Ethical decision-making of social workers in Spain during COVID-19: Cases and responses

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Abstract

In this article we address the ethical decision-making processes of social work professionals in Spain during the first wave of COVID-19. We present some of the findings from a broader international research project led by professor Sarah Banks and carried out in collaboration with the *International Federation of Social Workers.*

The first wave of COVID-19 had a major impact in Spain, hitting harder the most vulnerable groups. In this unprecedented and unexpected context, social workers had to make difficult ethical decisions on fundamental issues such as respecting service-user's autonomy, prioritizing wellbeing, maintaining confidentiality or deciding the fair distribution of the scarce resources. There were moments of uncertainty and difficult institutional responses.

The broader international project was carried out using an online questionnaire addressed to social work professionals in several countries. In this article, through several specific cases, we examine the ethical decision-making processes of social work professionals in Spain, as well as the way to resolve that situations. We have used a qualitative content analysis with a deductive approach to analyze the responses and cases.

Findings show many difficult situations concerning the prioritization of the wellbeing of users without limiting their autonomy, the invention of new organizational protocols to provide support and resources for vulnerable people… Social workers had to manage the bureaucracy and had to solve some emergency situations getting personally involved or developing other cooperation mechanisms. The pandemic forced them to look for new forms of social intervention.

Keywords: Social work ethics, ethical decision-making, autonomy, wellbeing, confidentiality, fair distribution of resources, COVID-19.

Introduction

In March 2020, the entire world was hit by one of the biggest pandemics in history: that of COVID-19. The impact of this pandemic was incredibly severe, causing millions of deaths worldwide. In Spain, the exceptional situation experienced during the first wave of the pandemic shook not only the health system, but also the social system (Amadasun, 2020; Roy and Kaur, 2020). Numerous vulnerable groups were severely affected by the pandemic: elderly people living in nursing homes, immigrants, homeless people, families in situations of social exclusion, people living alone , etc.

In the early days of the pandemic, most of the anxious Spanish population sought guidance and support from health professionals, who were on the front line in hospitals, emergency rooms and health centers. However, many other people sought help from professionals in social care, who were also working on the front line, although in this case in the social field: NGOs, general or specialized social services, primary care, hospitals, homes for the elderly, community care , etc.

In May 2020, Dr Sarah Banks, in collaboration with the *International Federation of Social Workers* (IFSW) (Banks et al., 2020a, 2020b, 2020c) led an international research group to analyze the ethical challenges that arose in social work during the first wave of the pandemic. Researchers from various countries participated in this group, designing an online questionnaire (in English, French, German, Chinese, Slovenian and Spanish) to obtain relevant information on the main ethical challenges faced by social work professionals worldwide. Of the total 505 responses received, 58 were answered by social work professionals in Spain and are the ones we will analyze in this article to determine the ethical decision-making processes for those professionals. The specific cases presented, and the way in which the workers resolved the conflicts they faced, have helped us to understand which ethical aspects carried the most weight when it came to take a decision.

We have classified the ethical decision-making processes into various thematic groups related to several of the main ethical principles that traditionally govern professional social work intervention (Mattison, 2000): respect for the autonomy of patients, the pursuit of wellbeing, the maintenance of confidentiality and justice. Building on these categories we have defined the different units of analysis that can be observed in Table 1. In addition, we have also addressed some of the main difficulties and obstacles surrounding correct professional conduct within social work, as well as the influence of emotions in ethical decision-making.

Methodology

The aim of this article is not to quantify the incidence of different types of ethical challenges faced by social work professionals in Spain during COVID-19, but to obtain a qualitative view of the ethical decision-making processes in their professional practice. We want to focus on how ethical decision-making was determined, demonstrating these processes through several cases shared by the professionals themselves.

In order to study the results obtained in Spain, qualitative content analysis was used. Content analysis differs from classic document study techniques (techniques of various kinds: historical, literary, legal, sociological, political, etc.) in that it tends to mediate the personal subjectivity of the researcher (Ahuvia, 2001; Bardin, 1996; Krippendorf, 1990; Mayring, 2000). This methodology aims to replace the subjective dimensions of the study of documents or

communications with increasingly standardized procedures, which attempt to objectify and convert the contents of certain documents or communications into data, so that they can be analyzed and processed mechanically.

