26-29). Clinical ethicists reported worries surrounding the mental health of vulnerable populations. These worries were justified by knowledge of pandemic effects on mental health at the time of their response (5,28,30,31). Of course, this is not to say that public health measures were not warranted, as the threat of COVID-19 was (and still is) a major concern (30). Nevertheless, it is justified to call for better scrutiny of the psychological effects of social distancing measures on the general population and to request improved access to much-needed mental health services (26,28,30).

Respondents also expressed concerns about the psychological and moral well-being of healthcare workers. They identified mandatory overtime to compensate for staff shortages as being particularly problematic for the well-being of frontline workers. Ethicists working in healthcare facilities (mostly clinical and organizational ethicists) were concerned about potential moral distress and moral injury of healthcare staff and dreaded their exhaustion as the pandemic dragged on. They observed that this exhaustion could lead to less consideration of ethical practices and ethical issues in the work of healthcare professionals:

> *Healthcare workers and their managers don't have much time to reflect on the ethical challenges [of their practice] and to discuss them. Since the start of the pandemic, this reality has worsened*. (P14, organizational ethics, translated by the authors)

The fear of non-compliance with practice guidelines by doctors and hospital staff in the context of additional and prolonged public health measures was also identified as a potential problem for society in general. Studies pointing to a high potential for morally distressing situations during the COVID-19 pandemic (10,15,18,32) supported these concerns. The effects of moral distress on mental health and ability to work have been documented in the literature (4,32) and observed in regions heavily affected by the pandemic (33). These studies also point to the need for evaluating healthcare worker's mental health status and their experience of moral distress during COVID-19 in order to better prepare and preserve our healthcare system for future emergency situations (4). It is part of the role of clinical and organizational ethicists to help frontline healthcare workers cope with their moral or emotional distress during difficult clinical situations. This role makes them acutely aware of the suffering of frontline healthcare workers and its effect on the healthcare organization's ability to meet its commitments to patients, families, and communities. While clinical and organizational ethicists had similar concerns prior to the pandemic, they pointed out that these fears increased due to the crisis. As such, the survey responses highlighted their role in facilitating the dialogue on the needs and concerns of all stakeholders, especially the most vulnerable.

Respondents working in research ethics also noted the need to strike the right balance between protecting individual rights and promoting public health. During the beginning of COVID-19 pandemic, research participants may have been exposing themselves to risks of a new nature and magnitude due to the emergency context and the need for research and development to operate quickly in highly stressful situations (13,17). As some of our respondents pointed out, publicly declared emergencies may have also impeded informed consent to participate or undermined public trust in research (13). The need to rapidly review research protocols while also maintaining the quality of evaluation and ensuring proper follow-up of ethical recommendations can put a great deal of pressure on REBs, and thus also on research ethicists (17). The WHO (17), the Canadian Tri-Council (i.e., the TCPS2) (34), and the Canadian Association of Research Ethics Boards (CAREB) (35), among others, have published guidelines and lists of resources for maintaining good REB evaluations during a pandemic (or other emergency) in order to help research ethicists and REBs overcome these challenges and maintain the quality of research ethics evaluations.

Emotional Response

Most respondents reported a negative impact of the pandemic on their stress levels (Table 1). They explained the stress-inducing context of the early pandemic in healthcare organizations:

> *In the early stages of the pandemic, I experienced a lot of anxiety and stress around my ability to adequately respond to the needs of my organization given the gravity of the situation and the tight timelines for responses. This subsided significantly when the situation became stable; however, I anticipate that the feeling of anxiety will return when services begin to ramp up again.* (P34, clinical ethics)

> *I feel like I'm on a roller coaster where my emotions and workload are constantly and rapidly changing without me having any control over them. The imposter syndrome experienced by many clinical and organizational ethicists is even more prominent.* (P26, clinical ethics, translated by the authors)

However, many respondents expressed mixed feelings regarding the way the pandemic affected their emotional status, moods, and sense of usefulness at work. One respondent, though admitting to being in a stressful environment, said that it was outweighed by the overall benefits for their work position:

> *…the pandemic has been an incredibly positive experience career-wise. The role and status of ethics at my hospital and in the region has never been so high. My ability to stay calm and rational during highly stressful situations has been extremely valuable during this crisis. I am actually enjoying it.* (P37, clinical ethics)

Responses to questions about the challenges of working from home varied greatly. Some respondents reported difficulties achieving balance between work and other personal obligations and maintaining good relationships with their colleagues in an isolated context (n=18). Others responded that they adapted well to working from home (n=2). While some respondents reported receiving substantial support from their organization (n=4), others reported difficulties due to a poor response to their individual efforts and needs (n=15). This suggests that recognizing the importance of ethics during this public health crisis and involving ethics practitioners in the COVID response proportionate to their capacities may have positively affected the ability of some bioethicists to emotionally cope with the situation.

The negative impact of the pandemic on the stress levels of many bioethicists (Table 1) underlines the importance of promoting healthy work-life balance within organizational culture as well as addressing the professional needs for human connections in the institution (3,4). Respondents pointed out that they should not be expected to reply to e-mails or inquiries from work while they are not on shift, especially in the context of working from home, where boundaries between life and work can be blurred:

> *During crisis mode, we are expected to respond no matter the time or day, weekend or workday, and this leads to longer work days which are exhausting to maintain.* (P40, clinical ethics)

Literature points to the importance of the "home as a refuge" and ensuring staff can have moments of decompression outside of work to preserve their mental health, wellness, and capacity to work (3,31). Recommendations for good management in

healthcare organizations during COVID-19 also point out familial issues as something to keep in mind and plan around when organizing staffing of all healthcare and essential workers (4,8), including those working in bioethics.

Needed Resources

Respondents identified resources that could help them better deal with the crisis, either emotionally or in relation to their work and tasks. Academic and professional bioethics organizations could provide three of the resources identified (Table 3). Many respondents wrote that their work was isolated from their peers in other institutions, a situation worsened by the pandemic.

Table 3: Requested resources by bioethics practitioners and their domains of application

Requested Resource	Application
Increased ethics staff	Hospital resources, Human resources
National guidelines, standards of work and tools (pandemic-related)	Bioethics organizations, academic support
Informational platforms (pandemic-related)	Bioethics organizations, academic support
Peer support and organized networking	Bioethics organizations, community organization

During this crisis, many respondents mentioned that they would have appreciated more guidance on their work-related responsibilities. Clinical ethicists requested national guidelines and standards for work in bioethics, specifically for clinical ethics consultants. They believed that standardized guidelines for pandemic response would help strengthen their ethical positioning with evidence and harmonize responses between different health organizations, upholding procedural justice. Respondents from all fields of bioethics also requested platforms where they could access up-to-date, conclusive evidence from the scientific and ethics literature relevant to their practical bioethics work, which would also strengthen their recommendations.

The need for better access to scientific and theoretical bioethics literature touches on another concern that respondents identified: the lack of communication between the fields of theoretical and applied bioethics. One respondent formulated a clear criticism on this topic:

> *Relationships between those of us working in healthcare institutions and those in academic positions are strained. We are overwhelmed with work and note that our academic colleagues often speak to the ethics of our institutional practices with clear gaps in their knowledge and with no effort to connect with us to provide advice, support, or to improve their understanding of the current state.* (P30, multiple fields of bioethics)

To address this concern, respondents requested more communication means and platforms, specifically for bridging theoretical and practical (or applied) bioethics and informing each other's work. Respondents believed that bridging this gap would allow for better communication and collaboration, a better voicing of needs, a better understanding of the different realities of each field, and a better translation of theoretical findings into practical use. In clinical or policy settings, there are clear expectations for specific and actionable recommendations, which is not necessarily the case in theoretical discussions (36). Better involving bioethics practitioners in these discussions may improve the applicability of these conversations to concrete situations and ethical issues.