Design

This study was conducted using qualitative content analysis with a deductive approach. The units of analysis were the texts written by social workers in an online survey form (qualitative questionnaire), through two main questions (for more details see Banks et al., 2020a): 1) Briefly describe some of the ethical challenges you are facing or have faced during the COVID-19 outbreak. 2) Provide more details about a particular situation that you found ethically challenging. Ethical challenges were described as 'situations that give you professional cause for concern, or when it is difficult to decide on the right action to take'.

Participants

Invitations to participate were distributed electronically by the *International Federation of Social Workers* (IFSW), as well as by members of the international research team, through national and provincial associations and other professional and academic networks. Responses were received from 505 social workers from various countries, 58 of those were from Spain. Some of these responses were based on telephone interviews or video calls using the survey questions.

Of the responses obtained in Spain, almost 80 per cent identified themselves as women. More than half of them had over 11 years of experience in social work, corresponding to various different fields of social intervention (social services, NGOs, social workers in hospitals and primary care centers, social workers in elderly care homes , etc.). The respondents are not a representative sample, as this was not the aim of the research. In addition, it should be noted that respondents had knowledge of the study, access to the internet, familiarity with one of the languages in which the survey was presented, and knowledge of the term 'ethical challenges'. Members of the research team shared the task of conducting preliminary analyses of the questionnaire responses, and those in languages other than English were read and translated by native speakers. Questions concerning meaning and translation were checked within the international group.

Data analysis

The set of responses obtained through the qualitative questionnaire was processed with the Atlas.ti 8.0 software. The analysis focused on the manifest content of the answers written by the professionals themselves and on the forms of reflection generated by them (Morris, 1994; Tesch, 1990).

The data analysis was conducted in three phases. The first step of the analysis was to develop a categorization matrix based on the predefined field of ethical dilemmas (Banks and Williams, 2005) (See Table 1). To do this, three researchers reviewed the existing literature and agreed on the records units on which to base the analysis, as well as the establishment of categories. In the second phase, once these units of context and analysis had been defined, the coding categories were defined. The coding rules (presence/absence of code, frequency, weighted frequency, intensity, level of concentration) were also clarified. All text fragments were then

repeatedly read and classified according to the predefined categories. The coding scheme was tested iteratively.
In the final phase of analysis, the results were amalgamated and selected for subsequent interpretation, always considering the theoretical reference framework and the coding rules (density, frequency, weighting, intensity, etc.), which ultimately led to a series of conclusions (presented below).

Table 1. Categorization matrix

Categories	Units of analysis
Autonomy	Competence
	Autonomous beings
	Co-responsible decisions
	Decision-making capacity
	Limited autonomy
	Paternalism
	Self-determination
Wellbeing	Commitment to users
	Quality cares
	Emotional stress
	Personal involvement
	Decision-making process
	How to access and use resources
	Interruption of services
	Sanitary protection material
Confidentiality	Conflicts of interest
	Informed consent
	Integrity
	Intimacy
	Privacy
	Use of information and communication technology
Justice	Allocate and access to limited resources
	Bureaucratic obstacles
	Cooperation tools
	Responsibility to larger society
	Vulnerability

Ethical Statement

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The article is related to a broader international research conducted by Professor Sarah Banks and the IFSW *(International Federation of Social Workers)*. Professor Banks was the main researcher of that international research and it received the ethical approval of Durham University. Informed consent was obtained from all individual participants involved in the study.

Findings

The ethical decision-making processes of social work professionals in Spain during the first wave of COVID-19 can be classified into the following thematic groups: 1) Respect for autonomy. 2) Prioritization of wellbeing. 3) Breaking confidentiality. 4) Distribution of available resources. 5) The professional practice of social work. 6) The empathetic response and emotional support.

In the following section, we will focus on the main difficulties found in each of these thematic groups, recounting several specific cases that reflect the complex ethical decision-making processes carried out by the social workers in their attempts to resolve the extreme situations they faced.

Respect for autonomy

Respect for the autonomy of service users is one of the main ethical principles that guide professional interventions in social work (Sasson, 2000). Service users are autonomous beings, with the capacity to make decisions. Moreover, it is the task of social workers to strengthen their autonomy, as well as encourage them to participate in, and be co-responsible for, making decisions about aspects that concern their own lives.

However, during the pandemic, there were many occasions when this principle of autonomy was severely affected. For example, in elderly care homes, the autonomy of users had to be limited in order to prioritize their health and, therefore, their wellbeing. As we know, residential care homes were one of the places hardest hit by the pandemic. It is estimated that more than 25,000 residents died in these centers in Spain, although there are still no definitive official figures. The extreme situation led to the adoption of measures such as isolating residents in their rooms, which obviously limited their autonomy and freedom of movement. In many cases, these people endured the pandemic almost entirely in solitude and isolation, physically and emotionally distanced from the affection of their families and loved ones. In these residences, strict guidelines were enforced:

> *In general, all residential visits have been denied and residents have been confined to their room 24 hours a day as a rule, without taking account of the opinion of those residents or of the family of those that cannot give an opinion due to their personal circumstances.* (Professional 51)

One of the main enemies of the principle of autonomy is paternalism. There are many degrees of paternalism, but, in general, a situation is understood to be paternalistic when certain actions are justified for protecting the wellbeing of users, but without involving them in the decision-making. The pandemic has brought to light situations in which the professionals themselves wondered whether, sometimes, in their desperate search to help users, they were perhaps adopting an excessively paternalistic attitude, given that they were vastly limiting the freedom and decision-making capacity of users.

The social worker of a mental health occupational center spoke of the case of a woman who had gone through several residential resources but was currently living alone in a flat owned by her family. During COVID-19, the team of educators and the occupational center manager could only contact her by telephone. The woman feels lonely, anxious, wants to leave her home and wants to verbalize everything she has done during the day. During the pandemic, the number of phone calls has increased considerably, so the center agreed to limit calls to one a

day. With so many calls, the social worker has concerns as to whether she is actually taking away the autonomy of the patient and ultimately, whether she is being excessively paternalistic:

We feel that we are encouraging her obsession with the phone and that it is growing, we can't calm her down either, because she hardly listens to us on the phone, she just talks and talks non-stop... We agreed, as a team, to stand firm with the decision taken and to notify the mental health center. This causes anxieties, in this situation, we know that she is going to be admitted, but we don't want her to be admitted, because we know that this means another trauma for her. (Professional 50. Social worker in an occupational center for people with mental illness).

During the first wave of COVID-19, social workers encountered many difficulties in trying to carry out their work and provide quality care. This is how one social worker described the case of a couple who fell ill with COVID and were left without a home to return to, because they did not have a legal rental contract and the tenant did not want them to return to their flat. The social worker tried to mediate with the tenant and searched for another rented flat. The situation was very complicated because at that time people were not allowed to be out in the street and only "social emergency" resources could be granted:

A decision was made together with the patients to seek benefits, on a temporary basis, while they were in isolation. The decision is based on autonomy and the wellbeing of personal and public health. We consulted with two colleagues. The feeling was one of relief at the prospect of keeping them off the streets, but with the negative feelings of having to act so quickly with little emotional involvement. (Professional 56. Healthcare Social Worker).

Prioritize wellbeing

Prioritizing the wellbeing of users is another of the basic ethical principles in social work intervention and, even more so, in situations of vulnerability, as these are situations in which users require special attention (Beddoe and Maidment, 2014). During the pandemic, professionals were always looking for ways to overcome any difficulties, keeping in mind the user's wellbeing as a priority, when it came to ensuring their basic needs were met; whether health, food or psychological. However, some decisions came at great emotional cost. This can be seen in cases where a patient's family member has become seriously ill with COVID, and they were not allowed to go and say goodbye to them, for the sake of their own wellbeing:

I thought it was inhumane and I think the person should have been given the option to say goodbye. Later it was allowed, but at the beginning it was not. My opinion is that they didn't care about the contagion and they have been left with that pain forever, and there is no alternative (Professional 44).