Academic bioethicists can assume a more critical stance regarding healthcare organizations and different policies due to their academic freedom, which is not granted to most bioethics practitioners working within healthcare organizations or government agencies. The need to consider their organization's reputation in their interventions may hinder the ability of bioethics practitioners to express their expert ethical concerns and opinions on certain situations (37-39). On the flipside, bioethics practitioners are well positioned to identify practical ethical issues in healthcare organizations, health policy, and research ethics settings. Therefore, establishing dialogue and partnerships between practical and academic bioethics could greatly benefit both groups: while practical bioethicists can be the "eyes and ears on the ground", academic bioethicists can be the voice of the bioethics community.

It is also worth noting that respondents who reported having difficulty coping with the emotional toll of the COVID-19 pandemic and its effect on their workload were also those who expressed the need for peer support.

All respondents who mentioned post-pandemic situations agreed on the need for long-term changes in the functioning of healthcare organizations (n=8). For some respondents, the pandemic only exacerbated problems in healthcare facilities. Moreover, respondents raised worries about whether healthcare organizations would be able to learn lessons from the current situation, adapt and implement a better response for future crises, or generally improve the quality of healthcare for a post-pandemic system. One respondent voiced apprehensions about the post-pandemic situation:

> *I am really concerned that the overall health care provider institutions and agencies will attempt to recreate the past normal, since they were relatively complacent with how it was functioning, or not functioning, such as mental health services and services to the homeless (major overlap there). This would be a serious mistake when there clearly is opportunity now to move in a different direction based on what we are seeing, for which evidence is beginning to emerge.* (P43, clinical ethics)

From these apprehensions, some respondents wished to see long-term changes in hospital management and practice emerging post-pandemic. However, there were concerns that changes that give a greater importance to ethical questions would not be welcomed equally in all organizations. This respondent voiced the wish to conserve their independence as an ethics consultant for their organization:

> *The pandemic offers a window of opportunity for organizational ethics in our healthcare establishments. I fear that the centralization of ethical questioning will emerge for the healthcare facilities in Québec. In my opinion, the ethics counsellor is a free electron at the service of their institution. It is not a "one size fits all".* (P25, clinical ethics, translated by the authors)

Bioethics practitioners in healthcare settings reaffirmed the need to promote their role within their organization, a task facilitated by managerial support. Respondents also pointed out that organizations should encourage transparency and allow for questions when discussing difficult situations or decisions. Literature on moral distress and its prevention supports this, as debriefing and discussing difficult clinical situations can improve healthcare workers' ability to deal with moral conflict (8,15). The goal of interventions should be to build long-term resilience by enabling staff to talk about their experiences and be at peace with decisions (4). This goal was well echoed by respondent answers on their future needs (e.g., peer support, guidelines for communication and pandemic updates), as many of their answers included wishes for expanded and enhanced networking and peer support.

Lastly, respondents indicated that ensuring proper communication between employees to maintain morale and a sense of unity within the healthcare and ethics teams was crucial during a crisis response. Indeed, maintaining frequent communication between healthcare staff, be it through debriefing sessions or peer support, is recommended to preserve staff morale and mental well-being as the pandemic drags on (7,8,14). Moreover, literature points out that not only does this need for communication apply to morale and mental health, but also to the good conduct of work duties in general. Being transparent and keeping all healthcare staff up to date on the hospital's situation, as well as their specific work responsibilities, is crucial to ensuring a proper response in this and future crises (8,14).

STUDY LIMITATIONS

The results of this study may not be fully representative of the views and experiences of bioethics practitioners across Canada. Most study respondents were from Ontario and Québec, with little or no representation from the other provinces and territories; the experiences bioethics practitioners working in rural versus urban settings, or in larger versus less populated provinces could vary substantially. This sampling bias is likely the result of the authors' professional networks and the fact that these are the two most populous provinces in the country. In addition, there was an unequal distribution of respondents across the different fields of bioethics. Clinical ethicists comprised most of the sample, along with some research ethicists, but with few or no organizational ethicists, health policy ethicists, or public health ethicists participating in the survey. As such, our results might disproportionately capture the experience of clinical ethicists as compared to other fields of bioethics. Note also that there is great variation between how different provincial healthcare systems in Canada provide and fund ethics services, which may have affected experiences and responses to this survey, complicating comparisons between bioethicists of different regions. These limitations indicate the need for a much larger and more diverse sample size to attain statistical significance. Another limitation pertains to the time of the data collection. Because the survey took place between May and June 2020, the study provides insight and understanding of how bioethicists perceived and adapted their practices during the early months of the pandemic. Further research is needed to understand how these changes have occurred over time and whether bioethicists' habituation to their new tasks, practices, and work environments has continued and improved, whether the situation has significantly changed with the various waves of COVID-19, and the new challenges these changes may have presented.