On the other hand, during the pandemic, family members' contact with people living in nursing homes was very limited. They could not see each other directly, which caused great uncertainty and emotional stress for both relatives and residents. In this situation, there were cases where imaginative solutions were sought. This was reported by a social worker of a nursing home:

My decision was to create a Facebook profile from my phone, as there are no technological possibilities in public residences. Moreover, it was forbidden to use private phones. This profile was not linked to any private phone and family members and users could see and talk to each other (Professional 35).

When health safety was compromised, either in the relationship with service users or with other professionals, the decision was made to prioritize health safety over physical proximity to the user and possible spread of the virus to other professionals. To this end, technology became a good ally. A social worker who worked as a counsellor in a detention center for minors under judicial measures stated:

> *It is impossible to keep a safe distance with so little space. And the measures to contact their relatives by video-calls are insufficient and they felt low... It has been difficult, but through conversation and trying to give more minutes of calls and video-calls it has been half solved, because there are many calls* (Professional 30).

In the endeavor to cover the basic needs of service users and look after their wellbeing, many social workers found themselves becoming personally involved because they have to provide support for people in extreme vulnerability, such as families with children, with nothing to eat and no job to enable them to pay rent. One primary care social worker who managed such a case decided to try to gather information about the family by her own (non-formal) means in order to manage assistance with the food bank,

> *Civil protection delivered food and provided vouchers by telephone and in letterboxes, personally, as well as changing the butane bottle, which I did myself... On reflexion I think that, when faced with adverse and urgent situations, we social workers are capable of drawing up action and organizational protocols (without them having been previously developed by the administrations)* (Professional 10. Social worker in primary care in a small municipality).

In many extreme situations, the necessary speed of response was incompatible with administrative procedures. That is why, in some cases, social workers decided to 'skip the administrative apparatus' in order to provide quick responses. This is how a social worker in the field of violence against women described the establishment of an alternative and emergency accommodation center for sex workers who had to leave their flats, clubs , etc. These were women in an irregular situation, poor, lacking a family network, who urgently needed to be removed from the flats due to domestic abuse:

> *Deciding between speed of response and waiting for the administrative procedure: do I wait until Monday to submit a request for accommodation for a woman who is being abused or do I submit it on Friday in contradiction to the established procedure?* (Professional 13).

How can confidentiality be maintained?

Confidentiality of a user's personal information is another of the ethical pillars on which the social work profession is based (Collingridge, Miller and Bowles, 2001; Millstein, 2000). In fact, when situations of a breach of confidentiality occur, they must be entirely justifiable.

For example, a social worker who had roles both as a manager and a direct care worker, related the case of a service user with a chronic infectious disease who, during the pandemic, was going to start working with an NGO delivering food. The user asked the social worker to maintain confidentiality and not to say anything about his illness. The social worker was informed about the type of work he would be doing while volunteering and understood that he might come into contact with food that was going to be served directly from a pot. The social worker was not a specialist in this disease, but felt it was important to find out the possible consequences of being in direct contact with such food. She decided to consult a medical specialist, who told her that

if the prescribed medical treatment was not taken properly, the user could become contagious. The social worker decided to talk to the person concerned and discussed the next steps:

> *1) Interview to make him aware of what he must be willing to do. 2) Ask his primary care doctor for a report on the current state of his illness, so that he can communicate it to the NGO... If the NGO asks me for references, I will be able to share with them, in addition to his personal and professional qualities, that he is in possession of a medical report that they should know about, without adding anything else. The person finally agrees to take these steps and to be the one to inform the NGO, upon presentation of the medical report* (Professional 23).

Another major difficulty faced by social workers during the COVID pandemic was obtaining informed consent from service users. In many of these cases, as time was short, they decided to act even without consent. As one health social worker stated, when coordinating to try to locate people or relatives, they had to:

> *Constantly deal with patients' personal data, for good purposes but often without their consent... There has been no time* (Professional 15).

The necessary obligation to tele-work and resolve cases by telephone during isolation meant that in many cases they were unable to guarantee and maintain professional secrecy. It was very difficult to access particularly vulnerable people through electronic means when they themselves did not have access. The situation was even more complex in cases involving minors (whose privacy is subject to special protection). This was reported by a social worker working in child protection: although she had authorization to meet with these minors outside, the police could challenge her for this authorization, which could be upsetting for the child:

> *...Perhaps there should be a system where we can identify ourselves, in the least uncomfortable way possible and maintaining confidentiality as much as possible.* (Professional 20. Social worker in family intervention and child protection).

In cases of mental health interventions, the situation was also very complicated. A social-health worker in a mental health center reported having learned from the municipal police that an elderly person with mental health problems was disoriented and was only drinking milk. This person had no telephone and lived alone. A home visit was needed to give her food, but according to the protocol, a relative must be notified beforehand to tell her that she was going to go home. The social worker asked the psychiatrist for permission to use the information she had found in the medical records about a niece she could contact... The social worker reflected on the situation and said:

> *In an emergency situation, access to information and decision-making needs to be streamlined in order to respond to the emergency, always keeping in mind that it is in the patient's best interest* (Professional 41).

Allocation of limited resources

The difficulties in terms of the resources available for different cases (Banks et al. 2020c), some we've seen before and some new, are reported in four main areas: a) difficulties in accessing resources and in providing immediate responses, b) difficulties in dealing with bureaucratic hurdles and a lack of progress, c) doubts about how to distribute resources fairly, d) difficulties in obtaining health related information.

a) In lockdown, access to public and private resources had two main difficulties: availability and access. When one of the two failed, the professionals in question were powerless. The telephone became the only mediation tool between users and health professionals. Mediation, together with information about private resources, was the solution that social workers found to overcome the difficulties of accessing resources. This was related by a social worker working on the inclusion of applicants for international protection when describing his intercultural mediation work with a family of Sahrawi origin:

> *They went to a hospital because one of the children showed possible symptoms of Covid-19. None of the family members spoke fluent Spanish and were unable to communicate and express themselves fluently, nor were any of the health staff on duty able to understand the family's message... I had to mediate between the family and the health staff via a phone call* (Professional 33).

In urgent cases requiring immediate response, the professionals did not hesitate to use all the resources available to them, whether or not they were the usual ones or the most appropriate for the case. It was the only thing available at the time and it was urgent to provide the user with a solution.

The health crisis meant that some food distribution organizations (Red Cross, Caritas...) in some municipalities were overwhelmed. In addition to that, it was also difficult to follow the traditional system of granting and paying social emergency aid, so a system of emergency aid was established so that social workers could establish lines of credit with supermarkets to which users in need could go. Obviously, the supermarkets had to know which patients were able to shop, which could risk stigmatizing them:

> *A system is set up in which only a couple of people in the supermarket know who they are. The ethical debate is between the urgency of providing a rapid and agile response to subsistence needs and the protection of the identity of these people and the debate around stigmatization... The response, as I have pointed out, was to put the satisfaction of the subsistence needs of the families before other types of needs that usually guide our actions at a professional level* (Professional 18. Director of social services in a municipality).

b) The difficulties inherent to the management of the pandemic were accompanied by the usual bureaucratic obstacles and slow administrative processes at a time when professionals were required to manage many things without resources, with a high volume of demand and without the possibility of intervening personally. They had to work on cases remotely and, in addition to that, prioritize by means of a kind of "social triage" without resources. The solution in these cases was, for the professionals, to give the best of themselves and to get personally involved.

A social worker from the mental health network reported the case of an immigrant patient who needed emergency social assistance. As she was unable to contact the municipal social services, the social worker herself attended to the patient even though she wasn’t a patient of the hospital where she worked:

> *I made a request for an NGO to provide food (outside the municipal area where the patient resides and due to the social sensitivity of this NGO, a volunteer service delivers it to her home). I carried out weekly monitoring of the case and she was supplied with drinking water in bottles on her own initiative (given that the food bank's benefits did not include this basic good* (Professional 34).