CONCLUSIONS

This study aimed to identify the challenges and concerns faced by Canadian bioethics practitioners in the early stages of the COVID-19 pandemic in 2020. At that time, emotional responses to the crisis varied greatly, regardless of respondents' field within bioethics. The study identified many factors affecting bioethics practitioners' ability to emotionally cope with and adapt to new circumstances, suggesting that these mixed responses were due to complex dynamics, both in their work environments and personal life. In addition to collecting insights for adjusting crisis responses in the future, we received valuable qualitative input on what bioethics can do as a field of study to support bioethics practitioners in their duties. We wish to emphasize the value of the qualitative responses to our survey in identifying challenges and apprehensions pointed out by bioethicists during the early days of this public health crisis.

During public health crises, bioethicists (academics and practitioners) can play important roles in identifying and reorienting situations deemed ethically inappropriate, building supportive and compassionate work environments, ensuring resilience of staff in healthcare facilities, and promoting transparent management practices (3,7,8,14,30). Ensuring appropriate responses to the ethical dilemmas and work-related stress resulting from COVID-19 is crucial since those in the healthcare sector have been disproportionately affected during the crisis (4). This is a situation where clinical ethicists can offer much-needed support. How bioethics practitioners have and will continue to negotiate pandemic-related issues will play an important role in shaping future responses to public health emergencies.

In the coming years, it will be important to keep reflecting on the lessons learned from the pandemic and assessing its long-lasting impact on the field of bioethics:

> *Will people have seen the value more so with ethics during the pandemic, which translates into them seeing how it could be helpful outside a pandemic? Or the flipside, was the ethicist role not utilized during the pandemic or was perceived to not make a clinically meaningful contribution, which will influence how people engage with ethics post pandemic?* (P41, clinical ethics)

Conducting a follow-up survey would be relevant and useful to better understand the changing views of bioethics practitioners in the aftermath of the COVID-19 pandemic.

Improving communication amongst academic bioethicists and bioethics practitioners working in different fields, as well as with healthcare providers from different fields (and even between countries), is crucial to building robust long-term solutions to future public health crises. This study has shed light on the preoccupations and challenges faced by Canadian bioethics practitioners, in the early days of a crisis. We hope these insights encourage future collaboration between bioethics practitioners and academics both in Canada and internationally.

Reçu/Received: 05/12/2021 **Publié/Published:** 9/12/2022

Remerciements
Nous tenons à remercier tous les participants aux réunions hebdomadaires organisées début 2020, qui nous ont encouragés à lancer cette étude, ainsi que tous les répondants à l'enquête pour leurs réflexions extrêmement pertinentes et sincères.

Acknowledgements
We would like to thank all the participants in the weekly meetings held in early 2020 who encouraged us to launch this study, as well as all the survey respondents for their extremely pertinent and sincere reflections.

Conflits d'intérêts
Bryn Williams-Jones est l'éditeur en chef de la *Revue canadienne de bioéthique*; Bryn Williams-Jones, Jean-Christophe Bélisle-Pipon, Vincent Couture et Charles Dupras sont membres fondateurs de la revue. Bélisle-Pipon, Couture, Dupras et Vardit Ravitsky font partie du conseil consultatif de rédaction de la revue. Aucun de ces auteurs n'a été impliqué dans l'évaluation ou l'acceptation du manuscrit.