Another social worker, an area-based officer of the Federation of Romany Associations, related the case of a family in a situation of social exclusion whose water supply had been suspended during the state of Emergency. In this situation, the family members had to go every day to fetch water from the village fountain. The Water Association of this area informed the social worker that,

> *as they are unable to take on a contract, the possibility of supplying water to the home is unfeasible. In other words, as a matter of administrative bureaucracy, they are ignoring the decrees that state that water supply companies may not suspend the supply to vulnerable or severely vulnerable consumers or those at risk of social exclusion. In this case, it was decided to seek protection from the Ombudsman* (Professional 42).

During the pandemic, health centers were prioritized over residential centers, as well as care for those most in need. An agile intervention was needed, without prior bureaucratic protocols. For this, it was sometimes necessary to develop other cooperation mechanisms:

> *On several occasions, volunteers, neighbors, third sector organizations came together, in short, interdependence through social and community cooperation was needed to overcome constraints or obstacles that stand in the way of a dignified life* (Professional 39).

c) The fair distribution of available resources is a major ethical issue, especially when resources are limited and there are many groups in need. This was raised by a social worker in municipal social services when reflecting on financial aid and the lack thereof:

> *I am finding it very difficult to decide to whom and how much I should give... Financial aid is one more tool for working with people, but it has to be accompanied by follow-up and interviews, time, and that is what we have less of right now* (Professional 12).

This social worker proposed using the minimum vital income to avoid these people having to beg and go back and forth between different institutions (basic social services, Red Cross, *Caritas*). How to prioritize some groups over others when they are all vulnerable? As a social worker focused on migrant related interventions recounted:

> *It is essential to prioritize emergency assistance (referrals) for families with children or in situations of extreme vulnerability and to offer employment to people who are in need, not necessarily to the most committed or skilled people* (Professional 32).

d) Finally, the difficulties in obtaining sanitary protection material (masks, gloves, disinfectants, hydro-alcoholic gel, etc.) was often solved by working without protection:

> *Many professionals had to work without protective equipment in order not to suspend essential services. The decision was made to work from the municipal social services attending to citizens without protective equipment* (Professional 36. Director of primary care social services).

Good professional practice

In the context of the pandemic (Muñoz-Montero, Chaves-Montero, Morilla-Luchena and Vázquez-Aguado, 2020; Redondo-Sama, Matulic, Munté-Pascual and De Vicente, 2020), the professional practice of social work was hindered by various factors: a) Difficulties in establishing a correct diagnosis and applying protocols. b) Difficulties in following up on cases and working as a team. c) Difficulties in obtaining institutional responses. d) Finally, the extreme situations that professionals had to deal with also led to a reflection on the role of social work as a profession.

a) The difficulties in establishing a correct diagnosis were dealt with on a case-by-case basis, using the means available at the time. When the diagnosis has to be made by telephone or video call, the information received by the professionals is much less than in a regular home visit and, furthermore, there is a risk of assuming information or data is trues when it is untrue, or only partially true. A social worker from a community social services center put it this way:

> *I have considered that I am not doing social work as such, and I have even had negative thoughts about the profession, seriously considering leaving my job and doing something else. Because we are working blind and, in my case, (I have been in this center for two months) I don't know the patients, which makes every decision I make even more difficult* (Professional 8).

b) The professionals also had to overcome difficulties in order to follow-up on the cases. A social worker in migration intervention, when describing the conflicts and problems of coexistence that a patient had had with other patients in the same program, emphasized the added difficulty of monitoring the case from a distance. Under these conditions, it was impossible to continue mediation work, so that, with the data available, the social worker had to make a difficult decision, feeling that the entire burden of the intervention was falling on her:

> *The decision was to not go for an ordinary extension due to non-compliance with the social contract, as well as the lack of engagement with therapy, lack of involvement in other areas, etc. In this case, I felt that the responsibility for taking a negative decision fell on me and, despite consulting with coordination and central services, in a way, I did not feel supported enough.* (Professional 32).

The isolation also seriously undermined teamwork between different professionals from different institutions. This meant that many decisions had to be taken alone:

> *During the health crisis, we have not been able to work much as a team. We had our own fears of death and contagion and didn't have the possibility to ask questions*. (Professional 25).

c) On other occasions, practitioners faced many difficulties in obtaining institutional responses. On these occasions they opted to take on cases themselves and seek the best possible solution:

> *As if she were one of my patients, as long as my organization allows me to do so and does not raise any objection, given the lack of response from the municipal bodies, I made a request for an NGO to provide food (outside the municipal area where the patient resides and due to the social sensitivity of this NGO, a volunteer service delivers it to her home). I carried out weekly monitoring of the case and she was supplied with drinking water in bottles on her own initiative (given that the food bank's benefits did not include this basic good. The patient expressed her gratitude and was reassured by the professional intervention carried out. The conclusion is as follows: out of professional ethics I took on the case (direct care and the need for support from a third person), even though it was not within my current institutional competencies.* (Professional 34)

d) The fact of having had to make such far-reaching ethical decisions in such extreme conditions provoked various reflections on the social work profession, its role in society and on the need for improvement and self-criticism. One social worker in social services management referred to a certain "resistance to change" on the part of the professionals themselves, as well as the need for innovation:

There is the possibility to re-invent oneself. Adapting to change is a characteristic of social work. Have we been able to adapt? Have we learned anything from this? Can we incorporate new strategies for the future? (Professional 54).

One of the great concerns that traditionally underlies social work is that it has become a purely bureaucratic and wellbeing-oriented job. The essence of social work goes beyond the mere management of certain benefits, but in those days of the pandemic, the most wellbeing-oriented part of the profession came to the fore: distribution of food, benefits management, emergency aid... One of the main objectives of social work is to improve people's quality of life, but this must be achieved by accompanying people in this process. The pandemic has further highlighted the impossibility of accompanying people in their journey and has provoked a reflection by the professionals themselves on the meaning, role in society and purpose of social work:

We need to work from a horizontal perspective. But nothing could be further from reality... We are increasingly immersed in a bureaucratized system with a lack of human resources that makes it complicated to implement the guidelines set out in the theoretical models (Professional 58. Social worker in primary care social services).

How can we continue to carry out our work without it being merely wellbeing-based? I understand that basic needs must be covered for those who do not have them, but there is 'no time' to do other kinds of work... We must carry out social interventions in a very neat manner. Reorganization of social services rather than the privatization of social services. (Professional 40. Social worker accompanying people at risk of marginalization).

The empathetic and supportive emotional response

In addition to reason, emotions also play an important role in ethical decision-making. Therefore, to conclude this article, we would like to reflect briefly on how social workers have felt emotionally when faced with such exceptional situations as those brought about by the "first wave" of COVID-19 and how these emotions have influenced their decision-making. As a professional who worked in health support and coordination said:

I became aware of the seriousness of the health and social crisis, the magnitude of the crisis and the need for far-reaching decisions, as we were dealing with life and death. I discussed it with some colleagues. Reality was imposing itself. I cried (Professional 49).

The extreme conditions of the pandemic caused stress, uncertainty, frustration, anxiety, anger... (Peinado, 2020). The harsh situation they experienced meant that, in many cases, they struggled with their own contradictory emotions, torn between the need to help and the fear of becoming infected by the coronavirus:

I feel that we haven't given it our best, at the distance... and it makes me feel uncomfortable and ashamed... But on the other hand, I feel more protected at home.... It's complicated (Professional 7. Mental Health Social Worker).

Finally, the feeling of "helplessness" was experienced by the majority of social workers. One of their main concerns was to provide service users not only with material resources, but also with empathy and as much emotional support as possible. However, they were not always able to achieve this and this gave the social workers a feeling of helplessness. A social worker from a CEAS (Social Action Centre) related the case of an elderly person with Alzheimer's disease

who needed to be admitted to a residential center, but the conditions of the pandemic prevented this:

It was only possible to contain the situation and provide emotional relief through psychological support by telephone and referral to the primary care doctor and/or specialist to assess the adjustment of medication for the person with Alzheimer's, until we can reopen the Alzheimer's Day Centre or give access to public places in residential centers. I felt helpless at first, although the response provided has been positive. Contact with the family is possible so the patient feels supported and we are able to improve care for the person with Alzheimer's and the quality of life of the family unit by providing emotional support throughout the confinement (Professional 5).