Conflicts of Interest
Bryn Williams-Jones is the Editor-in-chief of the *Canadian Journal of Bioethics*; Bryn Williams-Jones, Jean-Christophe Bélisle-Pipon, Vincent Couture, and Charles Dupras were founding members of the journal. Bélisle-Pipon, Couture, Dupras and Vardit Ravitsky are part of the journal's Editorial Advisory Board. None of these authors were involved in the evaluation or acceptance of the manuscript.

Édition/Editors: Lise Levesque
Les éditeurs suivent les recommandations et les procédures décrites dans le Code of Conduct and Best Practice Guidelines for Journal Editors de COPE. Plus précisément, ils travaillent pour s'assurer des plus hautes normes éthiques de la publication, y compris l'identification et la gestion des conflits d'intérêts (pour les éditeurs et pour les auteurs), la juste évaluation des manuscrits et la publication de manuscrits qui répondent aux normes d'excellence de la revue.

The editors follow the recommendations and procedures outlined in the COPE Code of Conduct and Best Practice Guidelines for Journal Editors. Specifically, the editors will work to ensure the highest ethical standards of publication, including: the identification and management of conflicts of interest (for editors and for authors), the fair evaluation of manuscripts, and the publication of manuscripts that meet the journal's standards of excellence.

Évaluation/Peer-Review: Marika Warren & Christy Simpson
Les recommandations des évaluateurs externes sont prises en considération de façon sérieuse par les éditeurs et les auteurs dans la préparation des manuscrits pour publication. Toutefois, être nommé comme évaluateurs n'indique pas nécessairement l'approbation de ce manuscrit. Les éditeurs de la *Revue canadienne de bioéthique* assument la responsabilité entière de l'acceptation finale et de la publication d'un article.

Reviewer evaluations are given serious consideration by the editors and authors in the preparation of manuscripts for publication. Nonetheless, being named as a reviewer does not necessarily denote approval of a manuscript; the editors of *Canadian Journal of Bioethics* take full responsibility for final acceptance and publication of an article.

REFERENCES

1. Rocca R. Canada's 1st confirmed COVID case was reported in Toronto 2 years ago today. Global News. 25 Jan 2022.
2. Public Health Agency of Canada. Coronavirus disease (COVID-19): Prevention and risks. Government of Canada. 2020.
3. McGuire D, Germain M-L, Reynolds K. Reshaping HRD in light of the COVID-19 pandemic: an ethics of care approach. Advances in Developing Human Resources. 2021;23(1):26-40.
4. Gavin B, Hayden J, Adamis D, McNicholas F. Caring for the psychological well-being of healthcare professionals in the Covid-19 pandemic crisis. Irish Medical Journal. 2020;113(4):51.
5. Janson M, Sharkey JD, del Cid DA. Predictors of mental health outcomes in grocery store workers amid the COVID-19 pandemic and implications for workplace safety and moral injury. International Journal of Environmental Research and Public Health. 2021;18(16):8675.
6. Coccia M. Pandemic prevention: lessons from COVID-19. Encyclopedia. 2021;1(2):433-44.
7. Garg M, Wray CM. Hospital medicine management in the time of COVID-19: Preparing for a sprint and a marathon. Journal of Hospital Medicine. 2020;15(5):305-7.

8. Meier KA, Jerardi KE, Statile AM, Shah SS. Pediatric hospital medicine management, staffing, and well-being in the face of COVID-19. Journal of Hospital Medicine. 2020;15(5):308-10.
9. Spinelli A, Pellino G. COVID-19 pandemic: perspectives on an unfolding crisis. British Journal of Surgery. 2020;107(7):785-7.
10. McDougall RJ, Gillam L, Ko D, Holmes I, Delany C. Balancing health worker well-being and duty to care: an ethical approach to staff safety in COVID-19 and beyond. Journal of Medical Ethics. 2020;medethics-2020-106557.
11. Al-Hussaini M, Mansour AH, Morreim H, Zawati MH, Arawi TA, editors. Bioethics amidst the COVID-19 pandemic. Frontiers. 2022.
12. World Health Organization. Ethics and COVID-19. 2020.
13. World Health Organization. Ethical standards for research during public health emergencies: Distilling existing guidance to support COVID-19 R&D. 2020.
14. Gopal Krishnan S, Hui Siu T, Lee Lee C. Moral distress and clinician well-being. In: Tan HS, Tan MKM, editors. Bioethics & COVID-19 Guidance for Clinicians. Kuala Lumpur: Malaysian Bioethics Community; 2020. p. 94-102.
15. Morley G, Sese D, Rajendram P, Horsburgh CC. Addressing caregiver moral distress during the COVID-19 pandemic. Cleveland Clinical Journal of Medicine. 2020;ccjm.87a.ccc047.
16. Public Health Agency of Canada. Government of Canada's research response to COVID-19. 2020.
17. World Health Organization. Guidance for research ethics committees for rapid review of research during public health emergencies. 28 May 2020.
18. Dunham AM, Rieder TN, Humbyrd CJ. A bioethical perspective for navigating moral dilemmas amidst the COVID-19 pandemic. Journal of the American Academy of Orthopaedic Surgeons. 2020;28(11):471-76.
19. Park M, Cook AR, Lim JT, Sun Y, Dickens BL. A systematic review of COVID-19 epidemiology based on current evidence. Journal of Clinical Medicine. 2020;9(4):967.
20. Dupras C, Williams-Jones B. The expert and the lay public: reflections on influenza A (H1N1) and the risk society. American Journal of Public Health. 2012;102(4):591-95.
21. Dercon K, Domaradzki1 M, Elisenberg HT, et al. Lessons from the Covid-19 pandemic. A collective autoethnography of bioethics education. Research Square. 2021. doi:10.21203/rs.3.rs-376414/v1
22. Government of Quebec. COVID-19 vaccination passport. 2021.
23. Wilson J. Embracing complexity: theory, cases and the future of bioethics. Monash Bioethics Review. 2014;32(1):3-21.
24. Baker N, Dickin J, Bailey PG, James-Abra E. H1N1 Flu of 2009 in Canada. The Canadian Encyclopedia. 2020.
25. Zaidi D, Favaro A. With more than 500,000 fewer surgeries due to COVID-19, delayed surgeries cost some their lives. CTVNews. 9 Dec 2021.
26. Gori A, Topino E. Across the COVID-19 waves; assessing temporal fluctuations in perceived stress, post-traumatic symptoms, worry, anxiety and civic moral disengagement over one year of pandemic. International Journal of Environmental Research and Public Health. 2021;18(11):5651.
27. Marazziti D, Stahl SM. The relevance of COVID-19 pandemic to psychiatry. World Psychiatry 2020;19(2):261.
28. Mucci F, Diolaiuti F, Mucci N. Lockdown and isolation: psychological aspects of COVID-19 pandemic in the general population. Clinical Neuropsychiatry. 2020;17(2):63-4.
29. Pierce M, Hope H, Ford T, et al Mental health before and during the COVID-19 pandemic: a longitudinal probability sample survey of the UK population. Lancet Psychiatry. 2020;7(10):883-92.
30. Brooks SK, Webster RK, Smith LE, et al. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. The Lancet. 2020;395(10227):912-20.
31. Matias T, Dominski FH, Marks DF. Human needs in COVID-19 isolation. Journal of Health Psychology. 2020;25(7):871-82.
32. Ramji N. Compassion-fatigue and moral distress in health care during COVID-19. Voices in Bioethics. 2020;6.
33. Lai J, Ma S, Wang Y, et al. Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. JAMA Network Open. 2020;3(3):e203976.
34. Panel on Research Ethics. COVID-19 Interpretations. Government of Canada. 2020.
35. CAREB. Resources related to COVID-19 Outbreak. Canadian Association of Research Ethics Boards. 2020.
36. Wolff J. Introduction. In: Ethics and Public Policy: A Philosophical Inquiry. London: Routledge; 2019.
37. Meyers C. Activism and the clinical ethicist. Hastings Center Report. 2021;51(4):22-31.
38. Hedgecoe A. Reputational risk, academic freedom and research ethics review. Sociology. 2016;50(3):486-501.
39. Rogers W. Bioethics and activism: A natural fit? Bioethics 2019;33(8):881-89.