Discussion and conclusion

The first wave of COVID-19 posed serious difficulties for social work professionals in Spain, both in terms of the traditional ethical principles of social work (autonomy, wellbeing, confidentiality) and in terms of the fair distribution of resources and correct professional practice.

In Spain, as in other countries, social workers had to face many ethical challenges: *maintaining trust, privacy, dignity and service user autonomy in remote relationships; allocating limited resources; balancing rights and needs of different parties; deciding whether to break or bend policies in the interests of service users; and handling emotions and ensuring care of self and colleagues* (Banks et al, (2020 a). In this context, as we have seen throughout this article, ethical decision-making processes were particularly complex.

Conflicts between autonomy and wellbeing have traditionally been one of the main roots of ethical dilemmas in professional social work. Respect for autonomy and the pursuit of wellbeing are two of the fundamental pillars of social interventions. During the pandemic, the autonomy of many patients (in homes for the elderly, for example) was limited or reduced. In these cases, social work professionals faced complex situations and at times had to implement institutional norms and guidelines that limited the patients' autonomy and to carry out interventions while trying to avoid paternalistic approaches.

As for the health and wellbeing of the patients, this was one of the main objectives in the minds of the professionals. They sought all possibilities to meet the basic needs of their patients and to prioritize health and safety. As we can see also from a global perspective (Banks et al, 2020 b), social workers had to balance service user needs against personal risk to social workers and others.

In some cases, this meant taking decisions as hard as advising a person not to provide support to a family member infected with COVID-19 (with the emotional cost that this entailed). In many cases, social workers became personally involved in cases in order to find solutions to ensure the wellbeing of their patients.

With regard to patients' confidential information, the difficult working conditions caused by the pandemic (lack of personal contact) made this impossible in many cases, as it was very difficult to access the necessary information online and to communicate it (in most cases by telephone) in a totally secure and reliable way. The situation was similar in other countries (Banks et al, 2020 b; Banks et al 2020, c)): it was very difficult to create and maintain a trust relationship via phone or internet and to ensure the privacy of the conversations. In other cases,

the urgency of the situation meant that action had to be taken without the explicit consent of the persons concerned.
Another complex ethical decision-making situation was deciding how to distribute the available resources as fairly as possible. In all the countries resources were unavailable and, in that situations, social workers had to decide how to prioritize service users demands (Banks et al, 2020 b). In many cases, professionals had to struggle with administrative bureaucracy, both trying to obtain health supplies and processing emergency aid for the most vulnerable people.
The pandemic also pushed social work professionals to reflect on the role of social work and its aims. They had to go to great lengths and look for imaginative solutions in order to carry out basic social work, such as providing a correct diagnosis and monitoring cases. With regard to the role of social work, there is consensus that the profession should go beyond mere assistance or granting benefits.
Finally, the first wave of COVID-19 led to a wave of (often contradictory) emotions among social work professionals. The main struggle was to overcome fear, anger and helplessness in the face of serious situations that went beyond the scope of their professional intervention. The emotional conflict was the same in all the countries (Banks et al, 2020 b): social workers had to handle emotions, fatigue, self-care… They also struggled to provide patients with as much empathy and emotional support as they would like.
In short, we can conclude by stating that the responses of the professionals we interviewed were, in some cases, in line with their professional experience and, in others, showed the courage of those social workers who refused to leave the most vulnerable people without assistance. Obviously, not all cases and needs could always be fully addressed, but there is no doubt that the professionals made every effort to meet the many new needs caused by the pandemic. Finally, it is also worth noting that the serious situation experienced in Spain has served to showcase social work as an essential and indispensable profession for the maintenance of our wellbeing state.

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